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 Intellectual Disabilities (ICF/ID) 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/ID 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

The work that the Lubbock State Supported Living Center (LBSSLC) staff do after each of the Monitoring Team's reviews to compare the Monitoring Team's findings with the Facility's findings, and modify actions plans, as necessary, shows a commitment to continuous quality improvement and has resulted in positive changes. As the Monitoring Team witnessed during the Quality Assurance/Quality Improvement (QA/QI) Council meeting held during the onsite review week, LBSSLC staff were in the process of developing a quality assurance system that continued to expand the data available to allow identification of strengths as well as weaknesses. Ultimately, such a system will result in the Facility's

ability to make corrections along the way across all of the essential programmatic and clinical areas. LBSSLC staff were doing this to varying degrees currently, and from the Monitoring Team's conversations with the executive leadership team, they were fully committed to expand these efforts. During this review, the Monitoring Team saw evidence of this commitment in the corrective action plans the Facility staff developed and presented. These plans represented thoughtful approaches to addressing difficult issues, such as medication variances and reduction in the use of pre-treatment sedation. The Monitoring Team encourages the Lubbock team to continue its efforts to make sure the data it collects is valid and reliable, as well as useful in telling Facility staff what they need to know, and then responding to problems identified in a measured and interdisciplinary manner.

It was clear that tremendous work went into preparing for and organizing the Monitoring Team's review, and the Monitoring Team is very appreciative of all of these efforts. During the week of the onsite visit, the Monitoring Team had a number of productive meetings with the Section Leads and other staff during which details of the Facility's progress as well as plans for future efforts were discussed. As always, the Monitoring Team thanks Facility staff for their time and commitment, as well as the individuals that welcomed us for sharing their time and homes with us.

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

<u>Restraints</u>

- Restraint use continued to decline with the use of innovative ideas, such as boat cushions to protect staff from aggression and the regrouping of some homes to reduce the peer-to-peer tensions that had been identified.
- Individuals with traditionally high restraint usage had shown declines as well.
- A prototype of an order for schedule and type of monitoring for medical and dental restraints was developed in March 2014, and nurses were trained in its use. Evidence of review of medical restraints could now be found in Morning Provider Meeting Minutes.
- A workgroup had developed a Corrective Action Plan (CAP) to address desensitization issues. This CAP offered a workable approach to sorting out the issues involved in determining who could benefit from some support to accept dental and medical procedures, and which specific procedures require some form of desensitization procedure. The Facility should continue to work through the desensitization issues and discover what interventions will work best for individuals.
- An area on which the Facility should continue to work is on the documentation of medical/dental restraints to get that process flowing smoothly.

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

- The Executive Safety Committee continued to refine its working process for reviewing complex data streams and identifying trends, issues, and individuals in need of focused attention. The data presentations were comprehensive and useful, and the committee's efforts were demonstrating how data could drive decision-

making. The committee discussion included comparison of data on falls and injuries against risk levels to question why injury experience for some individuals was high, when risk levels appeared low. Other discussions included referrals to IDTs of individuals who appeared to be having increased injuries or increased restraints to assure that actions were being taken to interrupt negative trends before they became more serious.

- The injury audit procedure was in place and while not uncovering many instances of failure to report serious injuries, the process was identifying issues with documentation in observation notes and in logs that needed attention.
- Recommendations were being made in almost every investigation report and tracked to completion.
- Although late reporting might occasionally occur, when it does occur, DFPS and the Facility need to make recommendations, and the Facility needs to act on the recommendations to prevent recurrence to the extent possible. When late reporting occurred during this review period, DFPS and the Facility did not react with an appropriate recommendation(s). It will be important for the Facility to determine why, on occasion, staff are not reporting suspicions of abuse, neglect, and exploitation immediately. When in doubt, staff should report, and allow the investigation process to determine the facts.
- Now that the system was in place for investigating possible abuse and neglect, it will be critical to be continuously vigilant with quality monitoring to insure that the processes in place stay vigorous and there is consistent follow-up on recommendations from investigations to help prevent abuse and neglect from happening in the first place.
- Some additional attention should be directed to monitoring the quality of the outcomes achieved as a result of recommendations from investigations.

<u>Quality Assurance</u>

- 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 Facility's progress in developing key indicators had moved forward using a thoughtful process aimed at engaging disciplines in identifying outcome measures for the performance of the Facility. This process provided an excellent example of how to discover the indicators that will be practical, yet ambitious measures of the Facility's progress. That this process had progressed to the stage of presenting data summaries to the QA/QI Council was remarkable. It was further remarkable that many of the key terms had been defined, and some of the methods for collecting data established. Benchmarks and goals had been set for indicators. While there is much more to do in this regard, such as identifying methods to assure the accuracy and reliability of data, the process had been established to create outcome measures and a workable system for evaluating progress going forward.
    - The sophistication of CAPs had continued to progress with committees devoted to CAP development, such as the Medication Variance group and the Desensitization group, both of which were examples of engaging people across disciplines in problem-solving for specific issues, identified through data analysis.

- The Executive Safety Committee 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.
- The number of Section Leads who reported on quality in their opening remarks and in discussions with Monitoring Team members throughout the onsite review week suggested that a Facility-wide system for evaluating and enhancing quality was emerging.

- Some of the areas that will need to continue to improve for the Facility to progress toward substantial compliance with the Settlement Agreement included:
  - Additional work was needed on development of CAPs and evaluating the outcomes to assure they accomplish the original goals.
  - Additional work was needed on the key indicators to assure the accuracy and reliability of data and to find ever-improving ways to analyze the issues that emerge from the data. 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.
  - 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.

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

- 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.
  - ISP meetings were generally being held annually and justification was provided for those that were not. Individuals newly-admitted to the Facility usually were having ISP meetings within 30 days of their admission. In addition, final ISP documents were generally being completed within 30 days of the meetings.

- The QIDP Department had added a number of components and reminders to the ISP Meeting Guide. These were positive additions that served to ensure teams discussed important aspects of individuals' preferences and strengths, as well as their supports and treatments, and the progress or lack thereof. For example, prompts were included for the team to review last year's actions plans, assessment recommendations relevant to a variety of areas, and preferences and strengths that supported individuals' goals. In addition, the LBSSLC ISP Meeting Guide included prompts for the teams to discuss the Psychiatric Treatment Plan/Psychoactive Medication Treatment Plan, guardianship prioritization, the Individual Activity Card (IAC), and enteral nutrition.
- The Facility had made progress in its efforts to develop and implement a system to train staff on the necessary components of the ISPs, but tracking this training to identify when all relevant staff had completed it was still a work in progress.

- 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 developed an outline for an Assessment Quality Checklist, and worked with discipline leads to individualize the checklist for their assessments. At the time of the onsite review, the audit forms had been finalized, and in June 2014, discipline leads began reviewing the assessments for a sample of four records each month. The next steps were aggregating and analyzing the data from these reviews to determine what action was needed.
  - Since the last review, the QIDP Coordinator had developed a Facilitation Skills Performance Tool, undated. The Facility submitted a list showing that 13 out of 15 QIDPs had been deemed competent using this tool. 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. However, based

on interview with the QIDP Coordinator, the Facility's goal was to begin completing integrated monthly reviews in August 2014. The monthly review would become a rolling document located in the shared drive into which each discipline would enter progress notes for the programs/supports for which they were responsible.

Integrated Clinical Services

- The Medical Department was able to demonstrate integrated clinical services at the morning provider meeting. Attendance by clinical and Facility departments was tracked. As of May 2014, all met a 90 percent attendance level, except the Qualified Intellectual Disabilities Professional (QIDP) Department representative. This meeting was effective and efficient in processing acute care information, hospitalization updates, consultation reports and updates of consultation status, closure to areas determined by the providers as needing review, and post-hospital Individual Support Plan Addenda (ISPAs). Several departments had specific days of the week scheduled to provide routine updates. Tracking occurred for any concern needing closure. Consults were reviewed and recommendations completed in a timely manner, or justification was documented. The consult tracking system was thorough.
- The completion of closure concerns, such as ISPAs for clinical areas identified at the morning provider meeting, needed further support from Facility Administration, as timeliness was a concern. Additionally, the primary care practitioners (PCPs) were only recorded as attending 36 percent of the post-hospital ISPA meetings, a meeting in which their clinical expertise was needed to guide the Interdisciplinary Team (IDT) in decision-making.
- Reviews of Integrated Health Care Plans (IHCPs), including those from recently developed ISPs, 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 hospitalization or Emergency Room (ER) visit.

Minimum Common Elements of Clinical Care

- For Section H, the Facility provided information indicating 80 percent of annual medical assessments were completed timely, and 90 percent of the most recently completed sample were timely. Ninety percent of quarterly medical reviews were completed in a timely manner. Over 99 percent of Quarterly Drug Regimen Reviews (QDDRs) had been completed in a timely manner. There was insufficient reliable data to determine timely completion of annual dental assessments. Several departments still had challenges filing the completed assessments 10 days prior to the annual ISP meeting. Completion rate for the most recent month of data (April 2014) indicated 41 percent compliance with the Medical Department, 50 percent with Psychiatry, and 64 percent with the Nursing Department.

- For specific diagnoses, the Medical Department had a mature internal QI system for assessing standards of care according to national standards. The Facility's self-assessment activities indicated sustained compliance. The internal QI system to review abnormal test results/change of status concerns appeared to have only recently been implemented, with the earliest data recorded from 4/22/14. The number of abnormal results, or abnormal results for a specific test was not determined and the adequacy of the sample size could not be determined. There needed to be evidence of monthly audits with an adequate sample size, with quarterly trend analysis, and demonstration of the QI process, similar to the other audit tools the Medical Department currently completed.
- 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, it was positive that the internal quality review system had begun to include 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.
- A number of policies were approved reflecting minimal common elements of clinical care for various aspects of health care and health services. The basic State Office policy for Section H, with adaptation to the SSLC, was not listed as having been approved or implemented.

<u>At-Risk Individuals</u>

- Since the last review, there had been a change in the Section Leads for Section I, including the Assistant Director of Programs (ADOP) and the Program Compliance Nurse (PCN). During the review, the Monitoring Team had some very promising discussions with the Section Leads regarding the various systems that constitute and feed into the overall At-Risk process as well as how the different disciplines, not just nursing, contribute to the integrated processes and systems addressing the at-risk population.
- Based on training records from Competency Training and Development (CTD) Department, the Facility's Self-Assessment indicated that 99.1% of relevant staff had completed training on the Facility's At-Risk procedure.
- Although from the ISP meetings the Monitoring Team observed during the onsite review some positive changes were noted, significant issues continued regarding the accuracy of the risk levels, the reflection in the Integrated Health Care Plans (IHCPs) of supports with 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.

Psychiatric Care and Services

- Since the last review, there had been significant changes in the staffing of the Department of Psychiatry. A previous staff Psychiatrist had become the Director of Psychiatry, after the departure of the previous Director. The Facility had been able to add a new full-time Psychiatrist, so there were two full-time Psychiatrists who were both Board Certified, as was the Consulting Psychiatrist, who continued four hours per week to update the Comprehensive Psychiatric Assessments (CPAs). In addition, the full-time Psychiatric Nurse continued to be a valuable asset and the Psychiatric Clerk position also had been filled.
- The CPA completion rate continued at 100 percent, and the Psychiatrists had attended the ISPs of the individuals they followed at a monthly rate of 100 percent, except for February, when it dropped to 92 percent. The problems with ISP documentation identified in the Monitoring Team's prior report had been rectified through close cooperation with the ISP team.
- Over the prior six months, eight individuals had been admitted to the Facility, all of whom had significant psychiatric and behavioral issues. For these individuals, community supports available had been insufficient to meet their needs. As might be expected, these individuals were admitted on multiple psychotropic medications. One individual had been prescribed seven psychotropic medications, while others had been prescribed five psychoactive medications. The Psychiatrists had begun to carefully decrease these medications. The rate of active polypharmacy had increased from 14 to 16 percent, which was in large part due to previously admitted individuals who had been there for greater than one year, migrating from the New Admissions category to the Active Polypharmacy List.
- The Psychiatrists had begun to perform the Dyskinesia Identification System: Condensed User Scale (DISCUS) evaluations themselves, rather than have the nurses perform them. These examinations were done in conjunction with the Quarterly Psychiatric Reviews.
- The rate of chemical restraint for the most recent six-month period was significantly less than the prior six-month period, despite the admission of eight individuals with problematic behavioral presentations in this timeframe. The Psychiatrists had begun to increase the routine daily medications for individuals who appeared to be entering the manic phase of their Bipolar Disorder and then decrease the dose after the crisis had passed. This was a reasonable clinical intervention, which might have contributed to the decrease in frequency with which chemical restraint was used at the Facility. There also had been an improvement in the quality of the review of the chemical restraint documentation by the Clinical Pharmacist and the Psychiatrist.
- During the Monitoring Team's onsite review, Facility staff presented the new initiative to improve the process of developing Desensitization Plans and other strategies to reduce the need for pre-treatment sedation for medical and dental procedures. The Facility had gathered together a multi-disciplinary team to reformulate and improve this initiative from the ground up.

Psychological Care and Services

- Since the Monitoring Team's last review, Behavioral Health Specialists' progress in their pursuit of certification as Board Certified Behavior Analysts (BCBAs) continued as three Specialists had completed coursework and supervision requirements and planned to take the BCBA exam in August 2014. However, a personnel change within the Behavioral Health Services Department resulted in the reduction of BCBAs from six to five. Other changes in this Department included the promotion of the former Director and the hiring of a qualified internal BCBA as the new Director. The ongoing supervision of the new Director by the former Director appeared likely to maintain continuity of psychological care throughout the Facility.
- Although the internal peer review process continued to reflect consistent, ongoing, and active review of behavioral programming, the previously noted progress evidenced through external peer review did not maintain since the Monitoring Team's last visit. That is, consistent monthly external peer reviews did not occur, thus evidencing less than satisfactory maintenance of ongoing critical review.
- The Facility's continued efforts were noted in promoting more accurate data through more rigorous monitoring of the data collection system. However, concerns were noted with how this data was monitored through the use of Monthly PBSP Progress notes. That is, concerns remained with regard to the adequacy of operational definitions for replacement behaviors, consistency between the notes and the current PBSP, consistent inclusion of inter-observer agreement (IOA) data, and the timeliness and adequacy of review.
- Progress was noted in updating psychological assessments using the Behavioral Health Assessment format. As previously noted and currently observed, the majority of scores from standardized tests of intelligence and tests of adaptive behavior remained outdated. However, since the Monitoring Team's last visit, the Facility reinitiated completion of standardized test of intelligence as well as adaptive behavior. Indeed, standardized test of intelligence and/or tests of adaptive behavior were completed for 21 individuals.
- A decline in the number of Structural and Functional Assessment (SFA)/ Structural and Functional Assessment Report (SFARs) updated annually was noted. In addition, almost half of the individuals residing at the Facility still had SFAs completed in the outdated format. Continued efforts are required to update these assessments using the most current format and to ensure their adequate completion, including emphasis on ensuring descriptive assessment methods, functionally equivalent replacement behaviors, and the consistent incorporation of data.
- Documentation revealed that all newly admitted individuals had a psychological assessment completed within 30 days of admission. However, several were incomplete, utilized the previous format, and/or contained outdated tests of intelligence and adaptive behavior.
- Since the Monitoring Team's last visit, the Facility had made efforts to upgrade the counseling Skill Acquisition Programs (SAPs). These revisions were an improvement compared to previously reviewed documents. The next step, as the Facility identified, was to ensure an adequate data collection system (i.e., use of counseling data cards), including ongoing monitoring of progress.

- Progress in the development of quality PBSPs continued to be noted. Indeed, the Facility was successful in maintaining progress in ensuring that PBSPs were written so that direct support professionals could understand them effectively. However, concerns were noted with regard to the quality of operational definitions for replacement behaviors, identification of functionally equivalent replacement behaviors, and inclusion of baseline data for target and replacement behaviors, as well as the need to conspicuously identify if SAPs were in place (or not) to teach replacement behaviors and provide clarity and specification with regard to reducing the intensity of interventions.
- The overall quality of the graphic display of data that was observed at the Monitoring Team's last visit continued to be noted. However, concerns were evident with regard to the availability of up-to-date data, accurate data (especially as identified in quarterly psychiatric notes), and the integration of IOA data in monthly PBSP notes.
- A member of the Monitoring Team's direct observation of staff training on a PBSP reflected elements of effective competency-based training. However, review of provided documentation led to concerns with regard to the adequate documentation of staff training on PBSPs, the timeliness of these trainings, the annual training of PBSPs, and, based on this documentation, concerns regarding adherence to the guidelines for PBSP Competency-Based Training.

<u>Medical Care</u>

- Timely preventive screening and tracking remained a strength of the Medical Department for mammograms, colonoscopies, cervical cancer screening, and DEXA scan completion. Timeliness of quarterly medical reviews had achieved 90 percent. Nutritional assessments provided the needed information concerning dietary and supplemental intake of calcium, as well as daily intake of Vitamin D. The morning provider meeting was efficient and effective and tracked the necessary clinical concerns identified through that meeting. A system was in place to follow through with recommendations for the administrative death reviews. However, although progress had been made with regard to closure of mortality review recommendations, the information presented did not address the recommendation in several cases. The medical services policy and procedure manual appeared to be comprehensive and up-to-date.
- Legibility was a concern, both in the written orders from the PCPs, and in the Integrated Progress Notes (IPNs), which were also dictated but not immediately available in the record. Internal quality review of abnormal tests/findings or change of status had begun recently, and a larger sample size was needed, along with assistance from the QA Department in developing a robust QI process for this aspect of clinical care. At the morning provider meeting, there appeared to be less emphasis on the PCPs providing a synopsis of current tests completed with results and plans formulated when discussing a change of health status. This would provide assurance of the identification of the clinical steps to be implemented that day, as well as provide needed information to the attendees of the meeting. The morning meeting would benefit from assuring this component of interdisciplinary discussion occurred for acute health issues.

Nursing Care

- Since the last review, nursing staffing continued to be a significant challenge for the Facility. As of May 2014, 82 out of 102 (80%) nursing positions were filled, and 67 of the 102 (66%) positions were direct care nursing positions. At the time of the Monitoring Team's onsite review, of the 67 direct care nursing positions, 49 (73%) were filled. As a result of these staffing challenges, the Facility indicated that since the last review, a total of 251 shifts fell below minimum staffing requirements due to the vacant nursing positions, extended sick leave, regular sick leave, and workman's compensation cases. Agency nurses and overtime hours were utilized to fill all the shifts that fell below the minimums staffing requirements.
- In April 2014, the Facility revised the Infection Control data reliability process to include a review of the Pharmacy's monthly antibiotic usage and a daily review of physicians' orders for antibiotics, antivirals, antifungals, and/or anti-parasitics to increase the reliability of the Facility's Infection Control data in order to accurately identify the Facility's trends related to infectious and communicable issues.
- Since the last review, the Facility focused much effort in reviewing the Facility's immunization database to verify if all immunizations, boosters, and titers were current and available in the records. The results of the review were being shared with the RN Case Managers for further follow-up and collaboration with physicians regarding immunization data that were not current.
- The Competency Training Department (CTD) staff continued to present a weekly report of the Emergency drills to the Incident Management Committee. The data indicated that of the 124 total drills conducted 118 (95%) were deemed as passing, which was a very positive finding.
- The Facility established a workgroup that developed a very specific and comprehensive Corrective Action Plan (CAP) addressing the Facility's medication systems with the goal of ultimately reducing the number of medication variances. At the time of the Monitoring Team's onsite review, the Facility had already held a number of Medication Systems CAP meetings, and was in the process of extensively examining all the Facility's medication systems, as well as implementing a number of steps contained in the CAP.
- Although the Facility had made some positive steps forward in the areas noted above, an overall lack of progress continued regarding 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 Reviews. Unfortunately, since the last review, the challenges in stabilizing the nursing coverage due to staff turnover continued to be a problem, and slowed the Facility's momentum in making measurable progress in many of the crucial areas affecting individuals' healthcare.

Pharmacy Services and Safe Medication Practices

- The Pharmacy continued to demonstrate an effective system of processing new orders. QDDRs were timely and appeared thorough. Adverse drug reaction training was up-to-date. There was a thorough internal QI system to review the results of the new order process, the components of the quarterly drug regimen reviews, the timely

response by the PCPs and psychiatrists to the recommendations, as well as the pharmacy review of chemical restraints.

- Medication variances remained a challenge. It was recently discovered that the data reports generated actual individual medications involved in variances rather than tracking them as events. However, information could be gained from both these approaches to database management. The Pharmacy indicated there were few unknown excess returned medications, and the concern was unexplained medication returns. The reason remained a challenge. Since the Monitoring Team's previous visit, an extensive corrective action plan had been implemented to address medication variances.

Physical and Nutritional Supports

- 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. 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 PNMT assessments included the necessary components. Additional work needed to be done to integrate PNMT recommendations and plans into individuals' IHCPs.
- The Facility continued to implement significant revisions in the Mealtime Procedures training curriculum with an emphasis on dining plans and Home Procedures as well as other initiatives. However, during this review, the percentage of mealtime observations that showed correct implementation of dining plans fell to 53% from 81% compliance during the last review. Of additional concern was the fact that although two of the homes in which problems were noted during the Monitoring Team's onsite review had CAPs in place, the CAPs were developed only after they had not met mealtime monitoring thresholds for seven of eight months (i.e., Fir) and/or eight of eight months (i.e., Violet). It was positive that onsite discussions with the Active Treatment Coordinator and Safety Officer showed a commitment to ameliorate mealtime errors observed during the onsite review, and the observations completed with the PNMT OT, PTA, RN, and the Monitoring Team showed adherence to PNMPs for positioning, transfers, and alternate positioning plans. However, adherence to mealtime plans is an essential component in reducing individuals' risks to the extent possible.
- The Facility had implemented a comprehensive physical and nutritional management (PNM) foundational training program for new employees and veteran staff. Mandatory PNM foundational annual refresher training continued to be implemented. New employees and veteran staff had successfully completed PNM foundational performance check-offs. The Facility therapists had identified 29 individuals who required Physical and Nutritional Management Plan (PNMP) individual-specific training. There was a sustainable system developed and implemented for the provision of individual-specific training for staff.

- 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 for individuals on their caseloads. However, an essential piece was missing in that IHCPs did not include measurable goals based on clinical indicators. As a result, it was difficult to determine the effectiveness of plans.
- The IDTs reviewed individuals in the sample who received enteral nutrition. 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. At the time of the review, none of the individuals' IDTs had recommended a return to oral eating or that individuals receive enteral nutrition in a less restrictive manner.

<u>Physical and Occupational Therapy</u>

- The eight individuals recently admitted to the Facility had Occupational Therapy Physical Therapy (OT/PT) assessments completed within 30 days of admission. Individuals' OT/PT assessments included the necessary assessment elements.
- A sample of three individuals receiving direct OT and/or PT interventions had therapy plans. However, 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 been integrated into individuals' ISPs for three of four individuals.
- Competency-based training for the implementation of PNMPs was consistently being provided.
- 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. However, as Section P.4 explicitly states: "…the Facility shall develop and implement a system to monitor and address… 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." Although a policy existed for monitoring treatment interventions, it was not fully implemented yet.

<u>Dental Services</u>

- For Section Q, Facility staff reviewed the databases and determined the information appeared not reliable and unverifiable. This problem was identified prior to the Monitoring Team's visit. At the time of the Monitoring

Team's visit, steps had been taken to begin development of a reliable database system for dental services. A new Dental Director recently had been hired to assist in developing quality dental services with quality database management.

- An area of focus should be teaching and monitoring oral hygiene in the residences. Two extensive CAPs had been developed since the Monitoring Team's last visit, one for dental desensitization, and one for suction tooth brushing. It was positive that the Facility had taken this comprehensive approach to addressing issues in both areas. These remained in an early implementation phase.

Communication

- 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 (AAC) to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.
- Eight 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.
- 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 two individuals with an AAC system in the sample.
- The Facility had policies/procedures related to monitoring communication supports provided to individuals. However, individuals' communication supports had not been monitored per Facility policy, and more work was needed to analyze and respond to the data.

Habilitation, Training, Education, and Skill Acquisition Programs

- Continued efforts to support the development of quality SAPs were noted. These efforts included interdisciplinary efforts at developing of a new SAP format and data sheet, revisions of SAP quality rubrics, and revision and development of curriculum/instructional guides as well as substantial trainings. Indeed, sampled SAPs revealed that those completed using the new format appeared of higher quality. Noted improvements included a more comprehensive behavioral objective, and more specification with regard to generalization and maintenance, prompting and fading, and error correction. In addition, newer SAP formats included more detail with regard to the rationale for the SAP. At times, however, these descriptions were found to be excessive and convoluted. Currently, only a small percentage of SAPs, including those designed for dental and/or medical desensitization, were developed using the most current format. Consequently, as the Facility progresses toward revising current SAPs, the majority of SAPs remained inadequate. In addition, consistent with findings of the

Monitoring Team's previous reviews, the adequate daily data collection as well as adequate and timely monitoring of skill acquisition data was not evident.

- Given the excessive demands on the Integrated Program Developers (IPDs), the Monitoring Team encourages the Facility to closely examine the nature of this position and determine if additional IPDs are necessary to ensure adequate development and implementation of SAPs. In addition, the Monitoring Team continued to encourage the State Office to provide more oversight to ensure that ongoing changes reflect improvements in quality of programming as well as sustainable change, including closely examining the current SAP format, data sheets and monthly progress note formats.
- The Facility's efforts to improve the SAP QA Rubric also were noted. However, the usefulness of this rubric in consistently estimating the quality of SAPs had not been established due to the lack of inter-rater reliability checks. Consequently, the Facility should initiate these checks as well as consider the limitations in reporting combined scores. Similar inadequacy in conducting inter-rater reliability checks on the use of the Vocational Assessment Quality Checklist, Preferences and Skills Inventory (PSI) Assessment Quality Checklist, and Functional Skills Assessment (FSA) Grading Tool were noted as well.
- Estimates of engagement appeared significantly lower compared to previous estimates. More specifically, based on data collected during brief visits to program and residential sites, overall engagement was 43%. Consistent with observations during the Monitoring Team's previous visits, the staff-to-individual ratios observed in some settings were concerning, including inadequate staff-to-individual ratios that appeared to impair active engagement or participation in more structured opportunities for skill acquisition. Since the Monitoring Team's last visit, however, the Facility had revised the engagement rubric and initiated engagement probes by both QA and Active Treatment staff using the same engagement tool.
- Ongoing efforts to improve opportunities for on-campus and community-based employment continued. However, significant declines in attendance at day programs were reported. As a result, the Monitoring Team encourages the Facility to develop and implement a formal comprehensive corrective action plan targeting improved attendance at day programs.

<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. When team members modified the opinions they had included in their assessments, generally no explanation was provided.
- 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 addition, these systemic issues appeared to have an impact on LARs' willingness to

consider transition to the community, and it was not clear that Facility and/or Local Authority staff were equipped to offer options to illustrate that sufficient supports could be offered in a community setting. For example, Individual #22's LAR expressed concerns about a referral to the community. One of her stated concerns was his going to jail if he moved to the community. Based on the documentation in the ISP, instead of providing the LAR with an explanation of the types of supports that could be in place in a community setting to protect Individual #22 and address his behavioral issues, the Local Authority staff "explain[ed] in Lubbock if consumers with a diagnosis of IDD or Behavioral health goes to jail, they are not placed in the general population, there is a separate population."

- Although teams were identifying obstacles to referral, 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.
- With regard to education of individuals about community options, most individuals had a plan in their ISP, and progress was made in that a couple of the plans were individualized. More work was needed, but 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.
- 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.
- As noted in the last report, four individuals that had transitioned to the community since the Settlement Agreement was signed had returned to the Facility, and two of these individuals were in jail before returning. Since then one individual returned from community placement due to police contact to address behavioral issues, and another individual, who had transitioned to the community in September 2011, also returned due to behavioral issues; and one death occurred following community placement. 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. On a positive note, the Incident Management Coordinator was planning to assist the Admissions Placement Department with reviews.
- Although it was clear that efforts were being made to conduct thorough post-move monitoring, the Post-Move Monitor needed to review all evidence listed as necessary in the CLDP and base findings on the supports as written. Reports submitted identified few issues, but the Facility had followed up on the few issues that were identified.

<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 a consulting group reviewing a revised

draft. 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, the ISP template included a section to prompt the team to discuss the potential need for guardianship. These discussions generally were not based on objective data.
- The updated prioritized list, dated 6/11/14, included names of 58 individuals served by LBSSLC. At the time of the review, Lubbock supported 204 individuals, of whom approximately 28% were estimated to need guardians, and 72% were identified as having guardians. Although it was unclear how individuals' lack of capacity to make decisions had been determined, based on the list, 36 individuals had a Priority I need for guardianship, 18 individuals were in the Priority II category, and four were in the Priority III category.
- LBSSLC had continued to work mostly with the families of individuals whose teams had identified a need for a guardian. Since the Monitoring Team's last review, these efforts had resulted in guardians being appointed for four individuals, with another five 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 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, for most months during the review period, at least five audits were being completed of records each month. The exception was when a new Unified Records Coordinator was hired. These audits were identifying a number of problems with the records. Although at the time of the last review, the Facility had taken steps to formalize the process for requesting corrective actions related to specific record reviews, a decision had been made to review and revise the process to make it more efficient. In addition to finalizing an individual record corrective action process, 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.
- The Unified Records Coordinator continued to provide a training session as part of New Employee Orientation. The new Unified Records Coordinator made changes to the presentation to include more written exercises, practice completing observation notes, discussion about the various tabs in the Active Record, as well as practice using the check-in and check-out sheet. These appeared to be good, practical modifications to the curricula that addressed some common documentation problems.

- LBSSLC had a working system for policy and procedure development and the completion of related training. Specifically, as noted in the last report, 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.

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 DADS Policy #001.2, dated 4/4/14;
o Positive Behavior Support: Limitation of Restraint, dated 5/8/14;
o Facility's list of processes to monitor the use of restraint (TX-LB-1407-II.3), undated;
o Do Not Restrain List, undated;
o List of Restraint Monitors, undated;
o List of all restraints, from 12/1/13 through 5/31/14;
o List of Individuals Restrained Off Grounds, from 12/1/13 through 5/31/14;
o Presentation Book for Section C;
o Handouts from the Incident Management Review Team (IMRT) meeting of 7/9/14;
o Completed Monitoring Tools for Section C, May 2014;
o Behavioral Services and QA Meeting Notes for Section C, December 2013 to June 2014;
o Self-Assessment for Section C, dated 6/20/14;
o Action Plans: Section C, dated 6/18/14;
o Minutes of the Quality Assurance/Quality Improvement (QA/QI) Committee, for November 2013 through April 2014;
o Executive Safety Committee: Addressing September 2013 through February 2014, revised 4/2/14;
o Executive Safety Committee: Addressing October 2013 through March 2014, revised 4/29/14;
o Executive Safety Committee: Addressing December 2013 through May 2014, presented 7/10/14.
o Injuries to Staff During Use of Restraint, from 6/15/13 through 5/14/14;
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:
<table>
<tr><th>Sample</th><th>Name</th><th>Date and Time</th></tr>
<tr><td>C1.1</td><td>Individual #288</td><td>3/5/14 at 8:16 a.m.</td></tr>
<tr><td>C1.2</td><td>Individual #288</td><td>3/5/14 at 8:34 a.m.</td></tr>
<tr><td>C1.3</td><td>Individual #288</td><td>3/5/14 at 8:24 a.m.</td></tr>
<tr><td>C1.4</td><td>Individual #288</td><td>3/5/14 at 8:29 a.m.</td></tr>
<tr><td>C1.5</td><td>Individual #288</td><td>3/5/14 at 8:38 a.m.</td></tr>
<tr><td>C1.6</td><td>Individual #27</td><td>1/13/14 at 11:46 a.m.</td></tr>
<tr><td>C1.7</td><td>Individual #27</td><td>3/8/14 at 5:02 p.m.</td></tr>
</table>
</td></tr>
</table>

C1.8	Individual #131	3/12/14 at 4:45 p.m.
C1.9	Individual #131	4/23/14 at 5:25 p.m.
C1.10	Individual #131	4/23/14 at 5:29 p.m.
C1.11	Individual #134	3/29/14 at 9:41 p.m.
C1.12	Individual #134	3/29/14 at 9:42 p.m.
C1.13	Individual #124	2/2/14 at 9:05 p.m.
C1.14	Individual #91	12/28/13 at 3:39 p.m.
C1.15	Individual #91	4/22/14 at 8:09 a.m.
C1.16	Individual #220	1/17/14 at 2:34 p.m.
C1.17	Individual #40	12/17/13 at 7:42 a.m.
C1.18	Individual #60	2/4/14 at 8:53 p.m.
C1.19	Individual #4	5/14/14 at 4:02 a.m.
C1.20	Individual #4	5/14/14 at 4:25 a.m.
C1.21	Individual #4	5/14/14 at 4:45 a.m.
C1.22	Individual #155	3/13/14 at 9:00 a.m.
C1.23	Individual #85	2/1/14 at 7:59 a.m.
C1.24	Individual #85	2/1/14 at 8:19 a.m.
C1.25	Individual #239	5/8/14 at 6:15 a.m.
C1.26	Individual #38	5/9/14 at 8:02 a.m.
C1.27	Individual #143	5/23/14 at 12:00 p.m.
C1.28	Individual #251	1/12/14 at 4:36 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	3/5/14 at 8:16 a.m.
C1.14	Individual #91	12/28/13 at 3:39 p.m.
C1.28	Individual #251	1/12/14 at 4:36 p.m.

- **Sample #C.2**: A small sample of the training records of 12 employees was examined to determine if they had been trained in a timely basis on use of restraint and PMAB techniques;
- **Sample #C.3**: Medical Restraints: From the list provided in response to document request II.7, a sample of six 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 #113	2/1/14 at 12:00 p.m.
C3.2	Individual #113	2/16/14 at 12:00 p.m.
C3.3	Individual #165	2/26/14 at 8:30 a.m.
C3.4	Individual #165	2/26/14 at 6:00 p.m.
C3.5	Individual #191	4/6/14 at 9:55 p.m.
C3.6	Individual #164	3/11/14 at 11:45 a.m.

- **Sample #C.4:** Chosen from II.7 in response to the document request. The total number of chemical restraints for crisis intervention was six. Sample size was three, or 50%. Note that these are also part of Sample #C.1 above 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
C1.12	Individual #134	3/29/14 at 9:42 p.m.
C1.21	Individual #4	5/14/14 at 4:45 a.m.
C1.24	Individual #85	2/1/14 at 8:19 a.m.

- **Sample #C.5:** For restraint used off-grounds, a sample of three or 100% of the off-grounds restraints. The following documentation was requested: the Restraint Checklist, face-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.

Name	Off-grounds Restraint
Individual #7	2/24/14 at 5:15 p.m.
Individual #31	4/17 at 7:10 p.m.
Individual #7	5/17/14 at 7:29 p.m.

- For Section C.4, Positive Behavior Support Plans (PBSPs), as available, for: Individual #70, Individual #154, Individual #213, Individual #235, Individual #73, Individual #68, Individual #167, Individual #254, Individual #280, Individual #273, Individual #241, and Individual #320;
- For Section C.4, Desensitization plans as identified SAPs or PBSPs, as provided, for: Individual #51, Individual #38, Individual #264, Individual #272, and Individual #109;
- For Sample #C.6, three individuals who were restrained more than three times in a 30-day period were selected from the list of individuals restrained as crisis intervention between 12/1/13 and 5/31/14. Restraint records were requested, including Crisis Intervention Restraint Checklists, Crisis Intervention Face-to-Face Assessment and Debriefing Reports, Crisis Intervention Plans (CIPs), Individual Support Plans (ISPs), ISP Addendums (ISPAs),

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:

	Name	Date and time	Type
C6.1	Individual #288	3/5/14 at 8:16 a.m.	Physical
C6.1		3/5/14 at 8:24 a.m.	Physical
C6.1		3/5/14 at 8:29 a.m.	Physical
C6.1		3/5/14 at 8:34 a.m.	Physical
C6.1		3/5/14 at 8:38 a.m.	Physical
C6.2	Individual #131	4/16/14 at 1:00 p.m.	Physical
C6.2		4/16/14 at 3:51 p.m.	Physical
C6.2		4/16/14 at 4:14 p.m.	Physical
C6.2		4/23/14 at 1:56 p.m.	Physical
C6.2		4/23/14 at 5:25 p.m.	Physical
C6.2		5/23/14 at 5:29 p.m.	Physical
C6.3	Individual #124	2/26/14 at 7:40 p.m.	Physical
C6.3		2/26/14 at 8:33 p.m.	Physical
C6.3		3/8/14 at 7:42 p.m.	Physical
C6.3		3/8/14 at 8:19 p.m.	Physical

- List of individuals restrained as crisis intervention ("All Categories of Restraints – 12/1/13 through 5/31/14);
- Summary listing "Crisis Intervention Restraint Plans" (TX-LB-1407-VIII.13);
- Nursing Restraint documentation from the Restraint Checklists, Interdisciplinary Progress Notes, and Client Injury Reports for the following individuals:
  - Individual #288 on 3/5/14 at 8:16 a.m.;
  - Individual #27 on 1/13/14 at 11:46 a.m., and 3/8/14 at 5:02 p.m.;
  - Individual #131 on 3/12/14 at 4:45 p.m., and 4/23/14 at 5:25 p.m.;
  - Individual #134 on 3/29/14 at 9:41 p.m.;
  - Individual #124 on 2/2/14 at 9:05 p.m.;
  - Individual #91 on 12/28/13 at 3:39 p.m., and 4/22/14 at 8:09 a.m.;
  - Individual #220 on 1/17/14 at 2:34 p.m.;
  - Individual #40 on 12/17/13 at 7:42 a.m.;
  - Individual #60 on 2/4/14 at 8:53 p.m.;
  - Individual #4 on 5/14/14 at 4:02 a.m.;
  - Individual #155 on 3/13/14 at 9:00 a.m.;
  - Individual #85 on 2/1/14 at 7:59 a.m.;
  - Individual #239 on 5/8/14 at 6:15 a.m.;
  - Individual #38 on 5/9/14 at 8:02 a.m.;

- Individual #143 on 5/23/14 at 12:00 p.m.;
- Individual #7 on 2/24/14 at 5:15 p.m., and 5/17/14 at 7:29 p.m.; and
- Individual #31 on 4/17/14 at 7:10 p.m.

- **Sample #C.7: Protective Mechanical Restraints to Prevent Self-Injurious Behavior (PMR-SIB):** This sample was chosen from the list of Protective Mechanical Restraints, submitted in response to Document Request II.7. One individual was 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	Type
C7.1	Individual #242	1/1/14	Protective/Mechanical
C7.2	Individual #242	3/1/14	Protective/Mechanical
C7.3	Individual #242	5/1/14	Protective/Mechanical

- **Interviews with**:
  - Libby Allen, Facility Director;
  - Jim Forbes, M.Ed., BCBA, Assistant Director of Programs (ADOP);
  - Rodney McWilliams, Incident Management Coordinator (IMC);
  - Beckie Crawford, Director of Behavioral Services;
  - Dawn Ripley, Director of Quality Assurance;
  - Stephanie Brasfield, Director of Residential Services;
  - Brandi Villarreal, RN, BSN, Chief Nurse Executive (CNE);
  - Lilly Burton, RN, Program Compliance Nurse (PCN); and
  - Informal interviews/conversations with staff and individuals.
- **Observations of**:
  - Quality Assurance/Quality Improvement Council, on 7/7/14;
  - Unit I and II Morning Meeting, on 7/9/14;
  - Incident Management Meeting, on 7/9/14;
  - Executive Safety Committee, on 7/10/14;
  - Visits to Residences #513, #514, #515, #516, #528, and #504S; and
  - Visit to the large workshop.

Facility Self-Assessment: The Lubbock State Supported Living Center Self-Assessment indicated the Facility was in substantial compliance with nine 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 6/20/14, 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. In February 2014, the Department of Behavioral Services began using the QA tool, allowing for determination of inter-rater reliability. ▪ 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, reviews of policies, and IMRT and Executive Safety Committee meeting notes. ▪ 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. However, the Department/QA monthly meeting notes indicated that discussion was underway to modify the guide. ▪ The following staff/positions were responsible for completing the audit tools: The Program Compliance Monitor from the Quality Assurance Department worked collaboratively with the Department staff, designated to conduct the audits. One Department staff position had been identified to conduct the reviews. ▪ Inter-rater reliability was being computed beginning with February data, and was generally scoring above 90% ▪ The Facility used some relevant data sources, and had begun to include some key indicators/outcome measures in addition to its audit data. The Facility used information from its training database, reviews of restraint use as seen on the video monitoring to detect use of prone restraint, and review of data on restraint as recorded in AVATAR. ▪ The Facility consistently presented some of the data in a meaningful/useful way. The Facility: 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; and 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 four provisions that were in substantial compliance during the last review. Progress was noted in a number of areas. Highlights of progress included: ▪ Restraint use continued to decline with the use of innovative ideas, such as boat cushions to protect staff from aggression and the regrouping of some homes to reduce the peer-to-peer tensions that had been identified. ▪ Individuals with traditionally high restraint usage had shown declines as well. ▪ A prototype of an order for schedule and type of monitoring for medical and dental restraints was developed in March 2014, and nurses were trained in its use. Evidence of review of medical restraints could now be found in Morning Provider Meeting Minutes. ▪ A workgroup had developed a Corrective Action Plan (CAP) to address desensitization issues. This CAP offered a workable approach to sorting out the issues involved in determining who could benefit from some support to accept dental and medical procedures, and which specific procedures require some form of desensitization procedure. 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: ▪ Continue to work through the desensitization issues and discover what interventions will work best for individuals. ▪ Continue to work on the documentation of medical/dental restraints to get that process flowing smoothly. ▪ Keep a close watch on all restraint documentation to assure that it follows procedures and that restraints are reviewed by the Incident Management Review Team (IMRT) and followed up by the Interdisciplinary Teams (IDTs).

<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,</td><td>Data the Facility provided showed:

<table>
<tr><th>Type of Restraint</th><th>6/1/13 to 11/30/13 (Six months)</th><th>12/1/13 to 5/31/14 (Six months)</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>227</td><td>157</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>23</td><td>7</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>250</td><td>164</td></tr>
</table></td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

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.

TOTAL individuals restrained in behavioral crisis	26	28
Of the above individuals, those restrained pursuant to a Crisis Intervention Plan	7	8
Medical/dental restraints	24	39
TOTAL individuals restrained for medical/dental reasons	9	7
Protective Mechanical Restraints for SIB	178	182
Total individuals restrained for PMR/SIB	2	1

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. Direct Support Professionals were not queried on prone restraints during this site visit. Previous visits indicated that staff were well aware of the prohibition on the use of prone restraint and knew they should release an individual immediately, should he/she move into a prone position.

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 28 of the 28 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others.

#	Provision	Assessment of Status	Compliance
		▪ g. For the 28 restraint records, a review of the descriptions of the events leading to behavior resulting in restraint found that 28 (100%) contained appropriate documentation that indicated that there was no evidence restraints were being used for the convenience of staff or as punishment. ▪ h. In 28 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. ▪ j. Based on the review of 25 restraints, involving 16 individuals, 25 (100%) were approved restraints. The remaining three restraints in Sample #C1 were chemical restraints, which also were approved for use at the Facility. k. In 28 of these records (100%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. 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. 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 restraint records involving the 16 individuals in Sample #C.1 were reviewed. Of these, four of the individuals had Crisis Intervention Plans that defined the use of restraint. a. For the four individuals who had Crisis Intervention Plans, there were six restraints that were not chemical and did not involve an escape from restraint. Of those six, six (100%) included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Crisis Intervention Plan. b. For the twelve individuals who did not have Crisis Intervention Plans, there were nine restraints that were not chemical and did not involve an escape from restraint. Of those nine, nine (100%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Based on this review, the Facility was in substantial compliance with this provision. The Facility found the same in its self-assessment.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The Facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. a. Review of the Facility's training curricula revealed that it included adequate training and competency-based measures in the following areas: ▪ Policies governing the use of restraint; ▪ Approved verbal and redirection techniques; ▪ Approved restraint techniques; and ▪ Adequate supervision of any individual in restraint. b. A sample of 11 current employees was selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that: ▪ Eleven of the 11 (100%) had current training in RES0105 Restraint Prevention and Rules. ▪ Eleven of the 11 (100%) had completed PMAB training within the past 12 months. Since this was a small sample, past history of training was not requested. The training reports indicated the percentage of staff completing training had been high for many months. c. Responses to the following questions were not collected from 10 direct support professionals since this was a small sample and these questions have routinely been answered appropriately. ▪ What policies govern the use of restraint? (___%); ▪ Describe two verbal or redirection techniques (___%); ▪ Describe two approved restraint techniques. (___%); and ▪ How would you supervise an individual in restraint? (____%). d. In 28 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. Based on this review, the Facility was in substantial compliance with this provision. The Facility found the same in its self-assessment.	Substantial Compliance
C4	Commencing within six months of	a. Based on a review of 28 restraint records (Sample #C.1), in 28 (100%) there was	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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 12 individuals who had PBSPs was identified. This sample was selected from those individuals who had an ISP meeting within the past six months, with two exceptions (i.e., Individual #241 and Individual #320), as well as from those who were rated at medium or high risk with regard to behavioral health (on the Integrated Risk Ratings summary, dated 6/10/14). Based on the PBSP Master List, dated 7/9/14, this sample of 12 individuals reflected 10% of total number (N=117) of active PBSPs. Of the 12 PBSPs reviewed, in 12 (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 28 of 28 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. In reviewing four ISPs for individuals for whom restraint had been used for the completion of medical or dental work (i.e., Sample #C3): ▪ g. One (25%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent). That one was Sample #C3.6. At the time of the current visit, it appeared the Facility had re-initiated its efforts at developing dental and medical desensitization programs. More specifically, since the Monitoring Team's last visit, the Facility established a Desensitization Workgroup to	

#	Provision	Assessment of Status	Compliance
		develop and implement a formal corrective action plan (CAP) to address desensitization issues preventing residents from receiving treatment. This was an inter-disciplinary group that initially worked to generate a list of individuals with desensitization issues and identify a small sample of individuals (N=15) to pilot developed processes. This included an effort to gather information from IDTs, as submitted through Interim Desensitization Referrals. Additional efforts included the development of probe questions and ultimately a questionnaire to gather data about the pilot group to determine their needs as related to desensitization and inform decisions regarding the form of intervention (e.g., IDT action plan, SAP, PBSP, desensitization plan). On May 15, 2014, the QA/QI Council approved the formal CAP. The CAP included efforts at developing procedures that would help IDTs in determining the appropriate action based on an individual needs (within the pilot group), but would also provide guidance to IDTs regarding individuals not in the pilot group. Ultimately, through the recommendations of the workgroup and the input and decision-making of the IDTs, individualized treatments plans were developed for 11 individuals within the pilot group. According to documentation, the workgroup examined the quality of these plans prior to their implementation (on 6/1/14), and planned to conduct ongoing monthly review of data trends to determine if progress was being made. Provided documentation indicated that desensitization programs could include behavioral strategies within formal SAPs, PBSPs, and/or other more informal strategies or supports (as prescribed within the ISP) that might increase the likelihood of an individual completing routine medical or dental exams or diagnostic testing. The Workgroup developed training materials to help IDTs as well as plan developers identify the most appropriate methods to employ to teach tolerance and decrease the need for use of restraint and sedation. This also included instructions and examplars developed to support the development of quality PBSPs and SAPs. In addition, it appeared that the Workgroup provided recommendations to IDTs who ultimately determined whether or not a desensitization plan was necessary and, if so, what form the plan would take. Ultimately, according to the provided summary documentation, plans for 11 individuals within the pilot group appeared to be currently implemented. Based on documentation, these plans appeared to include strategies outlined within PBSPs and/or SAPs. It should be noted that less formal strategies, also identified by IDTs and implemented for some individuals within the pilot group, were not reviewed. In an effort to examine the nature of these supports, a sample of formal plans recently developed for five (45%) of the 11 individuals from the pilot group were examined. This included two PBSPs (Individual #38 and Individual #264) and three SAPs (Individual #51, Individual #272, and Individual #109). As discussed with regard to Section S.1 of the Settlement Agreement, although sampled SAPs targeting desensitization appeared to be an improvement compared to those previously reviewed, the majority of those SAPs	

#	Provision	Assessment of Status	Compliance
		currently sampled were still determined to be inadequate. However, one of the SAPs currently reviewed, a medical/dental desensitization SAP recently developed for Individual #51, was found to be acceptable. As discussed with regard to Section K.9 of the Settlement Agreement, sampled PBSPs with integrated desensitization strategies targeting behaviors relevant to clinical appointments, although straightforward and relatively simple, were still found to be insufficient. That is, concerns regarding inadequate operational definitions, lack of specificity with regard to specified treatment, and/or prescribed data collection were observed. It should be noted that these sampled plans had been very recently implemented and collected data, if available, was not provided. These findings were consistent with the findings for other sampled PBSP and SAPs currently reviewed. Overall, although these plans appeared to be a substantial improvement compared to strategies previously reviewed, given that only a small number of revised desensitization plans have been developed, it continued to be unlikely that the majority of desensitization plans were currently promoting growth, development, and independence across most individuals served at LBSSLC. Based on this review: ▪ h. One of the five (20%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint. This included the SAP for Individual #51; and, ▪ i. Zero of five (0%) 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, and appropriate authorization for completion of medical and dental work.	
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	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, 31 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 28 restraints in Sample #C1. Based on a review of 28 restraint records (Sample #C1), a face-to-face assessment was conducted: ▪ d. In 28 out of 28 incidents of restraint (100%) by an adequately trained staff	Noncompliance

#	Provision	Assessment of Status	Compliance
	document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	member. ▪ e. In 25 out of 28 instances (89%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. In Samples #C1.6 and C1.16, the restraint monitor arrived in 20 minutes. In Sample #C1.28, the time of arrival of the restraint monitor was not recorded. ▪ f. In 28 instances (100%), the documentation showed that an assessment was completed of the application of the restraint. ▪ g. In 27 instances (96%), the documentation showed that an assessment was completed of the consequences of the restraint. Records that did not contain documentation of this included: o Sample #C1.6, where the description of the consequences in the Face-to-Face Assessment indicated there were no injuries, yet in the Restraint Checklist the nurse indicated there was an injury to the individual and indicated a Client Injury Report was filed. 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 18 restraint records for 15 individuals for restraints that occurred at the Facility (i.e., Individual #288, Individual #27, Individual #131, Individual #134, Individual #124, Individual #91, Individual #220, Individual #40, Individual #60, Individual #4, Individual #155, Individual #85, Individual #239, Individual #38, and Individual #143), there was documentation that a licensed health care professional: ▪ j. Conducted monitoring at least every 30 minutes from the initiation of the restraint in 16 (89%) of the instance of restraint. Records that did not contain documentation of this included: Individual #124 on 2/2/14 at 9:05 p.m., and Individual #239 on 5/8/14 at 6:15 a.m. ▪ k. Monitored and documented vital signs in 16 (89%) episodes. Records that did not contain documentation of this included: Individual #124 on 2/2/14 at 9:05 p.m., and Individual #4 on 5/14/14 at 4:02 a.m. ▪ l. Monitored and documented mental status in 17 (94%) episodes. Records that did not contain documentation of this included: Individual #124 on 2/2/14 at 9:05 p.m. Based on documentation the Facility provided, three restraint episodes for two Individuals had occurred off the grounds of the Facility in the last six months (i.e., Individual #7 and Individual #31). A licensed health care professional: ▪ m. Conducted monitoring within 30 minutes of the individual's return to the	

#	Provision	Assessment of Status	Compliance
		Facility in all three (100%). ▪ n. Monitored and documented vital signs in all three (100%). ▪ o. Monitored and documented mental status in all three (100%). Sample #C3 of six medical/dental restraints (four individuals) was selected from the list of 39 reports involving seven individuals who had medical restraint between 12/1/13 and 5/31/14, representing 57% of the individuals for whom medical restraint was used. (Sample #C3 is defined above in the Documents Reviewed section.) One record was eliminated since it appeared the entry into AVATAR was in error, leaving a sample of five records. For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. ▪ p. In four out of five (80%), the physician specified the schedule of monitoring required, or in one case (sedation for a mammogram), it was understood that the schedule was the one on the Restraint Checklist. The one that did not was Sample #C3.5, where there was no indication of the schedule of checks to be made of the abdominal binder. ▪ q. In four out of five (80%), the physician specified the type of monitoring required if it was different than the Facility policy. The one that did not was Sample #C3.5. ▪ r. In two out of five of the medical restraints (40%), 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 10:45 a.m. to 4:30 p.m., though there was no physician's order for that schedule and no form specifying monitoring every two hours. o Samples #C3.5, where an abdominal binder was used and monitored every two hours for circulation. However, there was no order for that schedule and nothing in the policy to indicate that was the appropriate schedule. o Sample #C3.6, where the monitoring schedule for sedation as outlined on the Restraint Checklist was not followed. 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 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	A sample (Sample #C.1) of 28 Restraint Checklists for individuals in crisis intervention	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	restraint was selected for review. The following compliance rates were identified for each of the required elements: ▪ a. In 28 (100%), continuous one-to-one supervision was provided; ▪ b. In 28 (100%), the date and time restraint was begun; ▪ c. In 28 (100%), the location of the restraint; ▪ d. In 28 (100%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint; ▪ e. In 28 (100%), the actions taken by staff prior to the use of restraint to permit adequate review per Section C.8. ▪ f. In 28 (100%), the specific reasons for the use of the restraint ▪ g. In 28 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; ▪ h. In 28 (100%), the names of staff involved in the restraint episode; ▪ In the 25 instances of physical restraint, observations of the individual and actions taken by staff while the individual was in restraint, including: o i. In 25 (100%), the observations documented every 15 minutes and at release; o j. None of the restraints lasted more than 15 minutes, so the specific behaviors of the individual that required continuing restraint past 15 minutes did not need to be recorded; 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. ▪ l. In 28 (100%), the level of supervision provided during the restraint episode; ▪ m. In 28 (100%), the date and time the individual was released from restraint. n. Based on a review of 18 restraint records for 15 individuals for restraints that occurred at the Facility (i.e., Individual #288, Individual #27, Individual #131, Individual #134, Individual #124, Individual #91, Individual #220, Individual #40, Individual #60, Individual #4, Individual #155, Individual #85, Individual #239, Individual #38, and Individual #143): ▪ In all 15 episodes (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. Based on documentation the Facility provided, three restraint episodes for two Individuals had occurred off the grounds of the Facility in the last six months (Individual #7 and Individual #31): ▪ In all three episodes (100%), the results of assessment by a licensed health care	

#	Provision	Assessment of Status	Compliance
		professional as to whether there were any restraint-related injuries or other negative health effects was appropriately documented. o. In a sample of 28 records (Sample #C.1), restraint debriefing forms had been completed for 26 (93%). The documentation that was present, but incomplete included: ▪ Sample #C1.13, where the debriefing form was largely illegible; and ▪ Sample #C1.18, where the debriefing form contained minimal information. p. A sample of four individuals subject to five medical restraints was reviewed (Sample #C.3), and in two (40%), 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. The three that did not were samples #C3.1, #C3.5 and #C3.6. Sample #C.4 was selected using the list the Facility provided of individuals who had had chemical restraint since the last onsite review. It was noted that the use of chemical restraint was down from 23 uses in the period of June 2013 through November 2013 to seven uses in the period of December 2013 through May 2014. This was a substantial drop, and it was not clear whether it was the result of policy changes in definitions or an actual drop in use. The Monitors will comment on the restraint policy changes in future reports. This sample of three individuals who were the subject of a chemical restraint was reviewed: q. In three (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.	
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 December 1, 2013 and May 31, 2014, a total of six individuals were placed in physical restraint more than three times in any rolling 30-day period. Of these six individuals, a	Noncompliance

#	Provision	Assessment of Status	Compliance
		random sample (Sample #C.6) of three of these individuals (reflecting a sample of 50%) 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. It also should be noted that ISPA for Individual #131 that the Facility provided appeared to have a "Decision/Recommendation" section (on the last page) that appeared cut-and-pasted from another individual's document. Consequently, information on this page was assumed to be inaccurate. Lastly, as discussed below with regard to Section C.7.f of the Settlement Agreement, integrity data appeared to cut-and-pasted across several individual's reports as well. Implications for the current review are noted below. 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 three instances (100%), 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: ▪ An ISPA dated 3/14/14 indicated that the IDT for Individual #288 met and discussed the five physical restraints that occurred on 3/5/14. Given that a Crisis Intervention Restraint Plan (dated 12/10/13) appeared to be in place at the time of the restraints, the timing of the IDT review appeared adequate. 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). ▪ An ISPA dated 3/19/14 indicated that the IDT for Individual #124 met and discussed the two and two physical restraints that occurred on 2/26/14 and 3/8/14, respectively. Given that a Crisis Intervention Restraint Plan (dated 8/26/13) appeared to be in place at the time of the restraints, the timing of the IDT review appeared adequate. 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).	

#	Provision	Assessment of Status	Compliance
		○ An ISPA dated 4/17/14 indicated that the IDT for Individual #131 met and discussed one, one, and two physical restraint(s) that occurred on 4/1/14, 4/15/14, and 4/16/14 (1:00 p.m. and 3:51 p.m.), respectively. This ISPA, however, did not reflect that the IDT identified and discussed the third of three restraints that occurred on 4/16/14 (4:14 p.m.). This final restraint occurring on 4/16/14 was one of six randomly selected restraints identified within the current sample (as detailed above). It should be noted that, in addition to the three restraints on 4/16/14, the Monitoring Team identified and selected two restraints that occurred on 4/23/14 and one that occurred on 5/23/14 for review. However, given that the IDT had recently met (on 4/17/14) to review four of the restraints occurring on 4/1/14, 4/15/14 and 4/16/14, the restraints occurring on 4/23/13 and 5/23/14 did not require IDT review. 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). b. Of the three individuals reviewed, one (33%) 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: ▪ Although the ISPA for Individual #131, dated 4/1/14, did reflect discussion of the individual's diagnosis of post-traumatic stress disorder (PTSD), the IDT did not evidence identification or discussion of the individual's current psychiatric diagnosis of Obsessive Compulsive Disorder (also described as obsessive compulsive personality traits). This condition was identified within the Structural and Functional Assessment Report (SFAR) (dated 6/3/13) and PBSP (7/9/13) as a potentially contributing factor to his maladaptive responding. ▪ The ISPA for Individual #124, dated 3/19/14, did not evidence identification or discussion of the individual's current psychiatric diagnosis of Personality Disorder, NOS. In addition to the PTSD, OCD was identified within the SFAR (dated 3/25/13) and PBSP (4/26/13) as a potentially contributing factor to his maladaptive responding. c. Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoke restraints in one (33%) of the cases. Of these, there was evidence of an action plan or discussion/recommendations, as identified in the ISPA, for modifying them to prevent the future probability of restraint in one (100%) of the cases.	

#	Provision	Assessment of Status	Compliance
		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 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. 100% cases had documentation of an ISPA following each occurrence of an individual having more than three restraints in a rolling 30 days. b. Of the three individuals reviewed, three (100%) of individuals' teams (as reflected in ISPAs) discussed the possibly contributing environmental conditions. c. Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoke restraints in two (67%) of the cases. Of these, there was evidence of an action plan for modifying them to prevent the future probability of restraint in one (50%) of the cases. The following is an example where the team failed to this adequately: ▪ Although the ISPA for Individual #131, dated 4/17/14, evidenced two potentially contributing environmental conditions, one of these (i.e., the presence of staff) did not appear to be specifically and conspicuously discussed and/or addressed in the conclusions or recommendations. Plus, as described below, the IDT team did not appear to address the potential of the setting or current environmental conditions that might predispose the maladaptive behavior that leads to restraint. This concern was identified in the previous SFA (dated 6/15/12). 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 adequate discussion involving potential environmental conditions that might have contributed to each target behavior that led to restraint.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	a. 100% cases had documentation of an ISPA following each occurrence of an individual having more than three restraints in a rolling 30 days. b. Three (100%) of these ISPAs reflected a discussion of potential environmental antecedents to the behaviors that provoked restraint. c. Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoked restraints in three (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 (67%) of the cases.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The following is an example where the team failed to do this adequately: ▪ The ISPA for Individual #131, dated 4/17/14, suggested that the maladaptive behavior might have been initiated by internal stimuli/private events (e.g., fear), and that this experience was consistent with his mental health diagnosis. And, although conclusions were made about having staff monitor for signs or symptoms of PTSD, no discussion about what the environmental antecedents might be related to these responses was conspicuous. That is, his previous Structural and Functional Assessment (SFA) and SFAR indicated there might be common features of residential programs that might occasion these private events. In addition, instead of indicating that a psychiatric consultation would be pursued, one of the conclusions indicated that: "psychiatry will increase Seroquel medication." It was unclear if this was an action plan in response to the potential experience of PTSD or the aggressive behavior that led to restraint. In addition, it was unclear how the IDT knew what the psychiatrist would ultimately recommend. Lastly, there was no discussion by the IDT regarding the need for counseling supports (i.e., it appeared that they were previously in place). 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 conspicuous evidence of IDT discussion regarding potential environmental antecedents likely precipitating identified behaviors that lead to restraint.	
	(d) review or perform functional assessments of the behavior provoking restraints;	a. 100% cases had documentation of an ISPA following each occurrence of an individual having more than three restraints in a rolling 30 days. b. 100% of ISPAs reflected a discussion of the variable or variables that potentially were maintaining the behavior provoking restraints. However, only two (67%) appeared to reflect an adequate discussion. The following is an example of where a team failed to do this adequately: ▪ The ISPA for Individual #131, dated 4/17/14, indicated the observed aggression that required restraint was in response to the individual wanting a desired item. The IDT discussed how this situation indicated a tangible function of the aggressive behavior that was consistent with the previous SFA and SFAR. However, the Monitoring Team's review of these documents did not evidence a stated tangible function of aggression. c. Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoked restraints in three of the cases (100%). Of these, there was evidence of an action plan for modifying them to prevent the future probability of restraint in two (67%) of the cases. That is, the function(s) identified by the IDT appeared consistent with the SFA/SFAR for Individual #288 and Individual #124.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The exception was Individual #131 (as described above), where the function identified by the IDT did not match that of previously completed SFA/SFAR and no discussion of the inconsistency and/or need for re-assessment was noted. 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 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 in the individual's ISP;	a. 100% cases had presence of PBSP and CIP for each individual having more than three restraints in a rolling 30-day period. b. 100% of PBSPs reviewed had operationally defined target behaviors. c. 67% of PBSPs reviewed contained functional replacement behaviors (when practical and possible). It appeared that the replacement behavior for Individual #131 was not adequate as it targeted "keeping a journal" to write down issues to discuss with his counselor (he was not receiving counseling services). d. 100% of PBSPs reviewed specified, as appropriate, the use of other programs to reduce or eliminate the use of restraint. e. 67% of PBSPs reviewed contained interventions to weaken or reduce the behaviors that provoked restraint that are clear, precise and based on a functional assessment. Although statements on the ISPA (dated 4/17/14) for Individual #131 indicated that the IDT had reviewed the functions of the aggressive behavior, it was not apparent that the IDT recognized the inconsistency between recent observations and identified functions with previous assessments. As a result, the IDT did not fully discuss the adequacy of the SFA (6/5/12) and SFAR (6/3/13). f. 100% crisis intervention plan delineated the type of restraint authorized. g. 100% crisis intervention plan specified the maximum duration of restraint authorized. h. 100% crisis intervention plans specified the designated approved restraint situation. i. 100% of crisis intervention plans specified the criteria for terminating the use of the restraint.	Noncompliance

#	Provision	Assessment of Status	Compliance
		For the Facility to attain substantial compliance, PBSPs should contain adequate functional replacement behaviors and 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. 100% cases showed presence of treatment integrity data for each individual having more than three restraints in a rolling 30 days. However, of these, zero (0%) evidenced the inclusion of treatment integrity data that was current. More specifically, all of the data presented was from December 2013 and January 2014. It should be noted, that the Monitoring Team believed that this section of the ISPAs was not accurate and likely "cut-and-pasted" into the reports as all three individuals sampled had the same exact information presented (including the probe dates, integrity and IOA estimates), which seemed highly unlikely to occur on the same dated with the same outcomes. b. 100% of individuals' treatment plans were implemented with at least 80% treatment integrity. However, as noted above, the accuracy of this evidence was highly questionable. 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 including their accurate documentation within ISPAs.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	a. 100% cases showed presence of a review of the PBSP in the ISPA for individuals having more than three restraints in a rolling 30 days. However, as noted above, only two (67%) appeared to accurately review the PBSP with regard to functions of identified target behaviors (i.e., Individual #131 was the exception). b. Of these individuals, the ISPA indicated that a revision was necessary in one (33%) of the cases (i.e., Individual #288). Of these, there was evidence of a revision in the PBSP in zero (0%) of the cases. It should be noted that, given the timing of the planned revision (predicted for July), it was unknown if the PBSP was updated for Individual #288 as planned (i.e., this documentation was not provided at the time of the onsite visit). 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 IDTs actively discuss the adequacy of the current PBSP (especially with regard to underlying function of target behaviors), whether or not it needs to be revised and, if so, that the PBSP is revised, reviewed, and implemented in a timely manner.	Noncompliance

#	Provision	Assessment of Status	Compliance
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 #C1.6, #C1.10, #C1.16, #C1.26, and #C1.28. 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. The format to guide and document IMRT discussions was in use and followed with minor exceptions. The form did help to capture information not on the Restraint Checklist or the Face-to-face and Debriefing forms such as identifying what triggered the behavior or enhancing descriptions of the behavior. ▪ e. In three (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 three, without a specific request by the IMRT. The remaining two did not require review. ▪ f. Of the three reviewed by the IDTs, one resulted in an appropriate change being made to the individual's ISP, and two recorded meetings and explained why changes were not needed. Based on this review, the Facility was in substantial compliance with this provision. The enhanced IMRT procedure appeared to be working to help assure that reviews were documented thoroughly in the IMRT minutes.	Substantial Compliance

<table>
<tr><th>SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management</th><th></th></tr>
<tr><td>Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.</td><td>
Steps Taken to Assess Compliance: The following activities occurred to assess compliance:

Review of Following Documents:

LBSSLC Incident Management: Managing Unusual Incidents, revised 11/20/13;
LBSSLC Incident Management: Observation Note Audit Procedure, revised 4/11/13;
Presentation Book for Section D;
Facility Self-Assessment for Section D, dated 6/20/14;
Facility Action Plan for Section D, dated 6/18/14;
List of Allegations from 11/1/13 through 5/31/14;
Adult Protective Services (APS) Training Transcript Crosswalk – Lubbock, undated;
Criminal Behavior Background Checks, FY 2014 – FY To-Date Results, undated;
List of Alleged Perpetrators with disciplinary actions 11/1/13 through 5/31/14;
Alphabetical list of individuals with all incidents and injuries, from 5/1/13 through 4/30/14;
Observation Note Audit Results: January 2014 through June 2014, dated 7/10/14;
Executive Safety Committee: Addressing September 2013 through February 2014, revised 4/2/14;
Executive Safety Committee: Addressing October 2013 through March 2014, revised 4/29/14;
Executive Safety Committee: Addressing December 2013 through May 2014, presented 7/10/14;
QA/QI Council Meeting minutes: November 2013 through April 2014;
QA/QI Council Meeting handouts, 7/7/14;
Completed CAP Tracking Log, undated;
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:

<table>
<tr><th>SAMPLE #</th><th>Name</th><th>Date</th><th>Facility #</th><th>DFPS #</th></tr>
<tr><td>D1.1</td><td>Individual #4</td><td>1/1/14</td><td>14-979</td><td>42980893</td></tr>
<tr><td>D1.2</td><td>Individual #27</td><td>1/18/14</td><td>14-084</td><td>42997639</td></tr>
<tr><td>D1.3</td><td>Individual #284</td><td>1/17/14</td><td>14-085</td><td>42928960</td></tr>
<tr><td>D1.4</td><td>Individual #139</td><td>1/22/14</td><td>14-088</td><td>43001746</td></tr>
<tr><td>D1.5</td><td>Individual #154</td><td>1/25/14</td><td>14-089</td><td>43004935</td></tr>
</table>
</td></tr>
</table>

D1.6	Individual #121	2/13/14	14-099	43027483
D1.7	Individual #155	3/6/14	14-108	43051431
D1.8	Individual #134	3/18/14	14-116	43063496
D1.9	Individual #232	3/24/14	14-121	43071298
D1.10	Individual #154	4/7/14	14-131	43088306
D1.11	Individual #173	4/11/14	14-134	43094369
D1.12	Individual #152	4/19/14	14-138	43109927
D1.13	Individual #76	5/2/14	14-147	43120646
D1.14	Individual #154	5/6/14	14-149	43125048
D1.15	Individual #71	5/21/14	14-158	43153312

- 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 #204	12/14/13	14-067
D2.2	Individual #36	12/23/13	14-071
D2.3	Individual #324	1/7/14	14-080
D2.4	Individual #320	2/9/14	14-096
D2.5	Individual #322	2/25/14	14-105
D2.6	Individual #94	3/11/14	14-114
D2.7	Individual #240	4/30/13	14-144
D2.8	Individual #127	5/24/14	14-154

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

Sample #	Name	Date of ISP
D4.1	Individual #134	2/10/14
D4.2	Individual #124	1/8/14

D4.3	Individual #91	1/3/14
D4.4	Individual #220	3/17/14
D4.5	Individual #60	12/18/13
D4.6	Individual #4	5/6/14
D4.7	Individual #155	12/5/13
D4.8	Individual #239	5/19/14
D4.9	Individual #38	12/10/13
D4.10	Individual #143	3/4/14
D4.11	Individual #113	1/24/14
D4.12	Individual #191	4/16/14
D4.13	Individual #164	3/24/14
D4.14	Individual #242	4/24/14

- 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 #
D1.1
D1.3
D1.7
D2.4
D2.5

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

Sample #	Name	Date Audit Completed
D6.1	Individual #83	1/6/14
D6.2	Individual #10	2/27/14
D6.3	Individual #279	1/2/14
D6.4	Individual #213	4/30/14
D6.5	Individual #211	4/30/14
D6.6	Individual #171	4/30/14
D6.7	Individual #322	6/3/14
D6.8	Individual #321	6/3/14
D6.9	Individual #172	6/23/14
D6.10	Individual #47	6/22/14

	○ 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 ▪ Individual Support Plan Amendment (ISPA) for Individual #124. ▪ **Interviews with**: ○ Libby Allen, Facility Director; ○ Jim Forbes, M.Ed., BCBA, Assistant Director of Programs (ADOP); ○ Rodney McWilliams, Incident Management Coordinator (IMC); ○ Dawn Ripley, Director of Quality Assurance; ○ Stephanie Brasfield, Director of Residential Services; and ○ Informal interviews/conversations with staff and individuals. ▪ **Observations of**: ○ Quality Assurance/Quality Improvement Council, on 7/7/14; ○ Unit I and II Morning Meeting, on 7/9/14; ○ Incident Management Meeting, on 7/9/14; ○ Executive Safety Committee, on 7/10/14; ○ Visits to Residences #513, #514, #515, #516, #528, and #504S; and ○ Visit to the large workshop.
	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 21 of the 22. The Facility submitted a Self-Assessment for Section D, dated 6/20/14. 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: ○ 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. ○ 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. ○ 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. "Appropriate" was not

	clearly defined, and there was no detailed evidence provided of observation in living units or interviews with individuals or staff. However, in the monitoring form reviewed (March 2014), there was no clear example of where such interview or observation by the monitor was needed. The monitoring appeared to consist of documentation review alone. While interviews and observations were not conducted in conjunction with the monitoring, it was noted that Campus Administrators and Campus Coordinators, who were trained as investigators and worked for the Incident Management office, conducted and documented interviews and observations as part of their regular duties. o The Self-Assessment identified the sample sizes, including the number of records reviewed (24) in comparison with the number of investigations (105) during the period, or 23%. This sample size was adequate to consider it a representative sample. 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 Inter-rater reliability was being checked and reported. While it was not at a 90% level on all monitoring tool questions, it was generally in the 80 to 90% range, and efforts such as monthly meetings with Quality Assurance were being held to improve the percentages. ▪ 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 abuse, neglect, and exploitation (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 The Facility did not consistently 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 21 out of 22 provisions of Section D, which was a decrease of one from the last review. Progress had been maintained in a number of areas, including: ▪ The Executive Safety Committee continued to refine its working process for reviewing complex data streams and identifying trends, issues, and individuals in need of focused attention. The data presentations were comprehensive and useful, and the committee's efforts were demonstrating how data could drive decision-making. The committee discussion included comparison of data on falls and injuries against risk levels to question why injury experience for some individuals was high, when risk levels appeared low. Other discussions included referrals to IDTs of individuals who appeared to be having increased injuries or increased restraints to assure that actions were

	being taken to interrupt negative trends before they became more serious. ▪ The injury audit procedure was in place and while not uncovering many instances of failure to report serious injuries, the process was identifying issues with documentation in observation notes and in logs that needed attention. ▪ Recommendations were being made in almost every investigation report and tracked to completion. Some of the areas in which ongoing attention was needed for the Facility to maintain full compliance with the Settlement Agreement included: ▪ Although late reporting might occasionally occur, when it does occur, DFPS and the Facility need to make recommendations, and the Facility needs to act on the recommendations to prevent recurrence to the extent possible. When late reporting occurred during this review period, DFPS and the Facility did not react with an appropriate recommendation(s). It will be important for the Facility to determine why, on occasion, staff are not reporting suspicions of abuse, neglect, and exploitation immediately. When in doubt, staff should report, and allow the investigation process to determine the facts. ▪ Now that the system was in place for investigating possible abuse and neglect, it will be critical to be continuously vigilant with quality monitoring to insure that the processes in place stay vigorous and there is consistent follow-up on recommendations from investigations to help prevent abuse and neglect from happening in the first place. ▪ Effort had been made to maintain the investigation skills of Campus Administrators and Campus Coordinators by assigning them to work on investigations weekly. It might prove useful to consider a training review or upgrade for investigators, who received their investigative training several years ago, to assure that their skills stay sharp and improve over time. ▪ Some additional attention should be directed to monitoring the quality of the outcomes achieved as a result of recommendations from investigations.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	Based on a recent agreement of the parties and the Monitors, Section D.1 has been interpreted to only address the development of a policy. Implementation of the policy is assessed in other Section D provisions. AUSSLC had a policy that: ▪ Included a commitment that abuse and neglect of individuals would not be tolerated; and ▪ Required that staff report abuse and/or neglect of individuals. As a result, the Facility was found to be in substantial compliance with this provision.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year,		

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>6/1/13 to 11/30/13</th><th>12/1/13 to 5/31/14</th></tr>
<tr><td>Total abuse allegations</td><td>84</td><td>81</td></tr>
<tr><td>Physical</td><td>51</td><td>64</td></tr>
<tr><td>Verbal/Emotional</td><td>17</td><td>17</td></tr>
<tr><td>Sexual</td><td>16</td><td>0</td></tr>
<tr><td>Abuse substantiated</td><td>7</td><td>8</td></tr>
<tr><td>Physical</td><td>6</td><td>8</td></tr>
<tr><td>Verbal/Emotional</td><td>1</td><td>0</td></tr>
<tr><td>Sexual</td><td>0</td><td>0</td></tr>
<tr><td>Total neglect allegations</td><td>29</td><td>18</td></tr>
<tr><td>Neglect substantiated</td><td>2</td><td>6</td></tr>
<tr><td>Total exploitation allegations</td><td>0</td><td>1</td></tr>
<tr><td>Exploitation substantiated</td><td>0</td><td>0</td></tr>
</table>

The numbers of Unusual Incidents investigated over the past year included:</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

	6/1/13 to 11/30/13	12/1/13 to 5/31/14
Deaths	7	3
Serious Injuries	25	16
Sexual Incidents	8	7
Suicide Threat (credible)	3	6
Unauthorized Departure	13	16
Choking	1	2
Other	3	2

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.

Since not required to assess compliance, and since the responses to questions on reporting abuse and unusual incidents have achieved 100% positive responses in previous interviews, these metrics were not assessed for this review.

- Metric 2.a.4: Although not used to assess compliance, based on responses to questions about reporting, ___of 10 (___%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for abuse, neglect, and/or exploitation.
- Metric 2.a.5: Although not used to assess compliance, based on responses to questions about reporting, __ of 10 (___%) 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: 12 (80%) included evidence that allegations of abuse, neglect,

#	Provision	Assessment of Status	Compliance
		and/or exploitation were reported within the timeframes required by DADS/Facility policy, or the records were considered compliant, because the time of the incident could not be determined. In most cases, the time of occurrence was not known, so it was not possible to determine timeliness for reports. o Sample #D1.1 involved a staff member who allegedly sprayed a naked individual in the hallway with water while another staff watched. The incident occurred on 1/1/14, at 8:37 p.m., but was not reported until 1/2/14 at 1:07 a.m. within the Facility. The incident was not reported until 1/3/14 at 12:39 p.m. to DFPS. The incident was not considered abuse or neglect initially, but after conversation with a DFPS investigator, the decision was made to proceed with a DFPS investigation, which led to a confirmation of both abuse and neglect. This incident should have been reported immediately, rather than taking time to conduct a preliminary investigation to determine if it might have been abuse. o In Sample #D1.15, an individual emerged from the bathroom after taking a shower and looked sad to her mother. The mother questioned her and she nodded in response to a question about whether she had been hurt by staff. This apparently was not reported as an allegation of abuse. However, the video was reviewed the next day, suggesting there was concern about what might have happened. A report of possible abuse was not made until a week later when the Facility Director was speaking with the mother and learned of the incident. The Director immediately made the report. Upon investigation, DFPS found the allegation unconfirmed and made no recommendations. The Facility accepted the report and entered a recommendation about communication with parents, but did not enter any recommendations about the need for timely reporting of allegations. In this case, the individual's allegation should have been reported immediately, without investigation to determine if it was a valid allegation. o In Sample #D1.12 an individual reported to staff that two other individuals were having sex and that staff was looking the other way. Efforts were made to determine who the staff were and whether it was possible that the individuals and staff could have been in the alleged location at the time of the incident. The Facility appeared to have treated the report as a sexual incident and began to investigate. They reported the incident to DFPS an allegation when it became clear that to report it to DADS regulatory required the DFPS report. After investigation by DFPS the allegation was determined to be unfounded. However, once the allegation was made, it should have been	

#	Provision	Assessment of Status	Compliance
		immediately reported to DFPS. The DFPS investigation should have included a recommendation that allegations such as this be reported immediately and that retraining be done to assure that result. ▪ 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 three allegations (Sample #D1.1, Sample #D1.12, and Sample #D1.15) for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, none of the UIRs/investigation folders (0%) included a recommendation for corrective actions with regard to the late reporting. Both the UIR and DFPS reports for Samples #D1.1, #D1.12, and #D1.15 focused on developing an understanding of what happened and whether there was abuse or 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 eight investigation reports included in Sample #D.2: ▪ Metric 2.a.9: Eight (100%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. ▪ Metric 2.a.10: Eight (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 23 investigation reports included in Samples #D.1 and #D.2, 23 (100%) contained a copy of the report utilizing the required standardized format and were completed fully. The sole issue identified in this provision was the lack of comment by either DFPS or the Facility on the delays in reporting three incidents in which abuse and neglect was confirmed, or there was reasonable cause to believe an allegation of abuse, neglect, and/or exploitation occurred. In the last report, the Monitoring Team made a similar finding, and indicated: "…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." Although late reporting might occasionally occur, when it does occur, DFPS and the Facility need to make recommendations, and the Facility needs to act on the recommendations to prevent recurrence to the extent possible. Given that this issue was raised in the last report, but when the issue recurred during this review period, DFPS and the Facility did not react with appropriate recommendations, the Facility was found to be in noncompliance with this provision.	

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	(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 eight 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 23 of the investigation reports, it was documented that adequate additional action was taken to protect individuals in 23 cases (100%). 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.	Substantial Compliance
	(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 conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. A small sample of 11 staff records (Sample #C.2) showed that 11 (100%) of these staff had completed competency-based training on abuse and neglect prior to working directly with individuals. Review of a list of staff that were delinquent in training was requested. It showed that all (100%) of staff had completed annual refresher training.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The Facility remained in substantial compliance with this provision.	
	(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 conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. A reduced sample of 11 staff (Sample #C.2) was randomly selected to determine if annual acknowledgements had been signed. Of the 11, 11 (100%) had signed annual acknowledgments. The Facility was asked for a list of staff who had been identified as having failed to report abuse and/or neglect. This generated a list of two instances of failure to report. ▪ UIR 14-069: a newly hired staff was late in reporting an allegation, fearing retaliation. The allegation of abuse was ultimately unconfirmed. The staff member was retrained regarding timely reporting and retaliation. ▪ UIR 14-116 (Sample #D1.8) allegations of neglect and abuse were reported timely, but secondhand. Staff were retrained on reporting, and the allegations were unconfirmed. To reinforce education and understanding of abuse reporting requirements, Campus Administrators and Campus Coordinators conducted random checks to quiz staff on their knowledge. The Facility reported that between 11/1/13 and 6/25/14, 324 such checks were performed, and if staff were unable to respond properly to questions, retraining was immediately provided. Suspicions of abuse or neglect need to be reported and the action by the Facility to reinforce the reporting rules by identifying failure to report, and retraining those that could not answer questions appropriately was a good practice. The spot checks on staff knowledge provided an excellent means to assure that staff remained current in their understanding about reporting. As a result, the Facility remained in substantial compliance with this provision.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide	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. In addition, review of 14 ISPs, drawn as part of the Section C sample revealed that 100% contained documentation that the individuals and the LARs were provided with information on identifying and reporting allegations of abuse, neglect and exploitation.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	It was noted that a notebook of LAR Education Acknowledgements was kept in the Incident Management Office. A running tally of the number of individuals with acknowledgements on file indicated 188 of 206 individuals (91%) had acknowledgements on file.	
	(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 conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. Posters were noted to be present in residences, workshop and office buildings the Monitoring Team visited. The Facility indicated that staff monitored posters monthly through the QA Monitoring Tool process. In addition, poster checks were made by Campus Administrators and Campus Coordinators during their rounds and reported through their log, which was provided in the Presentation Book. Since posters appeared to be in place in visited locations and the Facility had a process for checking and replacing posters, the Facility remained in substantial compliance with this provision.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	Based on a review of 15 allegation investigations completed by DFPS (Sample #D.1), in eight for which a referral to law enforcement was necessary/appropriate, DFPS had made referrals in eight (100%). Based on a review of eight investigations completed by the Facility (Sample #D.2), none required referral to law enforcement. The Facility remained in substantial compliance with this provision.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. Based on interviews with the Facility Director, the ADOP and the Incident Manager, the following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated:	Substantial Compliance

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	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.	▪ When an issue of retaliation was raised, it was reported to the OIG for investigation; ▪ New employees were trained by the OIG with regard to retaliation, and the fact that it would not be tolerated on or off the campus; and ▪ Posters were posted throughout the campus reminding staff of the policy of no retaliation, and Campus Administrators and Campus Coordinators performed poster checks. Staff and individuals were not specifically interviewed about retaliation for this reduced-sample monitoring. Based on a review of investigation records (Sample #D.1 and Sample #D.2), there were no concerns noted related to potential retaliation. There was one incident, reported by the Facility and noted with regard to Section D.2.d, where a new staff member reported an allegation late and indicated the reason was a fear of retaliation. The staff member was retrained. The Facility was asked for a list of staff against whom disciplinary action had been taken due to their involvement in retaliatory action against another employee who in good faith had reported an allegation of abuse/neglect/exploitation. The Facility did not identify any reports of retaliation by staff or any disciplinary action taken as a result. In discussion with the Facility Director, it was noted that there had been a recent complaint of retaliation that was being investigated and reported to OIG. Steps had been taken to protect the staff member who made the complaint. Based on the absence of any reports of retaliation during the reporting period and evidence of appropriate action being taken on the recent complaint, the Facility remained in substantial compliance with this provision.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Metric 2.i.1: The Facility policy and/or procedures did define sufficient procedures to audit whether significant injuries were 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, revised 4/11/13; and ▪ Observation Note Audits Results in the LBSSLC Executive Safety Committee report, dated 7/10/14, which provided additional details of the audit process. The method for drawing the sample was described in the Facility procedure, Observation	Substantial Compliance

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		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. While the trends did not always relate to injuries, they provided valuable information for consideration by IDTs. For example, audit trends included unusual sleep patterns (Sample #D6.2), routine removal of a Bi-Pap due to discomfort (Sample #D6.4), a jejunostomy tube (J-tube) that came out several times (Sample #D6.5), and inability of home nurses to reach the on-call physician after hours (Sample #D.6). As these trends indicated, the 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 Sample #D6.10, where the individual had episodes of scratching the back of her neck and SIB that included biting her arms or the palms of her hands. On 7/10/14, this was reported to the Executive Safety Committee and listed as a trend. The usual practice was for IDTs to follow up on identified trends, but this was not documented since the minutes of the meeting were not available at the time of the site visit. 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. The process was well established, and the process was expected to continue on an ongoing basis. Although the audit schedule had been interrupted briefly due to other pressing matters at the Facility, including turnover and vacancies, the total audits completed in the six-month period totaled 42 as planned. 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	

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		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 December 2013 and May 2014. 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 significant that the injury audit process was only one part of the Facility's review and analysis of injuries in general. The Executive Safety Committee minutes provided regular review and analysis of injury data, and the meeting discussions included such comparisons of the injury data to the risk ratings in the Individual Risk Rating Forms (IRRFs) with reporting to IDTs of disconnects between risk ratings and injury data. In addition, the Executive Safety Committee reviewed peer-to-peer injuries and restraint-related injuries for patterns and reported high numbers of injuries to IDTs for further analysis. The Facility had made good progress in implementing its audit procedure, which together with the work of the Executive Safety Committee, provided useful analysis of injuries and a sound method for identifying issues that, if corrected, could help reduce injuries. The Facility remained 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	The Facility had provided the policy describing training of investigators for previous reviews, and it was discussed in previous reports. The policy had not changed. Six DFPS investigators were assigned to investigations at LBSSLC. The training records	Substantial Compliance

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	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.	for these investigators were reviewed with the following results: ▪ Six out of six DFPS investigators (100%) had completed the requirements for investigations training. ▪ Six out of six DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. The staffing for Facility investigations included ten staff, trained as investigators. The training records for these staff were reviewed with the following results: ▪ Ten out of ten Facility investigators (100%) had completed the requirements for investigations training. ▪ Ten out of ten Facility investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities Since all investigators had received the required training, the Facility remained in substantial compliance with this provision.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Review of the investigation files in Sample #D.1 showed that in 15 out of 15 investigations (100%), Facility staff cooperated with DFPS investigators. In addition, quarterly meetings were held between DFPS, OIG, and LBSSLC staff, and minutes of those meetings were provided. There were no indications of lack of cooperation in conducting investigations. This appeared to be a healthy process for resolving any issues that might otherwise evolve into problems. The Facility remained in substantial compliance with this provision.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect, and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS and the Facility, the following was found: ▪ Of the 15 investigation records from DFPS (Sample #D.1), eight had been referred to law enforcement agencies. For eight out of these (100%), there was	Substantial Compliance

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		adequate coordination to ensure there was no interference with law enforcement's investigations. ▪ Of the eight investigation records from the Facility (Sample #D.2), none had been referred to law enforcement agencies. As a result, the Facility remained in substantial compliance with this provision.	
	(d) Provide for the safeguarding of evidence.	In the samples used for this review, there were no examples of the need to secure physical evidence. The Facility was prepared to secure evidence should it be needed in the Incident Management Offices. Documentary evidence was secured in the Incident Management Offices. In addition, video evidence was available in the surveillance office, which offered a secure location. As a result, the Facility remained in substantial compliance with this provision.	Substantial Compliance
	(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. ▪ Fifteen out of 15 (100%) were completed within 10 calendar days of the incident, including sign-off by the supervisor;	Substantial Compliance

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		▪ Fifteen (100%) resulted in a written report that included a summary of the investigation findings. Of the 15, three were returned as Information and Referrals (I&Rs). Those were samples #D1.3, #D1.4, and #D1.13. For those samples, the UIR was considered as the report. 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 15 of the investigations, recommendations were needed. In 15 of the investigations reviewed, recommendations for corrective action were included. In 12 of the investigations (80%), the recommendations were adequate to address the findings of the investigation. In addition, in Samples D1.12 and D1.15 recommendations were needed to ensure timely reporting. In Sample D1.1, a recommendation to report timely should have been included. It was noted that recommendations were sometimes in both the DFPS report and in the accompanying Facility UIR, and sometimes only in the Facility UIR. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ Eight out of eight (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. ▪ Eight out of eight (100%) were completed within 10 calendar days of the incident, including sign-off by the supervisor or had documentation of a written extension (one). ▪ Eight (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 seven of the investigations reviewed, recommendations for corrective action were included. In one, recommendations were not needed, and in the remaining seven investigations (100%), the recommendations were adequate to address the findings of the investigation. The Facility remained in substantial compliance with the provision. While one metric fell below the 90% threshold, the underlying issue of timely reporting was addressed with regard to Section D.2.a.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be	<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.	Substantial Compliance

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	sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	Metric 3.f.2: The Facility policy and procedures were consistent with the DADS policy with regard to the content of the investigation reports.
		
		DFPS Investigations
		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. For Sample #D1.13, the case was determined to be a clinical matter which was referred to the Medical Department for a peer review.
		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 eight out of eight 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 eight (100%), each unusual/serious incident or allegations of wrongdoing;
		o Metric 3.f.15: In eight (100%), the name(s) of all witnesses;
		o Metric 3.f.16: In eight (100%), the name(s) of all alleged victims and	

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		perpetrators; o Metric 3.f.17: In eight (100%), the names of all persons interviewed during the investigation; o Metric 3.f.18: In eight (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 eight (100%), all documents reviewed during the investigation; o Metric 3.f.20: In eight (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 eight (100%), the investigator's findings; and o Metric 3.f.22: In eight (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 was complete; and 2) the report was 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 Facility 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. 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	Substantial Compliance

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		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: Metric 3.g.8: Seven of eight (88%) 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 and final UIRs, when corrections were not needed to the original. While all but one file (Sample #D2.1) 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. Another indicator of ongoing review was the "Case Review Checklist," which tracked progress of the case, including responses to recommendations. The report 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 was Sample #D2.1. Metric 3.g.9: In seven out of eight investigation files reviewed (88%), 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 seven of eight, 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.2.1, where an "Administrative Death Review Summary" form was included in the file. 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 three, the supervisor had identified concerns. For these three investigations (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 three investigations, Samples #D1.1, #D1.12, and #D1.15 noted above (in Sections D.3.e and D.3.f) for which the Monitoring Team identified deficiencies. The supervisory review did not appear to address these deficiencies. This concern is addressed through Section D.2.a. The process for supervisory review was described in the Presentation Book. The Facility	

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		remained in substantial compliance with this provision. As noted above, the concerns related to Samples D1.1, D1.12, and D1.15 are addressed above with regard to Section D.2.a. However, to maintain substantial compliance with this provision in future reviews, the Facility's supervisory process should pay particular attention to the need to identify underlying causes for and remedy issues related to late reporting or failure of staff to report allegations.	
	(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 three out of three (100%) of the investigations reviewed in which disciplinary action was warranted, prompt and adequate disciplinary action had been taken and documented. Those three were Samples #D1.1, #D1.2, and #D1.9. In one sample (i.e., Sample #D1.3), a peer review was indicated for actions taken by a clinical staff member, and that review was completed and on file. 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. All recommendations from investigations were followed to completion by the IMRT through a "Pending Recommendations" log with comments such as "CC/CA [Campus	Substantial Compliance

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		Coordinator/Campus Administrator] monitoring after in-service for 30 days to ensure in-service is being followed."(UIR #14-143.) While not all recommendation outcomes were tracked with such clear regard for assuring achievement of the desired outcome, review assured that the recommendations were carried out. The Facility remained in substantial compliance with this provision. 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.	Recent investigation records were stored in the Incident Management Suite, to permit easy access to investigators and other appropriate personnel. Older records were maintained on site in a secure storage area that limited access to Incident Management Staff. The Facility remained in substantial compliance with this provision.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	Metric D.4.1: For all categories of unusual incidents 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 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	Substantial Compliance

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		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 continued beyond the requirements of this provision, as they had on the previous site visit, 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 was 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). This CAP was completed on 2/26/14. Another CAP was initiated on 10/15/13 regarding "Prevention of Peer-to-Peer Sexual Incidents." On 2/26/14, the QA/QI Council closed this CAP. Metric D.4.8: As appropriate, corrective action plans were developed both for specific individuals and at a systemic level. At each Executive Safety Committee Meeting, individuals were identified through data analysis that needed additional support or intervention. These individuals were referred to their IDTs for follow-up and ISPAs that the ADOP reviewed for quality. 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 CAPs for peer-to-peer aggression sexual incidents and for serious injuries related to peer-to-peer aggression. Metric D.4.10: The report/minutes did review, as appropriate, the effectiveness of previous corrective action plans. Based on a review of resulting action plans and documentation related to	

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		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 Facility. The Facility shall	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks. In concert with the State Office, the Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of ten employees confirmed that their background checks	Substantial Compliance

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	ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	were completed. The information obtained about volunteers was discussed and confirmed with the Facility Director. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees were subject to annual fingerprint checks during the month of September 2013. Once the fingerprints were entered into the system, the Facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Examination of the self-reporting information documented that there had been no terminations due to background checks. In an interview with the Facility Director, her decisions regarding the employment of a sample of applicants with any criminal history were discussed on a case-by-case basis. In each instance her decisions were based on the facts and were mindful of her responsibility to safeguard the individuals and staff of the Facility. The Facility remained in substantial compliance with this provision.	

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, revised 6/24/14; o LBSSLC Quality Assurance Matrix, undated; o Data Inventory, with updates through 6/2/14; o LBSSLC Correction Action Plan Tracking, undated; o Administrative Outcome Measures (Facility), undated; o Administrative Outcome Measures with data through May 2014; o Quarterly QA Section Monitoring Results/Analysis, format for reports from QA to Departments, revised 5/23/14; o Presentation Book for Section E; o Presentation Book for Medication Variance Corrective Action Plan; o Presentation Book for Desensitization Corrective Action Plan; o LBSSLC Self-Assessment Section E, dated 6/20/14; o LBSSLC Action Plans Section E, dated 6/18/14; o Quality Assurance/Quality Improvement (QA/QI) Council Meetings: November 2013 through April 2014: o Executive Safety Committee: Addressing September 2013 through February 2014, revised 4/2/14; o Executive Safety Committee: Addressing October 2013 through March 2014, revised 4/29/14; o Executive Safety Committee: Addressing December 2013 through May 2014, presented 7/10/14. 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, T, and U. ▪ **Interviews with**: o Libby Allen, Facility Director; o Jim Forbes, M.Ed., BCBA, Assistant Director of Programs (ADOP); o Rodney McWilliams, Incident Management Coordinator; o Dawn Ripley, Director of Quality Assurance; and o Informal interviews/conversations with staff and individuals. ▪ **Observations of**: o Quality Assurance/Quality Improvement Council, on 7/7/14; o Unit I and II Morning Meeting, on 7/9/14; o Incident Management Meeting, on 7/9/14; o Executive Safety Committee, on 7/10/14; o Visits to Residences #513, #514, #515, #516, #528, and #504S; and o Visit to the large workshop.

	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section E, dated 6/20/14. 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 a QA monitoring tool for the Self-Assessment, since it was clear that the existing tool was not a useful gauge of compliance. The Facility was exploring alternatives for developing a more useful tool. ▪ 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 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.2, the Quality Assurance Director reported reviewing the written description of how CAPs are generated, but acknowledged the need to include guidance as to the criteria used to determine compliance. ▪ 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 meeting notes between Program Compliance Monitors and discipline heads to improve the analysis and trending of data, and to focus on creation of CAPs and review of ongoing CAPs. ▪ The Self-Assessment contained information about steps needed to improve quality assurance. Section E.5 contained some observations of CAPs, and specifically, the need for evidence to show the effectiveness and completion of CAPs and the need for additional comments in the Tracking Log concerning effectiveness of CAPs; for Section E.1, the Self-Assessment indicated a need to improve instructions for some of the monitoring tools; for Section E.2, the Self-Assessment identified the need for additional analysis and trending, and for Section E.4 the need was identified to include dates that comments are entered into the tracking log as well as decisions made by the QA/QI Council. When the steps outlined in the self-assessment are completed, the Facility will have made substantial progress towards compliance.
	Summary of Monitor's Assessment: The Monitoring Team found the Facility to be in substantial compliance with one of the five subsections 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 Facility's progress in developing key indicators had moved forward using a thoughtful process aimed at engaging disciplines in identifying outcome measures for the performance of the Facility. This process provided an excellent example of how to discover the indicators that will be practical, yet ambitious measures of the Facility's progress. That this process had progressed to the stage of presenting data summaries to the QA/QI Council was remarkable. It was further remarkable that many of the key terms had been defined, and some of the methods for collecting data established. Benchmarks and goals had been set for indicators. While there is much more to do in this regard, such as identifying methods to assure the accuracy and reliability of data, the process had been established to create outcome measures and a workable system for evaluating progress going forward. ▪ Development and tracking of CAPs were progressing with improvements, such as keeping a binder for each CAP to capture the evidence of progress, and providing a potential reference for compiling reports for the QA/QI Council. ▪ The sophistication of CAPs had continued to progress with committees devoted to CAP development, such as the Medication Variance group and the Desensitization group, both of which were examples of engaging people across disciplines in problem-solving for specific issues, identified through data analysis. ▪ The number of Section Leads who reported on quality in their opening remarks and in discussions with Monitoring Team members throughout the onsite review week suggested that a Facility-wide system for evaluating and enhancing quality was emerging. ▪ The Executive Safety Committee 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 of the areas that will need to continue to improve for the Facility to progress toward substantial compliance with the Settlement Agreement included: ▪ Additional work was needed on development of CAPs and evaluating the outcomes to assure they accomplish the original goals. ▪ Additional work was needed on the key indicators to assure the accuracy and reliability of data and to find ever-improving ways to analyze the issues that emerge from the data. 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. ▪ 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.

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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> Metric E1.1: As was indicated in the last report, there was a State Office 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> Metric E1.2: Facility policies and procedures related to quality assurance (as listed in Documents Reviewed) were examined and found to support/implement the State QA Policy. <u>QA data list/inventory of data</u> Metric E.1.2: 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 G, H, I, and L, which were listed in the spreadsheets list. The names of tools in the matrix should match the names of tools in the data inventory, but this was not consistently done. 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 Office 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;	Noncompliance

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		▪ Supports; and ▪ Services. Most data in the data inventory was tied to the State's AVATAR system. The Facility could draw down data from the State system and create local databases, and 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. Metric E1.4: The data inventory was current according to Facility policy, having been updated as needed through 6/2/14. 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 additional changes are needed. <u>QA Plan Narrative</u> Metric E1.5: The QA plan narrative at the Facility was current as evidenced by the dates of revisions. Specifically, the QA plan narrative had been reviewed and revised, as appropriate, within the last 12 months. Metric E1.6: The QA plan narrative was generally complete in that it included the elements outlined below. 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, including the Executive Safety Committee; ▪ The QA reports; ▪ QA/QI Council and its role in reviewing data and guiding the entire QA process; and	

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		▪ A description of how corrective actions/CAPs were to be tracked. QA Plan Matrix: Key Indicators (process and outcome) for each Settlement Agreement section: ▪ Metric E1.7a: 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 continued to work on refining and using its list of indicators and the list remained a work in progress. Benchmarks and goals for key indicators had been established. Steps were still needed to assure that the data collected were accurate and reliable measures of progress. In order for an adequate set of key indicators to exist, these elements needed to be present. ▪ Metric E1.7b: 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. ▪ Metric E1.7c: 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. Self-monitoring tools for all Settlement Agreement provisions: Metric E1.8: The QA plan matrix did not include self-monitoring tools/self-monitoring procedures for the 20 sections of the Settlement Agreement. Copies of tools were not provided for Sections E and I. The self-monitoring tools, themselves, did not identify the frequency of monitoring, and the persons responsible for monitoring. These were identified in the matrix. All Data Collected by QA Department: Metric E1.9: All data that QA staff members collected based on monitoring tools were listed on the matrix. All Items in QA Plan Matrix Also Appear in the QA Data Inventory: Metric E1.10: All of the items in the QA plan matrix also appeared in the QA data list/inventory. All data in QA plan matrix were submitted and reviewed: The Monitoring Team reviewed the Quarterly QA Section Monitoring Results/Analysis	

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		reports covering the months of January, February, and March 2014 for all sections. 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 E and I. Sections E and I did not have monitoring tools in use during the reporting period. Metric E1.11: Of the 20 sections in the QA Plan Matrix, 18 sections (90%) were submitted/collected/received by the QA Department for the January through March 2014 reporting periods or for the quarter if scheduled for quarterly submissions. <u>Reviewed/analyzed</u>: Metric E1.12: Of the 20 sections in the QA plan matrix, 18 (90%) 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 not were sections E and I. As discussed below, the quality of these analyses required improvement. <u>Implement the QA Plan as written</u>: Metric E1.13: Of the 20 components of the QA plan matrix related to Settlement Agreement Sections, the Facility implemented 18 (90%). Those that were not implemented included those without monitoring tools (E and I). <u>QA Staff Assist Disciplines/Departments in Analysis of Data</u> Metric E1.14: 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 15 there was documentation indicating that QA staff had assisted the section leads with analysis in some respect. Those that did not included I (no monitoring form in use) and G, H, and L (medical services which were reviewed internally). However, as noted above, further improvement was needed in the analyses. More specifically, not all 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. <u>Content/validity</u>: Metric E1.15: Of the self-monitoring tools for the six sections of the Settlement Agreement in the sample (C, D, J, T, U and V): (a) the content of five (83%) included indicators relevant to compliance with the Settlement Agreement section. Those that did not were: ▪ 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	

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		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) Three (50%) were reviewed within the past six months, and revised. Those three were the tools for Section C, T and V. <u>Adequate instructions</u> Metric E1.16: Of the self-monitoring tools for the six sections of the Settlement Agreement in the sample, two (33%) had adequate instructions for the user. Those two were Sections C and D. Additional information on the other four 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> The following was based on a review of the QA/QI Council minutes through April 2014 and for July 2014, including the Quarterly Updates (May and June minutes were not available in the documents provided): Metric E1.17: Since the last onsite review, of the self-monitoring tools for six sampled sections of the Settlement Agreement, none (0%) were implemented as per the QA plan (e.g., number, schedule, person responsible, inter-observer agreement). Those that were not included: ▪ Section C: no inter-observer agreement done for January 2014; ▪ Section D: no information for April and May; ▪ Section J: no data reported after January 2014; ▪ Section T: no data reported after March 2014; ▪ Section U: Results for January, February, and March only reported at 7/7/14 QA/QI meeting. ▪ Section V: No results for April, May, and June 2014. <u>QA staff and department staff review of results</u> Metric E1.18: Since the last onsite review, of the six 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 five (83%) of the sections. The one that was not was Section V, where the Unified Records Coordinator was responsible for the audits and there was no evidence of meetings with anyone. Documentation was found in minutes of meetings between the PCM and the	

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		discipline head and in quarterly summaries prepared by the PCMs. Although the Facility made considerable progress with regard to Section E.1, the provision was not yet in substantial compliance. Improvements included adjustments to the plan narrative and to quarterly reports on monitoring by PCMs; changes to the monitoring for Section C so that inter-rater reliability could be determined; the set of key indicators had been approved and data was being collected; and the matrix was up-to-date. Some of the issues that required attention included establishing monitoring tools for Sections E and I; assuring that all monitoring tools have adequate indicators and/or instructions; resolving data collection problems where they are still occurring; adhering to schedules for submitting data and reporting to QA/QI; and improving the analyses of data such that they provide guidance in determining what corrective action plans might be needed.	
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.	<u>Data and QA Reports</u>: Metric: E2.1: 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. <u>Regular Meetings Between Discipline Department and QA Staff</u> 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: 3/25/14 and 4/25/14; ▪ Section F: 3/26/14 and 4/28/14; ▪ Section J: 3/24/14 and 4/25/14; ▪ Section T: 3/9/14 and 4/25/14; and ▪ Section U: 4/10/14 and 5/20/14. Metric E2.2: 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; ▪ The minutes of these meetings documented that the reviews that occurred in each meeting included the following: o In 80%, review of the data inventory and matrix. While comments in these	Noncompliance

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		eight were general and lacking specificity, for two (Section F on 3/26/14 and for Section T on 3/9/14), there were no comments. o In 80%, discussion of the data and outcomes at least at a minimum level. (Section F on 3/26/14, and Section T on 3/9/14 did not appear to have any data available.) o In 100%, review of the conduct of the self-monitoring tools, o In 0%, creation/proposal of corrective action plans o In 0%, review of previous corrective action plans, since there were no previous CAPs. <u>Data were available:</u> ▪ Metric E2.3: Since the last onsite review, during eight of the ten (80%) meetings, data were available to facilitate department/discipline analysis of data. <u>Data were reviewed/analyzed</u>: ▪ Metric E2.4: Since the last onsite review, during eight of the 10 (80%) meetings, data were reviewed and analyzed. However the analysis involved only the month the data were collected, rather than a trend over time. 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. ▪ Metric E2.5: Since the last onsite review, during none of the 10 (0%) 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. Metric E2.6: Since the last onsite review, Facility QA reports were created for all of the six (100%) months (December 2013 through May 2014). Metric E2.7: 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: a. Metric E2.8: Self-monitoring data i. Reported for a rolling 12 months or more; and	

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		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> Metric E2.9: 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> Metric E2.10: Since the last onsite review, the QA/QI Council did meet at least once each month, and in some months twice. Metric E2.11: Minutes from nine of the nine (100%) QA/QI Council meetings since the last review (November 2013 through April 2014) 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>: Metric E2.12: Minutes from none of the nine (0%) QA/QI Council meetings since the last review (November 2013 through April 2014) documented that: ▪ (a) Data from QA plan matrix (key indicators, self-monitoring) were presented, ▪ (b) The data presented were not trended over time in most section presentations, although an increasing number of the presentations graphed the data over months. ▪ (c) Comments/interpretation/analysis of current data were presented for some of the monitoring data. 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 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.	

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		Recommendations and Corrective Action Plans: ▪ Metric E2.13: In eight of the nine meetings (89%), recommendations were discussed, and CAPs were selected when appropriate to do so and were based on the data presented. In one meeting, the time was devoted to review of presentations in preparation for a Monitoring Team visit. The CAPs were generally solidly connected to data. For example: o CAP #17 (ISP attendance) was clearly connected to data indicating that attendance at ISP meetings by direct support professionals, the LARs and the individuals was below 90%. o CAP #24 (Meal Monitoring) was based on data indicating that Residence #516 had failed to meet the 80% monitoring threshold for seven of eight months. o CAP #23 (Desensitization) was not as clearly linked to monitoring data in the description of the CAP. However, there had been clear issues with desensitization to medical/dental procedures that had been under discussion for some time. System for generating CAPs: Metric E2.14: A written description ["LBSSLC Corrective Action Plan (CAP) Process"] did exist that indicated how CAPs were generated, but as noted below, some concerns were identified with the description. ▪ No description was included of how to evaluate indicators for criteria to signal the need to develop a CAP, 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). ▪ No instructions were included about how to connect the CAP to the data being reviewed. CAP development: Metric E2.15: When considering the full set of current CAPs, they did appear to have been chosen following the written description policy or procedure. Issues with identifying CAPs had been resolved by including a number for each CAP, assigned at the time of approval. When a CAP was modified, the tracking sheet shaded that CAP and added the modified CAP with a letter following the original number. This was an excellent way to permit tracking. Content of each CAP: Metric E2.16: Of the 14 CAPs the Monitoring Team reviewed (i.e., all 14 current CAPs), 14 (100%) appeared to address the specific problem for which they were created.	

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		<u>CAPs contained all necessary components:</u> Metric E2.17: Based on a sample of 14 CAPs, which represented 100% of the total of 14 CAPs: ▪ Fourteen (100%) included the actions to be taken to remedy and/or prevent the reoccurrence; ▪ Fourteen (100%) included the anticipated outcome of each action step; ▪ Fourteen (100%) included the person(s) responsible; and ▪ Fourteen (100%) included the time frame in which each action step must occur. While the components were present in all fourteen CAPs, the quality of those components differed. Some CAPs (e.g., CAP #24) included specific data describing the issue (meal monitoring data below 80% for Residence 516), but did not project what the expected outcome would be in terms of data (increased safety for meals for residents at 516). Others (e.g., CAP #17) described the issue as ISP attendance for direct support professionals, LARs and individuals as "below 90%" and expected outcome as an increase in attendance to 85% within three months, leaving open the question of how far below 90% was the baseline. The fourteen CAPs included eight on the same topic: Medication Variance. Those were CAPs #25 through #32. These CAPs represented a substantial amount of work to be done and breaking them into eight segments made sense. However, what was not clear was the number of medication returns at the outset and the number that would represent the expected outcome. Other issues included "improve the 90-day medication review process," but did not specify in measureable terms what those improvements would look like. The Facility was found to be in noncompliance with this provision of the Settlement Agreement. There had been progress on developing CAPs (from nine in the last reporting period to 14 in the current one), basing CAPs on data, and targeting issues for CAPs that were complex and required multi-disciplinary solutions (e.g., the CAPs on medication variance and desensitization). Progress also included the inclusion of key indicator data at QA/QI Council meetings. 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.	Metric E.3.1: Based on a sample of 14 CAPs, which represented 100% of the 14 CAPs, there were a. 14 (100%) that included documentation about how the CAP was disseminated; b. 14 (100%) that included documentation of when each CAP was disseminated; and c. 14 (100%) that included documentation of to whom it was disseminated, including specific person responsible.	Substantial Compliance

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		The Facility remained in substantial compliance with this provision.	
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.	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. A sample of ten CAPs was drawn: five from the list of current CAPs (#17, #19, #22, #24, and #28), and five from the list of completed CAPs (#4, #6, #8, #12, and #18). Metric E4.1: Based on a sample of five completed CAPs and five in process CAPs, 10 (100%) were implemented and seven (70%) of those were implemented in a timely manner. Those that were not implemented timely included: ▪ CAPs #17, #19, and # 22, where due dates for steps had passed without an entry in the tracking sheet to indicate the problem; and ▪ CAPs #17, and #22 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. However, the dates for entry of status updates were not included, making it difficult to determine if the status update corresponded to the specified due date for the step in the CAP. Metric E4.2: There were 14 open CAPs of which ten were new and did not have steps at completion, so no information on status was provided. Of the remaining four open CAPs the Facility was tracking, for three (75%) 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 #17, #19, and #20. For CAP #22, there was no indication of whether training had been provided timely. Management of CAPs: The Facility QA Director: ▪ Metric E4.3 (a): Did maintain summary information/data regarding CAPs and their status (number of CAPs and number overdue) that was updated within the month prior to the onsite review; and ▪ Metric E4.3 (b): Did present this information to QA/QI Council at least quarterly. The Facility was not in substantial compliance. Dates on status comments needed to be included. Since the majority of the current CAPs were new, it was not possible to accurately	Noncompliance

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		determine whether status was being updated on a regular basis.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The QA Director did not have a clearly stated 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 always filled out. In the list of completed plans, while timeframes for monitoring corrective action were not filled out, the column for re-monitoring score/information usually included a designation of "closed" with a date, and often indicated the presence or absence of supporting documentation. Gaps between due dates and completion dates were not always explained. <u>Evaluate effectiveness of CAPs, including outcomes and timely completion</u>: Metric E5.1: For five out of the 15 CAPs (33%) designated as completed, documentation showed review of their effectiveness (i.e., outcomes). Those five were CAPs #4, #6, #9, #11 and #12. However, even with these five, the outcome in terms of changes in the lives of the individuals was not clear. CAPs #4 through #11 involved efforts to reduce peer-to-peer sexual incidents. CAPs #4, #6, and #9 had to do with improving security around the gym area, locking some hallway restroom doors, and training on new procedures. All had process outcomes completed, but there was no evidence to indicate whether the changes were resulting in fewer incidents. While there was an indication that the Executive Safety Committee would monitor the changes in incidents, some description of how that would occur and what the baseline data indicated the number of incidents were prior to the actions would have made these CAPs much stronger. <u>CAPs are modified when needed</u>: Since expected outcomes were not always expressed as baselines and targets, it was difficult to evaluate whether modifications were completed as needed. A review of the four CAPs (#17, #19, #20, and #22) that were old enough to evaluate modifications showed: Metric E5.2: Of the four CAPs, three appeared to need modification and two of the three (67%) had been modified. The one that appeared to need modification, but had not been revised was CAP #17, where the due dates had passed without submission of evidence of completion. <u>Modifications/results were discussed at QA/QI Council:</u> Metric E5.3: Based on a sample of 15 completed CAPs and 14 in process CAPs, all (100%) had been discussed at QA/QI Council. <u>Modifications were implemented as written:</u> Metric E5.4: For none out of two (0%) modified CAPs (#19 and #20), evidence was present	Noncompliance

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		to show the due dates had been met or an explanation was provided for any delays. Metric E5.5: For none out of the two (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 ISP Meeting Guide, revised 11/21/13; o List of individuals with most recent ISP dates, dates ISPs were filed and previous ISP date, undated; o Assessment data report, for 5/1/13 through 5/31/14; o Team member participation data report, for 5/1/13 through 5/31/14; 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; 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, Integrated Health Care Plan, skill acquisition and teaching programs, Rights Assessment, last three monthly reviews, individual's daily schedule, ISP Preparation Meeting documentation, Individual Activity Cards, and documentation of training for direct support professionals on PNMPs, PBSPs, SAPs, etc., for: Individual #22, Individual #273, Individual #70, Individual #76, Individual #235, Individual #254, Individual #168, Individual #4, Individual #242, and Individual #223; o In response to request for draft Section F tool: "As requested per State Office we are unable to provide the Draft Section F tool from State Office due to it being a draft document;" o Documentation in response to request for: "For sample of ISPs provided as part of pre-review documents, percentage of staff trained for each component of ISPs (e.g., SAPs, PNMP, PBSP, IHCP, ISP action plans, etc.) and date training was completed;" o LBSSLC QIDP Facilitation Skills Performance Tool, undated; 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 March 2014; o List of QIDPs deemed competent in facilitation skills, undated;

	○ ISP Attendance Data, January to June 2014; ○ Aggregate Attendance Data for 11/1/13 to 6/30/14; ○ ISP Assessment Data, January to June 2014; ○ Over the last one-year period, the total number of ISP meetings held, the total that occurred more than 365 days after the previous one, and the total filed more than 30 days after the annual ISP meeting; ○ QIDP Current Assignments and Number of Individuals on Their Caseload, undated; ○ Training Materials for QIDP Training in Austin in March 2014; ○ LBSSLC criteria for when Pharmacy staff need to attend an ISP meeting; ○ Curriculum and training materials used to train staff on the Americans with Disabilities Act, and the Olmstead decision; ○ Provision Action Information; ○ Self-Assessment for Section T, updated 6/20/14; ○ Action Plans: Section T, updated 6/18/14; and ○ Presentation Book for Section F. ▪ **Interviews with**: ○ Sandra Soliz, QIDP Coordinator. ▪ **Observations of**: ○ ISP Meeting for Individual #290, on 7/7/14; and ○ ISP Meeting for Individual #195, on 7/9/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F, dated 6/20/14. 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 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: ○ Until March 2014, the Facility used the audit tool entitled: Annual ISP Meeting Preparation Checklist. The QA/QI Council discontinued use of the tool and deferred monitoring for March 2014. In April 2014, the Facility began use of the tool entitled: Settlement Agreement Cross Referenced with ICF-MR Standards – Section F: Integrated Protections, Services, Treatments and Supports, revised March 2014. ○ Of significant concern, the auditing tools were not being used to conduct the self-assessment. Rather, the QIDP Coordinator was conducting a separate review, and the indicators in the Self-Assessment were different than those included on either audit tool. This was not a good use of time, and defeated the purpose of having audit tools that are regularly implemented. ○ Although the Self-Assessment 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. For many indicators, terms

	and/or standards were not defined. As a result, it was not clear that quality would be assessed consistently. In addition, the Facility Self-Assessment did not address all of the requirements of the Settlement Agreement. o Although the Facility staff had done some work to develop instructions or guidelines for the tool it began using in April 2014, many of the instructions addressed to where to find documentation, or what to review. This was a good start. However, very few instructions related to the standards auditors should apply. 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 100% for the tool it began using in April 2014. However, because the QIDP Coordinator was not using this tool for the Self-Assessment, the only data included in the Self-Assessment, this was irrelevant. 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 data also was in the Self-Assessment. However, as discussed below, the validity of this data was questionable. ▪ 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. ▪ The Facility rated itself as being in substantial compliance with the following subsections of Section F: Section F.2.a.4 related to ISPs identifying the methods for implementation, time frames for completion, and the staff responsible; Section F.2.a.5 related to ISPs providing interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the SSLC and in community settings Section F.2.c related to

	ISPs being accessible and comprehensible to the staff responsible for implementing them; Section F.2.e related to competency-based training. This was not consistent with the Monitoring Team's findings. Because neither the Self-Assessment nor the audit tools included clear standards or criteria for compliance, it was difficult to determine why these significant differences in findings existed. ▪ 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, in a number of subsections, there was reference to the specific action plans that addressed the concerns the Facility identified. This was a positive aspect of the Self-Assessment.
	Summary of Monitor's Assessment: As noted in the last two reports, 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 had implemented a Corrective Action Plan to improve the attendance of individuals, their guardians, and direct support professionals. ▪ ISP meetings were generally being held annually and justification was provided for those that were not. Individuals newly-admitted to the Facility usually were having ISP meetings within 30 days of their admission. In addition, final ISP documents were generally being completed within 30 days of the meetings. ▪ The QIDP Department had added a number of components and reminders to the ISP Meeting Guide. These were positive additions that served to ensure teams discussed important aspects of individuals' preferences and strengths, as well as their supports and treatments, and the progress or lack thereof. For example, prompts were included for the team to review last year's actions plans, assessment recommendations relevant to a variety of areas, and preferences and strengths that supported individuals' goals. In addition, the LBSSLC ISP Meeting Guide included prompts for the teams to discuss the Psychiatric Treatment Plan/Psychoactive Medication Treatment Plan, guardianship prioritization, the Individual Activity Card (IAC), and enteral nutrition. ▪ The Facility had made progress in its efforts to develop and implement a system to train staff on

	the necessary components of the ISPs, but tracking this training to identify when all relevant staff had completed it was still a work in progress. 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 developed an outline for an Assessment Quality Checklist, and worked with discipline leads to individualize the checklist for their assessments. At the time of the onsite review, the audit forms had been finalized, and in June 2014, discipline leads began reviewing the assessments for a sample of four records each month. The next steps were aggregating and analyzing the data from these reviews to determine what action was needed. ▪ Since the last review, the QIDP Coordinator had developed a Facilitation Skills Performance Tool, undated. The Facility submitted a list showing that 13 out of 15 QIDPs had been deemed competent using this tool. 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. However, based on interview with the QIDP Coordinator, the Facility's goal was to begin completing integrated monthly reviews in August 2014. The monthly review would become a rolling document located in the shared drive into which each discipline would enter progress notes for the programs/supports for which they were responsible.

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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.	

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		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, Individual Activity Cards, ISP Preparation Meeting documentation, and documentation of training for direct support professionals on PNMPs, PBSPs, SAPs, Individual Activity Cards, and ISPs as available. The Facility provided the most recently developed ISPs from each residence on campus. From those, the Monitoring Team selected a sample of 10 ISPs, including those for: Individual #22, Individual #273, Individual #70, Individual #76, Individual #235, Individual #254, Individual #168, Individual #4, Individual #242, and Individual #223. As noted in the Monitoring Team's two previous reports, 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 revising treatments, services, and supports.	Progress had been made and/or sustained with regard to the facilitation of ISPs by one person from the team who ensured that members of the team participated in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports. Positive developments included: ▪ Policy #004.2 in Section II.F.1.b indicated that the QIDP would assist the 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.	Noncompliance

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		▪ With regard to staffing, a QIDP Coordinator oversaw the QIDP Department, there was one QIDP Educator, 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 15 QIDPs. At the time of the Monitoring Team's onsite review, two new QIDPs were finishing their on-the-job training. One QIDP was assigned to each residence. Based on the current census of 204, this would be an average ratio of 1:14, with a range of 1:11 to 1:19. ▪ Since the Monitoring Team's last review, the Facility had experienced a turnover rate of over 56% for QIDPs assigned to the residences. As the Monitors have 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. At LBSSLC, an action plan was being implemented with the goal of improving retention. This was a positive effort. Some of the action steps related to identifying priority tasks, providing assistance to QIDPs to ease their workload, hiring a floater QIDP, establishing a schedule and office space for "ghost days," evaluating and revising caseloads, and enhancing training for QIDPs. ▪ The QIDP Department had added a number of components and reminders to the ISP Meeting Guide. These were positive additions that served to ensure teams discussed important aspects of individuals' preferences and strengths, as well as their supports and treatments, and the progress or lack thereof. For example, prompts were included for the team to review last year's actions plans, assessment recommendations relevant to a variety of areas, and preferences and strengths that supported individuals' goals. In addition, the LBSSLC ISP Meeting Guide included prompts for the teams to discuss the Psychiatric Treatment Plan/Psychoactive Medication Treatment Plan, guardianship prioritization, the IAC, and enteral nutrition. ▪ During the week of the review, the Monitoring Team observed two team meetings. Progress continued to occur with regard to the facilitation of meetings. Based on these limited observations, some of the areas in which progress had begun or been sustained included: o At annual ISP meetings, an agenda was clearly set forth, along with ground rules. 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	

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		last report, some of the 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 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 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. Based on observations of meetings held the week of the onsite review and review of ISP	

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		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 modified the QIDP Facilitation Skills Performance Tool, undated. The Facility submitted a list showing that 13 out of 15 QIDPs had been deemed competent, with two QIDPs identified as still in on-the-job training. Unfortunately, the tool did not sufficiently measure QIDP competence with meeting facilitation. For example, although some efforts were made to define the standards or criteria used for each of the categories, they were not complete. This would be important to ensure the results could be replicated consistently and used to identify specific skills or competencies that needed improvement. In addition, although many of the elements of the checklist were important outcomes of good facilitation, it will be important to distinguish between the facilitation skills QIDPs need to demonstrate as opposed to outcomes that require other team members to demonstrate specific skills. ▪ 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 during recent reviews. A number of the action	

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		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, rather than as a change in the individual's life. 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, but 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." ▪ 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	Noncompliance

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		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 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 with attendance of individuals, their guardians, and direct support professionals. Based on interview with staff, this CAP had been closed. The CAP 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 June 2014, attendance of individuals had shown a fairly steady increase (i.e., 80% in July 2013 to 93% in December, with a range of 45% to 93%). However, of concern, different documentation provided different numbers. For example, for individual attendance pre-review documentation indicated 45% attendance of individuals in January 2014, while an onsite request indicated 65% for the same month. The Monitoring Team could not assess guardian attendance based on the significant differences between the two submissions (e.g., in April 2014, 44% for the documentation provided on site, and 100% for the data submitted as part of the pre-review request). The Monitoring Team also could not rely on the Facility's data related to direct support professional attendance, which showed 100% since November 2013, up from a low of 47% in June 2013. Unfortunately, this likely was not accurate. More specifically, the minutes from the 6/23/14 meeting between the QA Department and QIDP Coordinator included a curious interpretation. The minutes stated: "…according to the State Office ISP	

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		Coordinator the RC's [Residential Coordinator's] attendance at the ISP is now sufficient for supervisor and DSP [direct support professional] attendance." It is unclear how the attendance of a manager that is responsible for overseeing operations of a residence would meet the Settlement Agreement requirement for the attendance of "staff who regularly and directly provide services and supports to the individual." Other issues that impeded full participation of necessary team members included the following: ▪ LBSSLC had developed a list of reasons why a Pharmacy Department representative might need to attend an ISP meeting, but this list did not include reference to individuals' risk ratings, particularly, for example polypharmacy. ▪ Often, one HT representative was identified as a required team member, and their attendance was used as justification for other HT members not being present (e.g., as included in the example included in the Presentation Book). Depending on the individual's needs, more than one therapist might need to attend an ISP meeting, and in such cases, clear and individualized justification should be provided should the team decide they do not need to attend. ▪ Based on interview, Facility staff indicated that Behavioral Health Services staff only needed to attend ISP meetings if the individual had a PBSP. Clearly, for individuals with intellectual/developmental disabilities, many other potential reasons exist for Behavioral Health Services staff to be involved in their supports and attend their ISP meetings. The Facility provided data on attendance for the 13-month period from May 1, 2013 through May 31, 2014. According to the Facility's data, the average percentage of attendance by required team members was 90% in May 2013 and 86% in May 2014 (with a range of 79% to 90%). The Facility provided additional data for the month of June 2014, for which the average percentage of attendance was 86%, with a range per team member of 0% (i.e., Dental) to 100%. 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, eight teams (80%) defined the members of the team that should attend the annual meeting. The exceptions were Individual #223 and Individual #70 for whom meetings	

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		were held, but the pages delineating required team membership were not completed and/or submitted. ▪ For the eight individuals for whom documentation was submitted, six individuals had strengths, preferences, or needs that potentially required additional team member participation. The two exceptions were Individual #273 and Individual #4 for whom the team identified all necessary team members. For none of these eight 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 Representative." Teams should determine which therapists need to attend based on the individuals' needs, as well as strengths and preferences. Of additional concern, teams appeared to have the misperception that if an individual did not have a PBSP, there was no need for the participation of a Behavioral Health Specialist. ▪ For none of 10 (0%), 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 fairly 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 be present. In addition, even when IDTs required attendance of certain members, meetings occurred without the required attendance or explanations provided for excused absences. The Facility remained in noncompliance 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	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	Noncompliance

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	and needs.	individuals' specific needs. ▪ As noted in the Monitoring Team's last two reports, 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 two reports, 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 meetings. 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 At the time of the Monitoring Team's last review, State Office had issued assessment formats to all disciplines, and these formats required the inclusion of the information that LBSSLC had included on its "back pages," such as the individual's preferences, strengths, needs, and desired goals. 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 interview with the QIDP Coordinator, the ISP Workgroup was in the process of implementing a quality check system for the ISP assessments. More specifically, the ISP Workgroup developed an outline for an Assessment Quality Checklist, and worked with discipline leads to individualize the checklist for their assessments. At the time of the onsite review, the audit forms had been finalized, and in June 2014, discipline leads began reviewing the assessments for a sample of four records each month. The next steps were aggregating and analyzing the data from these reviews to determine what action was needed.	

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		Based on the Monitoring Team's review of a sample of assessment audit tools included in the Presentation Book, they varied in quality. For example, some appeared to address the quality of the assessments in more depth (e.g., OT/PT assessment audit that included questions such as: "All pertinent functional motor skills addressed, [and] describe how they are used throughout the day?"), while others included questions that could be answered without addressing quality (e.g., the medical assessment audit that included questions such as: "Was an interval history present," without any determination of whether it was accurate and complete). The Facility provided data on timeliness of assessments for the 13-month period from 5/1/13 to 5/31/14. The data was presented by discipline/type of assessment. For May 2013, the average was 82%, with the range of timeliness from 0% to 100%. For May 2014, the average was 85%, with the range of timeliness from 13% to 100%. The Facility also provided updated data for June 2014, when the average was 93%, with the range of timeliness from 50% 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 moved forward with its plan to develop audit tools, and implement them for a sample of assessments each month. If done correctly, 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 included a fairly extensive, although not exhaustive, list of supports the individual would require in the community. 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. ▪ Another issue identified was related to the listing of the individuals' strengths	

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		and needs in assessments. Although they were now more often listed 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 #223. ▪ In reviewing the ISP Preparation meeting materials for the nine individuals for whom the assessment list was provided, the teams for four individuals (44%) 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 #4, Individual #273, Individual #70, Individual #22, and Individual #235. ▪ For one of the 10 (10%) (i.e., Individual #235), 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 a month 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 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 recommended an annual review of incidents, and abuse, neglect, and exploitation allegations. Teams had begun to include this type of assessment in the ISPs. For the 10 individuals included in this sample, the ISPs listed the individual's injuries and allegations over the previous year. Some individuals appeared to have had few injuries or allegations. Only Individual #4's ISP, though, documented some team discussion about causes and potential ways to reduce the injuries the individual had sustained and/or the incidents in which the individual had been involved. For Individual #4, the documentation in the ISP showed a thoughtful analysis and review of the data related to injuries as well as restraints. In addition to identifying trends (e.g., related to peer-to-peer aggression and restraint), the team discussed and documented some of the actions taken and/or planned to address the trends. As a result of the minimal analysis and/or planning in other individuals' ISPs, it was not clear that the goal had been met of individuals' teams ensuring that all of the protections, supports, and services necessary	

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		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: ▪ For Individual #223, despite four incidents in which he was the victim of peer aggression during which he sustained injuries, the team concluded there was "no pattern noted." This was a trend that needed to be addressed. ▪ Over the previous year, Individual #242 had 96 injuries. Although the QIDP summarized the incidents and conducted some analysis of when they occurred (i.e., largely during a manic phase of her illness), the ISP did not document any team discussion regarding whether any actions had been or could be taken to reduce these injuries to the extent possible. ▪ Although Individual #22's team provided some detail regarding numerous peer-to-peer incidents, and identified a trend with one aggressive peer, no action was discussed. Although the Facility remained out of compliance with this provision, some progress had been made with regard to the identification of needed assessments and the timeliness of assessments. In addition, the ISP Workgroup had some plans in place to further address the remaining issues, particularly with regard to the quality of assessments.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	As indicated in previous reports, although the new ISP process had been specifically designed to be more interactive and staff were trained not to read their assessments at the meetings, teams continued to need to incorporate thoroughly the results of assessments in the ISPs. The following summarizes concerns related to the incorporation of assessments into ISPs: ▪ Based on the Monitoring Team's 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.	Noncompliance

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		○ The assessment results were not translated into recommended action plans, including measurable, functional objectives. ○ 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 States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	This provision is discussed in detail later in this report with respect to the Facility's progress in implementing the provisions included in Section T of the Settlement Agreement. Based on the review of the sample of 10 ISPs, 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: ○ Of the 10 ISPs reviewed, for none (0%), all of the assessments included the applicable statement/recommendation. Assessments that often did not include recommendations included nursing and day program. It appeared that the Facility might not have included the assessments requested for nursing (i.e., the physical assessment as opposed to the annual assessment). Although some improvement was seen with ISPs clearly stating the recommendations from residential staff and the QIDP, who did not complete separate assessments, this was not consistent, and often, direct support professionals' opinions were not documented. ○ For two of the 10 individuals (i.e., Individual #235 and Individual #70), pages from the ISP were missing, and, as a result, the following indicator could not be assessed. Of the remaining eight ISPs reviewed, seven	Noncompliance

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		individuals' ISPs (88%) included a clear recommendation from the professionals on the team to the individual and LAR. The exception was Individual #4. For Individual #4, the discipline members did not make a recommendation independent of the LAR. The first recommendation listed included the LAR as one of a number that said "no." Many other discipline team members said "yes," but these discrepancies were not reconciled. o However, for none of these individuals (0%) was adequate justification provided for the discipline team members' recommendation. Many examples of problems have been explained in detail in previous reports, and should be referred to as Facility staff continue to work towards improvements in this area. o For one of the 10 individuals (i.e., Individual #235), a page was missing from the ISP, and, as a result, the following indicator could not be assessed. 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, of these, six (67%) included appropriate justification (i.e., Individual #22, Individual #70, Individual #168, Individual #4, Individual #242, and Individual #223, whose guardians chose not to pursue transition). Examples of concerns have been included in previous reports, and should be referred to as Facility staff continue to work towards improvements in this area. ▪ Below, Section T.1.b.1 addresses teams' identification of obstacles to individuals moving to the most integrated setting, and plans to overcome such obstacles. In summary, teams were identifying obstacles, but the lists were not consistently complete, including the identification of the specific reasons for LAR's choice not to pursue transition to the community, and/or specific supports that were missing to address individuals' behavioral and/or medical needs. Action plans generally were being developed to address further educational opportunities for the individual, but not to address other obstacles (e.g., LAR Choice, Behavioral, Medical issues, etc.). In addition, they were not sufficiently individualized and often did not address the actual obstacle. Although team members generally were including statements in their assessments with regard to individuals' appropriateness for community transition, and making recommendations to the individuals and/or LARs, these recommendations 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, and were not individualized. The Facility remained out of compliance with this provision.	

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F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	This provision of the Settlement Agreement addresses a number of specific requirements, including identification and use of individuals' preferences and strengths, prioritization of needs and explanation for any need or barrier not addressed, and identification of supports needed to encourage community integration. Each of these is addressed separately below. DADS 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	Noncompliance

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		with regard to Section S.2). ▪ 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 previous reports 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. Of note, LBSSLC's ISP template now included a prompts for teams to list the "Preferences and Strengths that support this goal." However, based on review of 10 ISPs, teams had completed this infrequently, and even when they did, the quality of the information varied. For example, for each goal area, Individual #223's team had reiterated every strength and preference listed at the beginning of the ISP document, without making any delineation of which applied to which goals. For Individual #242, some preferences and strengths were connected clearly to the action plans (e.g., preference for interaction with her sister), but little evidence was seen of using preferences to expand the individual's horizons. Even when preferences were identified as being related to an action plan, it was not consistently clear how they were incorporated. For example, for Individual #242, the team associated being out doors and liking bright colors with the goal of attending a community outing every other month. However, neither the goal nor the action steps specifically identified activities that would involve time outside (other than for transportation), or bright colors. ▪ 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 previous reports of missed opportunities to build upon individuals' strengths. <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.	

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		▪ In none of the 10 ISPs reviewed (0%), barriers were identified. <u>Identification of Supports Needed to Encourage Community Integration</u> Based on a review of individuals' ISPs: ▪ None of the 10 ISPs reviewed (0%) included specific skill acquisition plans for implementation in the community. However, based on review of SAPs submitted, it appeared that Individual #70 had a SAP to make a purchase in the community, but it was not reflected in the ISP. Two individuals (i.e., Individual #168, for grasping objects or making choices; and Individual #22, for counting money when making purchase in the canteen or in the community) had SAPs that could be implemented either at the Facility or in the community. ▪ Six of 10 individuals' ISPs (60%) included at least one measurable objective to enhance individuals' general participation and integration into their communities. Those that did not were for Individual #70, Individual #273, Individual #235, and Individual #254. However, some of these were quite limited (e.g., for Individual #76, the objective was for the individual to be involved in community trips two times per year; and Individual #168, for whom last year's goal was weekly community outings, but this year, the only support listed was one outing to a Spanish concert). ▪ 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. 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.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies	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	Noncompliance

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	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;	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, in March 2014, a State Office Consultant provided training at LBSSLC on goals and objectives. Based on review of the presentation materials, it was positive that this training focused on the goal of individual planning being improving individuals' lives through the incorporation of individuals' strengths and preferences, as well as measurable action plans. The training provided some good examples of measurable goals, and also reviewed the components necessary for measurable skill acquisition programs. 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 competency-based training on the development of action plans, including the development of measurable goals. 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. ▪ In the section below that addresses Section T.1.b.1, there is 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 reports, numerous examples have been 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. The following briefly summarizes concerns related to action plans: ▪ As noted in previous monitoring reports, ISPs generally included some individualized and measurable goals/objectives, treatments or strategies, and supports. 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	

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		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 #232, "will be given the opportunity to increase his knowledge of community options," or "With supports in place, [Individual #232's] risk for complications r/t [related to] dysphagia, GERD, and Barrett's esophagus and risk of aspiration will be decreased"). ▪ The plans had begun to include some clinical indicators in the form of measurable goals. Occasionally, 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 was improving. The following examples were representative of the ISPs reviewed, and are used only to illustrate some positive and negative examples. o For Individual #254, the following provided good examples of measurable goals: "will have better control of her blood sugar as evidenced by HbAIC<6, serum glucose <212 over 12 months," or "will maintain her bone density as evidenced by a new DEXA scan by 9/20/14 with T score of -1.4 or better, and no osteoporotic fractures in the next 12 months." o Individual #235 was 228 pounds above his estimated desired weight range. However, his goal for weight was "will remain active for the next 12 months to improve his health." This did not represent a goal with realistic benchmarks to help determine if the supports provided were effective. o For Individual #242, the following goal did not have a mechanism for measuring the clinical indicator embedded in it: "will be provided with the appropriate supports: Proper positioning, diet, verbal prompting, and equipment per PNMP and Dining Plan to aid in prevention of choking and aspiration AEB [as evidenced by] clear lung sounds upon auscultation, proper positioning per PNMP and appropriate documentation over the next 12 months." o For Individual #4, the following did not provide a mechanism for the team to determine whether or not progress had occurred: "will maintain a controlled and safe environment for self and others for the next 12	

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		months." ▪ 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. Limited progress had been made in the expansion of the scope of goals and objectives, the measurability of objectives, as well as with the individualization of objectives and action steps. These remained areas in which significant work was needed. The Facility remained out of compliance with this provision.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Based on observations of meetings and team discussions, and review of ISPs, the following comments are made with regard to the comprehensiveness of ISPs: ▪ 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	Noncompliance

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		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 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 none of the 10 ISPs (0%), the roles of the persons identified as responsible were clearly defined. 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: ▪ Often two or more positions were identified as responsible for the completion of action steps, but it was not clear who was responsible for what. ▪ Although some improvement was seen, the use of terms such as "support in place" or "ongoing" 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 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	Noncompliance

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		like: "IPNs." 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. ▪ An issue related to the identification of staff responsible noted was the use of term "HT" or "QA" as opposed to a specific member(s) (e.g., 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. ▪ 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., the following are examples of actions steps that lacked adequate methodology: "[Individual #223] will be offered the opportunity to increase his relationship with his brother on campus," "strengthen contact with his LAR" or for maintaining a stable weight, the only methodology was for Individual #223 to be weighed monthly; many of the action steps in Individual #254's IHCP indicated staff would "encourage" her to do certain things (e.g., attend dental appointments, adhere to her diet, brush her teeth, etc.), but no direction was provided regarding what such encouragement should entail]. ▪ Methodologies were often reactive as opposed to proactive. For example, nursing protocols were to be implemented: "when signs and symptoms of	

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		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. The Facility remained out of compliance with this provision. In addition to better defining the methodologies in action plans, clear timeframes should be established and specific team members should be identified as responsible for the various steps required to complete the action plans.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	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, nursing care plans, psychiatric treatment 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, 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. Only one individual in the sample had a cooking goal (i.e., Individual #235), and the goal involved a cooking class, as opposed to cooking at home. Similarly, individuals generally did not have objectives related to housekeeping or yard work, which would be typical activities for independent	Noncompliance

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		adults. One individual in the sample had a laundry goal (i.e., Individual #254). 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 bring lunch and eat at their work sites or in the vicinity of their activity or vocational setting. These low expectations failed to provide individuals with functional skills to allow successful transition to a community setting, where regular participation in a day program or job would be expected. The different set of rules on campus coupled with individuals' limited exposure to the community could become a disadvantage for individuals who decide to transition to the community. 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. 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 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.	Noncompliance

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		Since the last review, some limited 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.	
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 included some key information about the individual, including, for example, allergies, and preferences for activities. The Active Treatment Department was responsible for updating these cards, 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. ▪ As noted in the Monitoring Team's last report, 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 were implementing 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. This was a	Noncompliance

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		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. 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 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 staff need to provide 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.	
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	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, nine individuals (90%) had three monthly reviews (i.e., Individual #22 was the exception), 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	Noncompliance

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	ISP needs to be modified, and shall modify the ISP, as appropriate.	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 nine of the 10 individuals (i.e., the exception was Individual #22), a lack of expected progress was noted requiring action. For one of the nine (11%), it appeared action was taken (i.e., Individual #273, but it was unclear whether it was effective, because it was repeated for two consecutive months), and/or action was taken for all identified issues (i.e., Individual #223, 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. As noted in the Monitoring Team's previous report, in October 2013, training was provided to QIDPs on the monthly review process. The QIDP Educator was reviewing monthly reports, and providing constructive feedback to the QIDPs and teams, which was a positive practice. Although some data was lost due to staffing changes, a tracking system also was in place to ensure that QIDPs completed monthly reviews. Based on interview with the QIDP Coordinator, the Facility's goal was to begin completing integrated monthly reviews in August 2014. The monthly review would become a rolling document located in the shared drive into which each discipline would enter progress notes for the programs/supports for which they were responsible. These changes should assist the Facility in moving towards substantial compliance with this subsection. It will be important as this initiative moves forward to ensure that in conducting monthly reviews, all disciplines analyze data relevant to measurable goals and objectives in the ISPs. 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. 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.	

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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 previous reports, 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 Educator with New Hire Supporting Visions Training. ▪ New QIDPs continued to undergo Q Construction training. They used the training State Office had developed in 2010 and individualized it for LBSSLC. As noted in the last report, 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, the QIDP Educator 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. A detailed schedule had been developed, and training was now provided over a two-week period of time. This included concentrated time with the QIDP Educator. 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. ▪ In March 2014, a State Office Consultant provided training at LBSSLC on goals and objectives. Based on review of the presentation materials, it was positive that this training focused on the goal of individual planning being improving individuals' lives through the incorporation of individuals' strengths and preferences, as well as measurable action plans. The training provided some good examples of measurable goals, and also reviewed the components necessary for measurable skill acquisition programs. ▪ In March 2014, State Office held a QIDP Conference. Based on the training materials and agenda, it appeared the conference provided some basic information on a variety of topics, such as person-centered planning and the use of data. 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 demonstrate competency in meeting facilitation and the development of an	Noncompliance

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		appropriate ISP document. Such competency measures should be clearly defined and include criteria for achieving competence. Since the last review, the QIDP Coordinator had modified the QIDP Facilitation Skills Performance Tool, undated. The Facility submitted a list showing that 13 out of 15 QIDPs had been deemed competent, with two QIDPs identified as still in on-the-job training. Unfortunately, the tool did not sufficiently measure QIDP competence with meeting facilitation. For example, although some efforts were made to define the standards or criteria used for each of the categories, they were not complete. This would be important to ensure the results could be replicated consistently and used to identify specific skills or competencies that needed improvement. In addition, although many of the elements of the checklist were important outcomes of good facilitation, it will be important to distinguish between the facilitation skills QIDPs need to demonstrate as opposed to outcomes that require other team members to demonstrate specific skills. ▪ The Facility had not yet begun to implement competency-based measures for the writing of ISPs. ▪ Competency measures for other team members had not yet been identified. Such measures should be identified and used to evaluate whether additional training is needed. ▪ As recommended in the previous report, there should be additional training on how to the develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the individual's preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof. It will be important to provide teams with the tools necessary to focus on individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs. Although since the last review, some training had been provided on action plans, the Facility staff indicated writing action plans continued to be an area of focus. ▪ 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." 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	

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		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 11/15/13 and 5/15/13, nine individuals had been admitted to the Facility. Eight of the nine individuals' 30-day ISP meetings (89%) had been held within 30 days of their admission. The one that did not was Individual #234. Based on data the Facility provided, 216 ISP meetings were held between 5/1/13 and 5/31/13. Four 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 the four meetings that exceeded 365 days. 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. In each case, the memo showed the Facility Director's approval. 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 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 Educator 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 ISP document and send it for filing in the Active Record. These steps had a very positive impact. Based on data the Facility provided, for the 216 ISP meetings held between 5/1/13 and 5/31/14, 214 (99%) were filed within 30 days	Noncompliance

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		after the ISP meeting. [Of note, the documentation the Facility provided indicated two ISPs or 9% were filed past 30 days. One of these numbers was incorrect, because two out of 216 is 1%, as opposed to 9%. In making this finding, the Monitoring Team has used the raw number, as opposed to the percentage the Facility provided.] 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 interview with the QIDP Coordinator, the Residential Coordinator completed training on the ISP, IRRF, ISP Action Plans, and the SAPs. Based on the data report the Facility submitted, for the 94 ISPs that occurred between 11/1/13 and 4/1/14, training rosters were submitted within 14 days of the ISP Technician sending the ISP to the Residential Coordinator for 32 individuals (34%). 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 PBSP, and IHCPs, as well staff's review of the ISP, and IAC. However, 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. The Monitoring Team requested: "For the sample of ISPs provided as part of the pre-review documents, the percentage of staff trained… and the date of the training." The Facility provided copies of all related sign-in sheets, but did not provide percentage of staff trained. The Monitoring Team did not attempt to calculate the percentages.	

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		The Facility remained out of compliance with this provision. However, progress had been made or sustained. QIDPs were now finalizing the ISP documents within 30 days of the ISP meetings, and the Facility was generally holding ISP meetings within 30 days of individuals' admissions to the LBSSLC. 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. ▪ In February 2014, the QA/QI Council decided to defer monitoring of Section F in March, and to stop using the three-part tool for monitoring the ISP process. According to staff, this was done for a few reasons, including the inability to enter data from the newer tool into a database, inability to determine inter-rater reliability, as well as questions about the validity of the data collected from the newer tool (i.e., many "yes" responses, despite problems with ISPs). In April 2014, the Facility began using the previous tool entitled: "Settlement Agreement Cross Referenced with ICF-MR Standards – Section F: Integrated Protections, Services, Treatments, and Supports," revised March 2014. LBSSLC staff added more instructions to the tools. ▪ 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 two reports, the Facility Director had set up the ISP Workgroup, 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	Noncompliance

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		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, implemented, and closed 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 developed 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: ▪ Although it was positive that Facility staff had added some instructions to the monitoring tool, many of the instructions addressed to where to find documentation, or what to review. This was a good start. However, very few instructions related to the standards auditors should apply. As one example, which the Monitoring Team member and QIDP Coordinator discussed extensively during the onsite review, in assessing whether or not the appropriate IDT members attended the ISP meeting, simply looking at the ISP Preparation documentation to determine whether "required" team members attended is not sufficient. Rather, the auditor needs to determine whether or not the individual had needs that necessitated a team member's participation, and if that team member was not required to attend, then the auditor needs to review the team's justification to determine its adequacy. Such a justification would need to be individualized, and specifically address why the team member's participation was not necessary. ▪ Based on the Facility's data included in the June 23, 2014 QA meeting minutes, inter-rater reliability was 100%. 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	

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		action plans or CAPs. However, the meeting minutes for meetings between the QA Department and QIDP Department showed limited analysis of data or identification of issues. For example, the June 2014 meeting minutes only identified concern that SAPs and Action Plans did not consistently match. However, as noted above, the validity of the Facility's monitoring results was questionable, resulting in them being of limited use in a quality assurance process. 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 morning medical meeting minutes, copy of all minutes, handouts, logs from Infirmary, hospitalizations, and 24-hour reports discussed for following dates: 6/30/14 -7/3/14; o For hospitalizations in prior six months, copies of follow-up Individual Support Plan Addendum (ISPA) for the following individuals and dates of ISPA: Individual #313 (1/6/14, 1/14/14, and 3/12/14), Individual #76 (1/30/14 and 5/8/14), Individual #250 (1/6/14), Individual #312 (3/14/14), Individual #136, Individual #299 (1/14/14 and 1/17/14), Individual #270 (3/19/14), Individual #171 (2/14/14), Individual #269 (5/8/14), Individual #45 (2/6/14), Individual #104 (4/23/14), Individual #280 (1/7/14), Individual #191 (2/13/14), Individual #165 (2/20/14 and 3/6/14), Individual #134 (3/6/14), Individual #139 (4/3/14), Individual #55 (4/15/14), Individual #311 (1/22/14 and 1/30/14), Individual #168 (2/18/14), Individual #115 (2/24/14), Individual #128, and Individual #109 (5/9/14); and o For one individual from each residence, copies of all consultant reports (medicine and surgery inclusive of subspecialties) since the Monitoring Team's last visit and all integrated progress notes (IPN) commenting on consultant reports (medicine and surgery inclusive of subspecialties; agreeing or reason not agreeing) and any ISPA related to the consultant report: Individual #315 (Vision 12/13/13 and Endocrinology 1/29/14), Individual #213 (Neurology 1/8/14 and Endocrinology 1/29/14), Individual #146 (Endocrinology 11/7/13, Vision 12/13/13, Neurology 12/20/13, Podiatry 12/18/13, and Cardiology 2/4/14), Individual #71 (Neurology 3/7/14 and Podiatry 3/19/14), Individual #275 (Neurology 12/18/13, Hematology 1/21/14, and Hematology 4/22/14), Individual #290 (Vision 11/6/13, Neurology 12/18/13, Epileptology 1/15/14, Allergy 3/11/14, Vision 4/2/14, and Epileptology 4/16/14), Individual #235 (Wound Clinic 11/5/13, Wound Clinic 11/12/13, Wound Clinic 11/19/13, Gastroenterology 11/21/13, Wound Clinic 12/3/13, Wound Clinic 12/10/13, Wound Clinic 12/17/13, Wound Clinic 12/23/13, Wound Clinic 12/31/13, Wound Clinic 1/8/14, Wound Clinic 1/16/14, Wound Clinic 1/23/14, Endocrinology 1/29/14, Wound Clinic 1/30/14, Vision 2/12/14, Lymphedema Center 2/28/14, Lymphedema Center 4/10/14, and Surgery 1/13/14), Individual #4 (Podiatry 1/22/14 and Vision 3/12/14), Individual #87 (Endocrinology 12/4/13, Podiatry 12/18/13, Podiatry 2/19/14, and Endocrinology 3/26/14), Individual #181 (Gastroenterology 12/13/13, Vision 1/8/14, Neurology 2/21/14, and Endocrinology 3/26/14), Individual #293 (Internal Medicine 11/13/13, Surgery 12/12/13, Surgery 1/23/14, and Endocrinology 1/29/14) Individual #33 (Endocrinology 11/7/13, Allergy 12/3/13, Radiology 12/10/13, Radiology 1/7/14, Allergy 1/14/14, Radiology 1/15/14, Endocrinology 2/26/14, and Otorhinolaryngology 4/7/14), Individual #288 (Endocrinology 12/4/13, Podiatry 12/18/13, Cardiology 1/15/14,

	Vision 2/12/14, and Podiatry 2/19/14), Individual #160 (Neurology 12/18/13, Endocrinology 2/26/14, and Gastroenterology 4/24/14), and Individual #67 (Cardiology 11/13/13, Gastroenterology 2/11/14, Endocrinology 2/26/14, Gastroenterology 3/14/14, Vision 4/2/14, and Gastroenterology 4/10/14). ▪ **Interviews with**: o Glenn Shipley, DO, MPH, Medical Director; and o Leah Shults, RN, BSN, Medical Program Compliance Nurse.
	Facility Self-Assessment: For Section G, in conducting its self-assessment: ▪ The Facility used 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: open record reviews of hospitalized individuals. o This monitoring/audit tool included indicators in template format to allow the Facility to investigate acute care to determine areas needing improvement. However, Section G includes requirements that go beyond the provision of acute care. Therefore, to determine compliance with Section G of the Settlement Agreement additional indicators are necessary. o The monitoring tool included an audit of the active record for seven days or more prior to the hospitalization. Areas to be reviewed were included in the template to ensure all areas were reviewed. However, there were differences in adequacy of detail provided in the record reviews. o Sample size was not applicable as 100 percent of acute care hospitalizations had a record audit. However, for Section G, as noted above, other audits were necessary. o The monitoring/audit results varied in detail of content, and indicated need for further instructions/guidelines to ensure consistency of review. o The following staff/positions were responsible for completing the audit tools: assigned staff attending the morning provider meeting. ▪ The Facility used other relevant data sources and/or key indicators/outcome measures to show whether or not the intended outcomes of the Settlement Agreement are being reached. The quality of the data maintained in the databases was noted to be complete and accurate. Examples of databases/data sources included morning provider meeting attendance tracking, tracking of post-hospital ISPAs for closure, Primary Care Practitioner (PCP) attendance at post-hospital ISPAs, tracking other concerns needing closure, and tracking consultation review to closure. ▪ The Facility presented some data in a meaningful/useful way. Specifically, the Facility: o Provided monthly data for attendance in chart form in its Self-Assessment. The data appeared consistent across the months. o Presented findings consistently based on specific, measurable indicators, such as the consultation tracking system. o In many instances, reviewed the quality as well as presence of items, such as the post-hospital ISPA.

	○ Distinguished data collected by the Quality Assurance (QA) Department versus the program/discipline. ▪ The Facility rated itself as being noncompliant with Section G.1, and in substantial compliance with Section G.2. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of improvement, such as timeliness of post-hospital ISPAs, and PCP attendance at ISPA meetings.
	Summary of Monitor's Assessment: The Medical Department was able to demonstrate integrated clinical services at the morning provider meeting. Attendance by clinical and Facility departments was tracked. As of May 2014, all met a 90 percent attendance level, except the Qualified Intellectual Disabilities Professional (QIDP) Department representative. This meeting was effective and efficient in processing acute care information, hospitalization updates, consultation reports and updates of consultation status, closure to areas determined by the providers as needing review, and post-hospital Individual Support Plan Addenda (ISPAs). Several departments had specific days of the week scheduled to provide routine updates. Tracking occurred for any concern needing closure. Consults were reviewed and recommendations completed in a timely manner, or justification was documented. The consult tracking system was thorough. The completion of closure concerns, such as ISPAs for clinical areas identified at the morning provider meeting, needed further support from Facility Administration, as timeliness was a concern. Additionally, the primary care practitioners (PCPs) were only recorded as attending 36 percent of the post-hospital ISPA meetings, a meeting in which their clinical expertise was needed to guide the Interdisciplinary Team (IDT) in decision-making. The Facility was in compliance with Section G.2 and was noncompliant with Section G.1.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The Medical Department tracked attendance at the morning provider meetings each month. Data was submitted for the months of November 2013 through May 2014. From this information, the following was the attendance per department per month:	Noncompliance

Department	December 2013	January 2014	February 2014	March 2014	April 2014	May 2014
Medical (PCPs)	100%	100%	100%	100%	100%	100%
Psychiatry	89%	95%	95%	86%	90%	95%
Dental	72%	90%	89%	95%	80%	90%
Pharmacy	100%	95%	100%	100%	100%	95%
QIDP	89%	90%	95%	95%	75%	86%
Psychology	89%	100%	74%	57%	90%	95%
Nursing	94%	95%	100%	100%	100%	100%

#	Provision	Assessment of Status	Compliance

Habilitation Therapy	100%	100%	100%	95%	100%	100%
QA	94%	100%	89%	100%	100%	100%

A sample of provider morning meeting minutes was submitted. The dates of these meeting minutes were from 6/30/14 to 7/3/14, with a total of four business days. Specific staff and departments were tracked for percentage attendance. The following information was obtained from the submitted information for this time period:

Department	Number of Days Attended	Department	Number of Days Attended
Nursing Administration	2	Med Compliance RN	3
Hospital Liaison	3	Infection Control	4
Habilitation Therapy	4	Physical Nutritional Management Team (PNMT)	4
QIDP Department	4	Medical	4
Dietary	0	QA/QI	4
RN Case Manager	3	Pharmacy	4
Behavioral	4	Psychiatry	4
Dental	4		

The following information summarizes the contents of the morning medical meeting minutes for the week of 6/30/14 through 7/3/14, the week prior to the Monitoring Team's visit:

- The number of meeting minutes totaled four.
- Four of four (100%) meeting minutes recorded attendance.
- Four of four (100%) minutes included discussion of the Campus Coordinator Log.
- Four of four (100%) minutes included discussion of the On-Call Provider Report, when applicable.
- Four of four (100%) minutes included a report by the Hospital Liaison Nurse.
- Two of four 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. Three assignments were documented for these four meeting minutes.
- The hospital census was discussed at four of four meetings. There were three to four hospitalized individuals on each of the days reviewed.

#	Provision	Assessment of Status	Compliance
		▪ Three of four minutes included discussion of results of an open record review. There were four open record reviews. ▪ From the information submitted to the Monitoring Team member, there were three closure concerns assigned during the four meetings. ▪ Zero meeting minutes included additional information provided through a Medical Director announcement. ▪ Four meeting minutes included discussion and/or resolution of closure items. There was closure of four items/concerns. For one individual, there was additional discussion, but not closure. ▪ No chemical restraints were reviewed during the four meetings. ▪ Three meeting minutes reviewed ISPAs as part of the closure process at the medical morning meeting. A total of six ISPAs were reviewed. ▪ The medical morning meeting participants approved five of six ISPAs at their initial discussion as addressing the concern directed to the IDT. ▪ One of six ISPAs was returned to the IDT for further review to address the concern. ▪ Three meeting minutes reviewed consult reports, as well as whether scheduled consults were not completed. A total of 31 consults were reported or updates provided as to status of the consultation. ▪ One of four meeting minutes recorded a PNMT report. ▪ One of four meeting minutes included information provided by the Dental Department. ▪ Two of four meeting minutes included an update by the Infection Control nurse. ▪ One of four meeting minutes recorded a skin integrity report. ▪ Zero of four meeting minutes recorded a report of any individuals with significant weight gain or loss. <u>Post-hospital ISPAs</u> The Facility submitted ISPAs generated for hospitalizations that occurred during the 30-day time period of 15 through 45 days prior to the Monitoring Team's visit. Submitted were documents for 29 post-hospitalization ISPAs involving 24 individuals for 25 hospitalizations. Twenty-one hospitalizations were each followed by one ISPA. Four hospitalizations were each followed by two ISPAs. These post-hospital ISPAs were reviewed to determine the reason for hospitalization, evidence of a record review for events prior to the hospitalization, evidence of identification of new triggers as early signs and symptoms of illness, evidence of recommendations to increase/change monitoring of specific parameters, and additional steps implemented to reduce the risk of recurrence of illness and 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	

#	Provision	Assessment of Status	Compliance
		more processes in a number of cases. The findings included the following: ▪ Reference to a record review in the ISPA was documented in three of 25 post-hospitalizations. ▪ The IDT identified new triggers or early signs/symptoms in three of 25 post-hospitalizations ▪ The IDT identified the need for increased monitoring in one or more aspects of care in 23 of 25 post-hospitalizations. ▪ The IDT identified the need for additional consultation in 15 of 25 post-hospitalizations. ▪ The IDT identified the need for additional treatment in nine of 25 post-hospitalizations. ▪ The IDT identified the need for additional tests in 14 of 25 post-hospitalizations. ▪ The IDT identified the need for additional departmental assessments in seven of 25 post-hospitalizations. ▪ The IDT identified specific additional/new preventive steps to be implemented to reduce the recurrence of the cause of the hospitalization in 18 of 25 post-hospitalizations. ▪ The IDT identified the need for other steps to be taken in five of 25 post-hospitalizations. ▪ For 25 of 25 ISPAs, the IDT appeared to have conducted an appropriate review and reached appropriate conclusions concerning additional steps needed, if applicable. The time from discharge from the hospitalization to the creation of the initial ISPA was within five days for 24 of 25 (96%) ISPAs submitted. For nine of 25 (36%) post-hospitalizations, evidence was submitted verifying PCP attendance at the ISPA meeting. The Medical Department submitted documentation of closure to morning medical meetings for the time period 30 to 60 days prior to the Monitoring Team's visit. This would allow sufficient time for follow-up to occur in relation to concerns documented at the morning medical meeting during this time period. Twelve closure concerns were submitted that were tracked. Nine of 12 had been closed with evidence of closure. One was closed without evidence of closure, as the document required was never initiated, hence, a completed document could not be obtained. One remained open pending information to be obtained in the future. One closure remained open and was overdue. It was noted that for one closure, the minutes did not reflect the assignment, but the tracking sheet did follow the concern to closure. Separately, the provider morning meetings tracked 26 ISPAs for concerns that were post-hospitalizations as well as other concerns necessitating ISPAs. Dates of the ISPA due date ranged from 2/20/14 through 5/29/14. These were then sent to the provider morning	

#	Provision	Assessment of Status	Compliance
		meeting when completed for review to determine if the contents addressed the needs of the individual. Eleven were completed and closed by the due date. Six were completed and closed past the due date. Four were overdue and were not submitted during the reviewed time period. Four ISPAs had been assigned, but were not overdue during the time period reviewed. One had been submitted, but was not accepted and returned to the IDT for further review, and finalization of the ISPA remained pending. Six of the 26 ISPAs were reviewed by the provider morning meeting and returned to the IDT for further analysis and decision-making. At times there appeared to be delays (e.g., up to six weeks) from the date of the IDT meeting in creating the ISPA, and the date documented as the Medical Department having received the documentation for presentation to the provider morning meeting. That 10 of 26 were overdue indicated the need for Facility Administration's assistance in ensuring departments are compliant with the established due dates. Data was provided concerning completion of open record reviews for individuals hospitalized or admitted to the Infirmary. From April through May 2014, there were 13 open record reviews assigned or reviewed. Ten of 13 were completed, and the average time to completion varied from one to 12 days. Three of 13 were assigned, but not due during the submitted time period. Tracking of open record reviews appeared to be thorough. Attendance at ISPs was one measurement of integrated clinical services. Information was derived from the self-assessment documents, and was not confirmed by separately submitted evidence. However, the following provides information for several clinical departments per month (i.e., the number of ISPs per month is listed, the number of ISPs attended by each department, and the number of ISPs per month that each department was required to attend, followed by attendance rate per required ISPs per month):	

Department	February Number of ISPs Required to Attend	February % of Required ISPs Attended	March Number of ISPs Required to Attend	March % of Required ISPs Attended	April Number of ISPs Required to Attend	April % of Required ISPs Attended
Number of ISPs per month	21		23		22	
PCP	21	95%	23	96%	22	77%
Dental	21	0%	23	0%	22	0%
Pharmacy	NA*	NA	NA	NA	NA	NA

#	Provision	Assessment of Status	Compliance

Psychiatry	21	93%	23	88%	22	82%
Nursing	21	100%	23	96%	22	100%
Occupational Therapy (OT)	21	100%	23	100%	22	100%
Physical Therapy (PT)	21	100%	23	100%	22	100%
Speech	21	100%	23	100%	22	100%
Psychology	21	100%	23	82%	22	84%
Dietary	21	100%	23	73%	22	76%

*Advance notice was provided to Pharmacy staff if attendance was required.

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 CAPs presented to the Monitoring Team during the onsite review week related to medication variances and strategies to address the use of pre-treatment sedation showed interdisciplinary collaboration.

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, dental had low attendance at these meetings, and in some months, medical and dietary staff were not consistently attending.
- Reviews of Integrated Health Care Plans, including those from recently developed ISPs, 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 hospitalization or ER visit.

#	Provision	Assessment of Status	Compliance
		In summary, the Medical Department appeared to have been in compliance in most aspects of this section, but other Facility departments needed improvement in this area, with further Facility support and monitoring. There were delays in presentation of post-hospital ISPAs at the morning provider meeting. Several ISPAs needed to be returned to address preventive issues. This was an important monitoring step included in the morning provider meeting. It did demonstrate there was more training to be done among IDTs concerning the discussion, decisions, and focus needed in completing a quality ISPA. PCP attendance or documentation of attendance at post-hospital ISPA needed to improve. 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 IPN commenting on the consultant reports. Consultations for 15 individuals were submitted, with a range of two to 18 consultations per individual. A total of 74 consultant reports were submitted. These are listed above in the documents reviewed section. Review of these documents revealed the following: ▪ Of the 74 reviewed, 74 (100%) included the PCP initials, indicating review by the PCP. ▪ Of the 74 reviewed, 74 (100%) included the date on which the PCP conducted the review. ▪ Of the 74 reviewed, 74 (100%) consults included documentation of agreement or not with the consultant recommendations. ▪ Of these 74, 72 (97%) included PCP IPN entries. o Of these, there was one of 74, which was followed by an IDT referral/review. ▪ Of the one referred for IDT meeting/review, no information was submitted as to whether the IDT met or whether an ISPA was developed. 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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		additional clarification was needed. Review of information from the provider morning meetings showed this system was working. In addition, the Medical Department completed a monthly audit of PCP response to consultant reports. Consult reports were randomly selected each month (i.e., from seven to 21 records), and reviewed to determine if the PCP had written agreement or not with the consultant recommendations and whether an IPN had been dictated. Compliance per month varied from 86 to 100 percent per month. For this subsection, the Facility appeared to maintain compliance and had a system in place to internally track the process for sustainability.	

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section H; o For a sample of 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, for the following individuals: Individual #154, Individual #102, Individual #185, Individual #298, Individual #213, Individual #266, Individual #252, Individual #23, Individual #155, Individual #106, Individual #293, Individual #191, Individual #108, Individual #151, Individual #238, Individual #90, Individual #276, Individual #67, Individual #28, and Individual #112; o Medical Departmental review of abnormal test reports for following individuals: Individual #283, Individual #26, Individual #76, Individual #182, Individual #34, and Individual #8; and o Most recent results/report of the medical quality improvement program, including identification of trends and descriptions of improvement actions taken. ▪ **Interviews with**: o Glenn Shipley, DO, MPH, Medical Director; and o Leah Shults, 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: six medical management audits for the external and internal medical peer reviews (diabetes mellitus, aspiration pneumonia, and osteoporosis were reviewed during the prior six months), and numerous departmental audits quality tools focused on care for specific diagnoses (ER/hospitalization audit, constipation audit, diabetes mellitus audit, Down syndrome audit, metabolic syndrome audit, osteoporosis audit, aspiration pneumonia audit, Prader-Willi audit, seizure audit, tuberous sclerosis audit, Ogilvie syndrome audit, GERD audit, UTI audit, and hypertension audit). o These monitoring/audit tools did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement for the external medical management audit. 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 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 not

	adequate to consider them representative samples in all instances, such as the response to abnormal test results. 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 had been established between the various Facility staff responsible for the completion of the tools in some cases (i.e., external and internal medical peer reviews). ▪ The Facility used other relevant data sources and/or key indicators/outcome measures to show whether or not the intended outcomes of the Settlement Agreement were being reached, such as timely completion of annual assessments and quarterly medical reviews. The quality of the data maintained in the databases was noted to be complete and accurate. There were occasional inconsistencies across databases, but these were minimal considering the volume of data collected and reviewed. ▪ The Facility consistently presented some 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. It was noted that there were quality content reviews for annual medical assessments and quarterly medical reviews, but copies of raw data and analysis of data was not provided for these specific areas. o A new campus-wide system was implemented with numerous clinical indicators for medical services as well as other clinical departments. ▪ The Facility rated itself as being in compliance with the following sub-sections of Section H: Section H.2, Section H.6, and Section H.7. Except for a similar finding of substantial compliance with Section H.2, this was not consistent with the Monitoring Team's findings. ▪ The Facility data did not identify areas in need of improvement in many areas as compliance was rated 100 percent indicating no need for improvement. However, for the external and internal medical peer review audits, corrective actions were implemented and completed. A QI system was in place, and involved meeting with the PCPs at medical staff meetings to discuss results of the QI initiatives. For those areas in which the Facility did identify a need, the Facility Self-Assessment provided an analysis of the information. The Facility determined it was noncompliant in Sections H.1, H.3, H.4, and H.5.
	Summary of Monitor's Assessment: For Section H, the Facility provided information indicating 80 percent of annual medical assessments were completed timely, and 90 percent of the most recently completed sample were timely. Ninety percent of quarterly medical reviews were completed in a timely manner. Over 99 percent of Quarterly Drug Regimen Reviews (QDDRs) had been completed in a timely manner. There was insufficient reliable data to determine timely completion of annual dental assessments. Several departments still had challenges filing the completed assessments 10 days prior to the annual ISP meeting. Completion rate for the most recent month of data (April 2014) indicated 41 percent compliance with the Medical Department, 50 percent with Psychiatry, and 64 percent with the Nursing Department.

	For specific diagnoses, the Medical Department had a mature internal QI system for assessing standards of care according to national standards. The Facility's self-assessment results indicated sustained compliance. The internal QI system to review abnormal test results/change of status concerns appeared to have only recently been implemented, with the earliest data recorded from 4/22/14. The number of abnormal results, or abnormal results for a specific test was not determined and the adequacy of the sample size could not be determined. There needed to be evidence of monthly audits with an adequate sample size, with quarterly trend analysis, and demonstration of the QI process, similar to the other audit tools the Medical Department currently completed. 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, it was positive that the internal quality review system had begun to include 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. A number of policies were approved reflecting minimal common elements of clinical care for various aspects of health care and health services. The basic State Office policy for Section H, with adaptation to the SSLC, was not listed as having been approved or implemented. The Facility was in compliance with Section H.2, but remained in noncompliance with Sections H.1, H.3, H.4, H.5, H.6, and H.7.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	Several routine and periodic assessments for several clinical departments were reviewed for timeliness in submitted documents. These included the following: ▪ For the year, 156 of 196 (80%) annual medical assessments were completed within 365 days. ▪ 18 of 20 (90%) of the most recent medical annual assessments reviewed were completed in a timely manner. ▪ A review of six active records indicated that a medical annual assessment had been completed in the last 365 days in six of six (100%). ▪ A determination of timeliness of completion of annual dental assessments could not be made, as data was not available. ▪ During the past two calendar quarters, 435 of 436 (99.8%) QDRRs were	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>completed in a timely manner.

Departments were required to submit completed annual assessments 10 days prior to the ISP meeting date. Information was included in the Self-Assessment. The following is information derived from the submitted information concerning compliance with timely submission of assessments for the ISP process:

<table>
<tr><th>Department</th><th>November 2013</th><th>December 2013</th><th>January 2014</th><th>February 2014</th><th>March 2014</th><th>April 2014</th></tr>
<tr><td>Number of ISPs completed</td><td>20</td><td>12</td><td>23</td><td>21</td><td>23</td><td>22</td></tr>
<tr><td>Dental</td><td>79%</td><td>100%</td><td>96%</td><td>81%</td><td>86%</td><td>82%</td></tr>
<tr><td>Medical</td><td>93%</td><td>83%</td><td>91%</td><td>81%</td><td>68%</td><td>41%</td></tr>
<tr><td>Psychology</td><td>93%</td><td>75%</td><td>100%</td><td>89%</td><td>71%</td><td>95%</td></tr>
<tr><td>Psychiatry</td><td>100%</td><td>86%</td><td>92%</td><td>77%</td><td>40%</td><td>59%</td></tr>
<tr><td>Nursing</td><td>79%</td><td>92%</td><td>74%</td><td>57%</td><td>45%</td><td>64%</td></tr>
<tr><td>OT</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>83%</td><td>83%</td><td>93%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>PT</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Nutrition</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</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. While some met the 90% percent compliance threshold, for others, this area remained a challenge. The Facility remained in noncompliance with this provision.</td><td></td></tr>
<tr><td>H2</td><td>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.</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>H3</td><td>Commencing within six months of</td><td>As a measure of timely quality treatment/interventions, the Medical Department utilized</td><td>Noncompliance</td></tr>
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	the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	the results of the external and internal medical management audit. An external and internal medical peer review general quality assurance audit was completed during February 2014. External and internal medical management audits were completed in February 2014. Additionally, an internal medical peer review general quality assurance audit was completed in May 2014, and an internal medical peer review medical management audit was completed in May 2014. Compliance per PCP ranged from 86 to 100 percent with the audit questions. The narrative related to Sections L.2 and L.3 provides more detailed information. The QA Department provided a monitoring tool that included a number of aspects of clinical services for appropriateness of treatment and intervention based on diagnosis and assessments, as well as timeliness of treatment. The audit tool utilized was entitled "Settlement Agreement cross referenced with ICF-MR standards. Section F: Integrated Protections, Services, Treatments, and Supports." Subsections of this tool included review of departmental presence/active participation/assessment of the individual for the IDT meeting, development/monitoring/revisions of treatments, services, and supports, demonstration of clinical evaluations reflecting individual's strengths, preferences, and needs, for departmental assessments. Additionally, comprehensive content, timely completion, and current information including any changes in the individuals life, quality of the content and breadth of the ISP document, ISPA development as applicable for change of status, competency based training of the ISP, and timely creation, updating, and implementation of the ISP were reviewed. The PCM completed this five page-monitoring tool. Copies of four audits were submitted. This lengthy document appeared to provide a method to track timeliness of IDT response, departmental assessment completion, and appropriateness of interventions based on these assessments. A component of this audit tool also tracked change of status documentation and response of the clinical team to this change in status. This appeared to be a global review of health care and safety, which was important. It did not appear to provide a system or methodology that ensured in-depth review of needed clinical supports and review of whether these were in place. As was noted with regard to Section G.1, the IDT response after hospitalizations needed further review to ensure timeliness, as well as appropriateness. Several ISPAs were returned to the team for further revision. 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	

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		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 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.	The Medical Department had created a number of additional quality medical care monitoring tools with specific measurable indicators. Copies of the tools were submitted. These tools were used at periodic intervals to audit a number of specific diagnoses or medical events for which treatment was provided at LBSSLC. The Medical Compliance Nurse or Clinic Nurse completed an audit of a sample of records for each of several clinical categories. The clinical categories, number of audits per clinical category, and audit completion dates included the following: ▪ There were six clinical indicators reviewed for osteoporosis. ▪ Copies of the results of seven record audits were provided. ▪ Dates of audit completion were 1/22/14, 2/14/14, 2/18/14, 2/24/14, 3/27/14, 5/9/14, and 5/16/14. ▪ Compliance was 100 percent for seven of seven audits. ▪ There were five clinical indicators reviewed for gastroesophageal (GERD). ▪ Copies of the results of eight record audits were provided. ▪ Dates of audit completion were 1/28/14, 1/29/14 (x2), 2/1/14, 4/8/14, 4/15/14, 4/24/14, and 5/16/14. ▪ Compliance was 100 percent for eight of eight audits. ▪ There were five clinical indicators reviewed for urinary tract infections (UTIs). ▪ Copies of the results of four record audits were provided. ▪ Dates of audit completion were 3/6/14, 4/8/14, and 4/15/14 (x2). ▪ Compliance was 100 percent for three of four audits. ▪ There were five clinical indicators reviewed for Down syndrome. ▪ A copy of the result of one record audit was provided. Date of audit completion was 1/30/14. Compliance was 100 percent for one of one audit. ▪ There were six clinical indicators reviewed for Ogilvie syndrome.	Noncompliance

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		▪ Copies of the results of three record audits were provided. ▪ Dates of audit completion were 4/23/14 (x2), and 5/7/13. ▪ Compliance was 100 percent for three of three audits. o It was noted that all three audits occurred on one individual (two on one day by different auditors, and two weeks later a third audit for the same diagnosis was completed). ▪ There were five clinical indicators reviewed for pneumonia. Copies of the results of two record audits were provided. ▪ Dates of audit completion were 2/18/14 and 4/24/14. ▪ Compliance was 100 percent for two of two audits. ▪ There were five clinical indicators reviewed for ER/Hospital visits. ▪ Copies of the results of 12 record audits were provided. ▪ Dates of audit completion were 2/18/14 (x2), 2/25/14, 3/6/14 (x2), 3/14/14, 4/10/14 (x2), 4/24/14 (x2), and 5/12/14 (x2). ▪ Compliance was 100 percent for 11 of 12 audits. ▪ There were six clinical indicators reviewed for metabolic syndrome. ▪ A copy of the results of one record audit was provided. ▪ Date of audit completion was 2/27/14. ▪ Compliance was 100 percent for one of one audit. ▪ There were five clinical indicators reviewed for constipation. ▪ Copies of the results of eight record audits were provided. ▪ Dates of audit completion were 1/30/14, 2/14/14, 2/18/14, 2/21/14, 3/27/14, 4/8/14, 5/9/14, and 5/13/14. ▪ Compliance was 100 percent for eight of eight audits. ▪ There were four clinical indicators for seizures. ▪ Copies of the results of nine record audits were provided. ▪ Dates of audit completion were 1/29/14 (x2), 2/18/14, 2/21/14 3/28/14 (x2), 4/23/14, 5/9/14, and 5/13/14. ▪ Compliance was 100 percent for seven of nine audits. ▪ There were seven clinical indicators for diabetes mellitus. ▪ Copies of the results of four record audits were provided. ▪ Dates of audit completion were 1/29/14, 2/19/14, 2/27/14, and 3/27/14. ▪ Compliance was 100 percent for four of four audits. ▪ There were four clinical indicators for quarterly progress notes.	

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		▪ Copies of the results of 13 chart audits were provided. These were provided in the Presentation Book as examples, and may not have been the total number of audits completed for this clinical area. ▪ Dates of audit completion were 2/3/14, 2/4/14, 3/25/14, 3/26/14 (x3), 4/8/14, 4/23/14 (x2), 4/28/14, 5/9/14, 5/12/14, and 5/13/14. ▪ Compliance was 100 percent for four of 13 audits. A copy of "LBSSLC Standard Precautions Monitoring Tool: Infection Control" audit tool was submitted. This included 19 indicators for hand washing, five indicators for personal protection, seven indicators for sanitation, eight indicators for equipment, and four indicators for cross contamination. This was an undated document. There were no completed audits submitted for review for this section. These internal periodic reviews represented quality review of timely assessment/testing, treatment, and intervention. 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 documentation provided, 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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H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	Three hundred sixty eight of 407 (90%) active medical records included current medical quarterly notes. Along with serial departmental assessments, the morning medical meeting each business day provided an up-to-date review of all acute health status changes for those individuals on campus as well as those hospitalized. This was done through the On-Call PCP Report, a review of the 24-hour log, the Infirmary admissions report, and the Hospital Liaison Nurse report. The handouts and minutes provided written documentation of review and discussion of each case. Open record reviews were assigned and reported at the morning medical meeting. Discussion regarding Sections G.1 and L.1 provides further information concerning the morning provider meeting content. This was an effective and efficient system to bring information about acute health changes to the attention of the PCPs and Medical Department. However, more work was needed to ensure changes in health status were identified early in the process. 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 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	Noncompliance

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		plans, dining plans, risk plans, such as fall prevention, etc.). It would allow determination of the health of individuals residing at LBSSLC. LBSSLC remained in noncompliance with this provision.	
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 (i.e., change dosage, add medication, remove medication, other therapies added, etc.). When change was indicated, the audit would need to 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. The Medical Department submitted a list of clinical indicators reviewed when completing an "Abnormal Lab/X-ray monitoring form." There were six indicators: 1) if the current treatment was adequate or if treatment needed to be changed? 2) When change was indicated, was there evidence that the change occurred? 3) Was the change implemented in a timely manner? 4) Was there need for further monitoring or intervention? 5) Was there need for further consultation? 6) Was there need for further lab testing, scans, x-ray, etc.? There was an additional summary indicator: "Overall, was the PCP's response to abnormal lab values/X-rays appropriate and timely? The Medical Compliance RN completed the monitoring. This appeared to be an effective tool to review acute health status change indicators, such as abnormal test results. Copies of the completed forms and supporting data were provided. Dates of audit were: 4/22/14 (x2), 4/29/14, 5/16/14, and 5/29/14 (x2). These indicated a thorough review of the data. Four of six had no findings, and six of six had no findings for the PCP. One did generate a finding of lack of follow-through for an ordered test, which was overdue. One review indicated limited testing and specialty appointments based on decisions/consent by the guardian. It was not clear whether Facility Administration needed to further review this latter case, or whether the Facility Administration was aware of the guardian's decisions. One review indicated the need for training for direct support professionals, and there was a statement made that training was completed, but no training rosters were provided. This appeared to be a recently initiated audit. It was not determined how the six records were selected for review. There appeared to be no need for the PCPs to follow-up. In two cases, the Nursing Department needed to follow up. Evidence, including training documentation, was provided for one of two. It is recommended that the criteria for the	Noncompliance

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		sample be determined, and that a monthly random sample be reviewed, and that all training be confirmed with documentation. Given the number of tests completed monthly with findings, this appeared to be a small sample size and inadequate for a review process. However, criteria for selecting the sample were not provided to determine the denominator. It is recommended that the QA Department provide guidance in development and implementation of this area of QA monitoring (i.e., criteria, sample size, trend analysis, documentation of discussion of findings with the medical staff, reporting to the QA/QI Council, etc.). The Medical Department provided information concerning medical open record reviews as a process in evaluating and modifying treatments and interventions based on findings listed in these medical open record reviews. These reviews were assigned to various clinical staff at the morning provider meetings for individuals that had been hospitalized and were tracked to completion. Open record reviews were to include the following components (as listed by the Medical Department): ▪ Determination of appropriateness of clinical care; ▪ Determination of timeliness of clinical care; ▪ Determination if implemented treatments/interventions that occurred were initiated appropriately; ▪ Determination if implemented treatments/interventions that occurred were initiated in a timely manner; and ▪ Determination if implemented treatments/interventions were initiated in response to clinical indicators/findings. To ensure uniformity in reviewing the appropriate aspects of cases, a "Medical Open Chart Review Template" was used. These reviews were presented at the morning provider meeting, and copies were forwarded to the PCP, QIDP, and RN Case Manager. Recommendations from the review were to be implemented if agreed upon by these clinical staff. Agreed upon recommendations were to be included in the plan of care by the appropriate department as well as the ISPA. Depending on the clinical background of the reviewer, the details of the content of these reviews varied. Copies of 25 open record reviews were submitted. One was incomplete, as the active record could not be found at the time of the review. Ten of 25 indicated potential areas needing improvement. For several observations/recommendations, there was no information submitted as to their status. This information might have been included on other documents. It was noted that several findings indicated need for training. Information concerning the impact of these open record reviews on actual changes in clinical care (i.e., change in orders, treatments, monitoring, etc.), as well as additional training completed for individual staff or across a department, was not submitted. These open record reviews could have had a significant positive impact on	

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		findings in areas needing improvement, and a method to track impact is recommended. Three of 10 included documentation of follow-up, with training documents as indicated. A trend analysis per quarter of the number of new orders generated, new consults, changes in monitoring, number of in-services provided to address recommendations, etc., would determine the impact of these reviews and whether additional areas would benefit from review. That only three of 25 open record reviews were referenced in the post-hospital ISPAs remained problematic. It is recommended that the ISPA document the content of the open record reviews as the issues are discussed, to ensure all concerns in the open record review are addressed in the ISPA. 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 integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	The Facility submitted a number of departmental specific policies and procedures important to the goal of integrated clinical services. These included the following: ▪ "Occupational Therapy/Physical Therapy/Speech Therapy Direct Services Protocol" (dated 4/23/14); ▪ "Dental Services Overview" (revised 12/13/13); ▪ "Protocol for Dental Department when providing treatment for individuals who are at high risk for aspiration" (dated 11/6/13); ▪ "Protocol for Pathway for return to oral eating and/or for least restrictive intake" (dated 1/8/14) with "Consultation report to habilitation therapies" (revised form 4/28/14); ▪ "PNMT Guideline" (dated 5/16/14); ▪ "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); ▪ "Guideline for pharmacy for texture/fluids" (reviewed/revised 2/12/14); and ▪ "Occupational Therapy/Physical Therapy/ Speech Therapy use of consult for Change of Status Protocol" (dated 3/11/14). The content of these protocols provided defined responsibilities for members of the department and collaboration with other departments. The Dental and Habilitation Therapies Departments developed these protocols. When implemented, they provided clear expectations of members of the department in completing a breadth of clinical tasks as part of minimum common elements of clinical care in their respective departments. It was noted that the "Desensitization" section of the "Dental Services Overview" had not been implemented. This section indicated: "If medical restraint or sedation is required for routine dental care (examination or prophy) for an individual with behavioral	Noncompliance

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		supports, the health care professional will attempt to minimize or eliminate the need for their use. A desensitization plan will be the prudent program implemented to minimize or eliminate the need for use of restraint or sedation. The IDT in association with the Dental staff will create a desensitization plan for the individual." As noted with regard to Section I, the ISPs did not address the need for such plans even for individuals requiring Total Intravenous Anesthesia (TIVA)/general anesthesia for exam and prophylaxis. Individuals were scheduled periodically for exam and cleaning under TIVA/general anesthesia with no further information as to how the team was developing and implementing a plan to improve cooperation with routine procedures as noted in the protocol. It is important that policies and protocols be developed and finalized with clear evidence of implementation of these documents across campus. This is an area for which an interdisciplinary corrective action plan had been developed and 15 individuals were initially reviewed to determine need for a plan to improve cooperation, as well as creation and implementation of the plan. This was in early stages of addressing the needs of desensitization/behavioral compliance for individuals residing at LBSSLC. An approved and implemented policy providing guidance for Section H (i.e., minimum common elements of clinical care) was not submitted. 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 For the following individuals' active records, selected documents: DG-1, most current annual medical assessment and physical exam, preventive care flow sheet, most current nursing assessment, past one year of IPN, 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, DNR forms if applicable, physician orders past one year, most recent ISP and subsequent addendums, most recent BSP, past three medical quarterly reviews, IRRF past one year, risk action plan past one year for the following individuals: Individual #171, Individual #68, Individual #161, Individual #113, Individual #181, and Individual #74; and 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 #304, Individual #68, and Individual #269 for aspiration; Individual #322, Individual #288, and Individual #131 for behavioral issues; Individual #181, Individual #225, and Individual #242 for fluid imbalance issues; Individual #223, Individual #161, and Individual #30 for gastrointestinal issues; Individual #293, Individual #317, and Individual #323 for infections; Individual #276, Individual #76, and Individual #136 for weight issues; and Individual #175, Individual #179, and Individual #111 for constipation. ▪ **Interviews with**: o Jim Forbes, Assistant Director of Programs; and o Lilly Burton, RN, Program Compliance Nurse. ▪ **Observations of**: o ISP Meeting for Individual #290, on 7/7/14; and o ISP Meeting for Individual #195, on 7/9/14.
	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, revising, and implementing monitoring tools for Section F and 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, the Facility continued forward movement regarding adding 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 sample sizes of 15% to 20% to generate much of the data. This was generally an adequate sample size to ensure the data were 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 various disciplines' assessments 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. ▪ Of special note, the Facility had made significant progress in its efforts to monitor as well as present the data regarding Section I in a meaningful and structured manner that included more information about the suspected reasons for some of the low compliance scores found in certain

areas. However, the lack of specific compliance criteria and the use of a single compliance score rendered some of the Facility's data inaccurate and uninterpretable. Specifically, the Facility's Self-Assessment:

- Did not present some findings based on specific, measurable indicators. For example, the Facility should be clear regarding what specific criteria had been used to determine compliance.
- Did not measure the quality of the documentation versus the completion of the documentation, which the Facility recognized and was in the process of developing indicators of quality at the time of the review.

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, as noted above, the Monitoring Team's findings focused on the quality aspect of the supports provided and documentation maintained, rather than just the completion of these documents. 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.

Summary of Monitor's Assessment: Since the last review, there had been a change in the Section Leads for Section I, including the Assistant Director of Programs (ADOP) and the Program Compliance Nurse (PCN). During the review, the Monitoring Team had some very promising discussions with the Section Leads regarding the various systems that constitute and feed into the overall At-Risk process as well as how the different disciplines, not just nursing, contribute to the integrated processes and systems addressing the at-risk population.

Based on training records from the Competency Training and Development (CTD) Department, the Facility's Self-Assessment indicated that 99.1% of relevant staff had completed training on the Facility's At-Risk procedure.

Regarding the information provided in the Facility's Self-Assessment, significant positive forward movement was noted regarding the presentation of the data and the associated information regarding issues such as how the samples were selected, the percent sample sizes that the data reflected, and explanations addressing the compliance scores. In addition, most of the indicators the Facility used were in alignment with the requirements of the Settlement Agreement. At the time of the review, the Facility was in the process of assessing the quality aspect of the documentation and expected to be able to generate the associated data by the next review, which is essential to this particular area. 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.

Although from the ISP meetings the Monitoring Team observed during the onsite review some positive changes were noted, significant issues continued regarding the accuracy of the risk levels, the reflection in the Integrated Health Care Plans (IHCPs) of supports with 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. Going forward, 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.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. In response to this requirement, LBSSLC's Self-Assessment indicated that since the last review, the following activities were implemented: ▪ Since the last review, there had been a change in the Section Leads for Section I that included the Assistant Director of Programs (ADOP) and the Program Compliance Nurse (PCN). During the review, the Monitoring Team had some very promising discussions with the Section Leads regarding the various systems that constitute and feed into the overall At-Risk process as well as how the different disciplines, not just nursing, contribute to the integrated processes and systems addressing the at-risk population. It is the hope of the Monitoring Team that the impressive increase in the ADOP's understanding of the requirements of Section I will continue to move the Facility forward regarding the At-Risk system. ▪ Based on training records from the Competency Training and Development (CTD) Department, the Facility's Self-Assessment indicated that 99.1% of relevant staff had completed training on the Facility's At-Risk procedure. The staff that had not yet completed the training included three Qualified Intellectual Disability Professionals (QIDPs), one Psychiatrist, one Residential Coordinator, one RN Case manager (RNCM), one Primary Care Provider (PCP) that was out on extended leave during the initial training, and three Direct Support Professionals also out on extended leave during the initial training. A plan was developed to ensure training was conducted with these staff by July 2014. ▪ In addition, the information contained in the Self-Assessment indicated that compliance regarding keeping the current risk ratings maintained and updated was expected to be at least 95% or greater for each of the 12 months and was found to be 83% for 10 of 12 months. Problematic issues included the data for January 2014 was unavailable due to database updates and computer updates, and in October 2013, the problematic issue was related to input errors and database issues. In addition, individual risk ratings that were not current were due to the failure of the QIDP to turn in the data input form to be entered into the database, data input errors from the data not being entered timely or incorrectly, and database errors related to the database not being updated properly. The Facility indicated that this area would continue to be monitored. ▪ Each month, the ADOP reviewed a 20% random sample of IRRFs to determine if the At-Risk procedure was being accurately implemented. The sample was selected by randomly selecting the fourth ISP from the monthly ISP schedule for each month from November 2013 through April 2014, which yielded a total of 116 IRRFs from which 28 (24%) were reviewed. The Facility's data indicated the following:	Noncompliance

#	Provision	Assessment of Status	Compliance

Probe	Nov13	Dec13	Jan14	Feb14	Mar14	Apr14	Overall compliance
Risk ratings current	67%	100%	83%	100%	83%	100%	89%
Current status has all relevant data	33%	100%	67%	100%	83%	100%	81%
Current supports	67%	67%	50%	80%	83%	100%	74%
Historical data	67%	100%	50%	100%	100%	100%	86%
IDT discussion/recommendations	33%	67%	33%	60%	50%	75%	53%
Rationale	33%	67%	50%	80%	50%	75%	59%
IRRF current in record	100%	100%	83%	100%	100%	100%	97%
Total Population (N)	15	12	23	21	23	22	116
Sample (n)	3	3	6	5	6	5	28

- Also, the Facility reported that the QA Program Compliance Monitor (PCM) monitored a 20% random sample of ISP meetings each month to assess implementation of risk screening process. The PCM randomly selected the sample 90 days in advance from the monthly ISP schedule. From a total of 26 ISPs, six (22%) were selected to be monitored with the findings noted below for November and December 2013:

Probe	Nov13	Dec13	Jan14	Feb14	Mar14	Apr14	Overall compliance
Did the IDT discuss how the individual's preferences, strengths, and goals affect risk and the necessary supports to minimize these risks?	100%	100%	Deferred	Deferred	Deferred	New Monitoring Tool Does Not Measure	100%
Were discussions of risk conducted by risk groups and related conditions to avoid repetition?	100%	100%					100%
Were current	100%	100%					100%

#	Provision	Assessment of Status								Compliance
		supports and their efficacy described for each risk category?								
		Were specific PNM supports identified for related medium or high-risk areas when appropriate?	100%	100%					100%	
		Was data presented to support decisions in each risk category?	100%	100%					100%	
		Was there an analysis of the data or assessment results that provided the rational for proposed recommendations?	100%	100%					100%	
		Were the deliberations and discussion of the IDT sufficient to support the final recommendations?	100%	100%					100%	
		Did the IHCP reflect all appropriate services and supports to reduce the impact of the risk?	100.0%	100.0%					100%	
		Total Population (N)	15	12					27	
		Sample (n)	4	2					6	

#	Provision	Assessment of Status	Compliance
		The Facility indicated that monitoring for Section F was temporarily deferred in January 2014, and the new Section F monitoring tool was implemented in April 2014. However, the new tool did not assess the integration of the risk information into the ISP at the ISP meeting. Consequently, there was only data available for November and December 2013. The Self-Assessment indicated that Action Plan I.1 Step 5 was initiated in order to address the need for the Facility to determine the most appropriate way to monitor risk implementation at the ISP meeting. ▪ The Facility also indicated that the ADOP conducted a review of a 20% random sample of IRRFs each month to determine if the At-Risk procedure was being accurately implemented. The sample was selected by randomly selecting the fourth ISP from the monthly ISP schedule for each month (November 2013 through April 2014), which included a total of 116 IRRFs of which 28 (24%) were reviewed. The Facility's findings included: risk ratings were overall current; compliance regarding the inclusion of historical data had improved over the past six months (86%) as compared to the previous six-month period (70%); and the quality of the documentation appeared to improve with supports being categorized by the discipline providing them and a comparison being made in current status section to data from the prior year to determine if the individual was doing better, worse, or maintaining as compared to the prior year. Areas addressing the IDT discussion and rational for risk ratings were areas that were found to be in need of improvement. ▪ The Facility's review of a 20% random sample of ISPs, IRRFs, and Integrated Health Care Plans (IHCPs) found the following:	

Probe	Nov13	Dec13	Jan14	Feb14	Mar14	Apr14	Overall compliance
Risk is integrated into ISP	100%	100%	83%	100%	100%	100%	97%
IHCP is part of ISP action plan	0%	67%	60%	80%	67%	50%	54%
Evidence of integrated discussion in IRRF	33%	33%	40%	60%	50%	75%	49%
Total Population (N)	15	12	23	21	23	22	116
Sample (n)	3	3	6	5	6	5	28

The Facility indicated that an area where IDTs were struggling was in ensuring integrated discussions were documented within the IRRF. Training was being scheduled to improve the documentation of the integrated discussion at the ISP meeting.

▪ In addition, the Facility's review of the submission of required assessments 10 days prior to the Individual Support Plan meeting found the following:

#	Provision	Assessment of Status	Compliance

	Nov-13	*Dec-13*	*Jan-14*	*Feb-14*	Mar-14	Apr-14
FSA	100%	75%	83%	57%	86%	82%
PSI	100%	100%	96%	90%	95%	95%
Psychological Assessment	93%	75%	100%	89%	71%	95%
Psychiatric Assessment	100%	86%	92%	77%	40%	59%
Occupational Therapy	100%	100%	100%	100%	100%	100%
Physical Therapy	100%	100%	100%	100%	100%	100%
Speech	83%	83%	93%	100%	100%	100%
Audiology	100%	100%	71%	100%	100%	100%
Nutrition Services Evaluation	100%	100%	100%	100%	100%	100%
Annual Physical	93%	83%	91%	81%	68%	41%
Annual Nursing	79%	92%	74%	57%	45%	64%
SAMs	7%	17%	36%	33%	24%	48%
Dental	79%	100%	96%	81%	86%	82%
Water Safety	93%	100%	75%	61%	95%	100%
Vocational	89%	100%	91%	90%	91%	95%
Day Programs	100%	100%	100%	100%	100%	93%
Recreation Summary	79%	67%	86%	88%	86%	100%
Risk Report	100%	67%	45%	100%	100%	100%
Facility Compliance	89%	86%	85%	84%	83%	86%

The Facility's data above indicated that there were several areas of strength with the Facility's overall compliance being greater than 80% for six of six months. In addition, submission of Dental Assessments had significantly improved over the past six months as well. Areas in need of

#	Provision	Assessment of Status	Compliance
		improvement continued to be Nursing Annual Assessments and the Self-Administration of Medication Assessments for which there were current corrective action plans. Also, the areas regarding psychiatric assessments and annual physical assessments also had corrective actions developed addressing the timely submission of assessments. However, as discussed in further detail with regard to Section F.1.c, the Facility could not rely on its data related to timeliness of assessments. This was due to the fact that the data was based on the "required" assessments as defined by individuals' IDTs at the ISP Preparation meetings. IDTs still were not consistently accurately determining which assessments were necessary or providing a justification for why they were not necessary, and the Facility's monitoring activities for Section F were not yet evaluating teams' ability to accurately identify needed assessments. ▪ Regarding the quality of assessments, the Facility's Self-Assessment indicated data was unavailable at the time of the review due to the fact the Facility had only recently implemented a process for monitoring the quality of assessments. <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 components of the risk screening system are not being consistently implemented or completed at the expected level of quality. Action Plans for Section I.1 addresses issues related to implementation and refinement of a quality risk screening system." Regarding the information provided in the Facility's Self-Assessment, there was noted to be significant positive forward movement regarding the presentation of the data and the associated information regarding issues such as how the samples were selected, the percent sample sizes that the data reflected, and explanations addressing the compliance scores. In addition, most of the indicators the Facility used were in alignment with the requirements of the Settlement Agreement. As noted above, at the time of the review, the Facility was in the process of assessing the quality aspect of the documentation and was expected to be able to generate the associated data by the next review. Since the last review, the Facility clearly had invested a great deal of effort in reviewing the requirements of this area and their overall systems for monitoring and presenting data related to the At-Risk system at LBSSLC. Conversations with the ADOP and PCN indicated that there was a greater recognition that the At-Risk process consisted of many complex facets that had to be woven together in order for the system to be effective and proactive. However, at the time of the review, there continued to be a 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 21 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 two individuals' ISPs meetings (i.e., Individual #290, and Individual #195) while on site. Specifically, the observations of the ISP meetings indicated that:	

#	Provision	Assessment of Status	Compliance
		▪ All appropriate disciplines were present at both (100%) of the observed ISP meetings. ▪ The staff present at the ISP meetings were the actual staff that worked with the individual, and not substitute staff sitting in for other staff members for both (100%) of the ISP meetings. ▪ The individual was present at both (100%) of the ISPs meetings observed. ▪ The IDT consistently used the Risk Level Guidelines when determining risk levels at both (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 #290, and Individual #195 when determining risk levels. For example, Individual #290 was rated at medium risk for constipation. The only data discussed was that he had a KUB in July 2013 that showed constipation. Otherwise, the only summary of his status was the nurse stating: "he doesn't have any big problems" with constipation. Similarly, although T scores were discussed for his osteoporosis diagnosis, it was just noted that he has a "Vitamin D deficiency" without any lab values. Calcium levels were not discussed, and there was no comparison of relevant levels from year to year. In the meeting, the nurse showed the graph of his seizure activity, which was helpful, but it should have been included in the IRRF. ▪ Overall, the risk levels the IDT designated were appropriate for each category for none of the ISPs observed (0%), based on information and data provided by the IDTs. The lack of comparison clinical data found at both ISPs made it difficult if not impossible to determine if the risks levels assigned were appropriate, and it was unclear why more data was not requested by the IDTs in several instances. ▪ There was adequate and appropriate clinical discussion among appropriate team members in decisions regarding risk levels in both (100%) of the ISPs meetings observed. However, the lack of clinical data presented at both ISPs rendered the discussions limited. ▪ 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 two (100%) of the ISPs meetings. In addition, other positive observations from the Monitoring Team regarding the ISP meetings included: ▪ Individual #290's team was respectful of his inability to tolerate a lengthy meeting, and when he indicated he needed a break, the team encouraged him to take one. ▪ The team for Individual #290 reviewed the IHCPs for the high and medium risk ratings. This allowed the team to ensure that the supports discussed were included in the IHCPs. ▪ The PCP for Individual #195 took an active role in all the IDT's discussions and brought up many pertinent issues related to her functioning and abilities. ▪ Although not always included in the documentation on the IRRFs, the IDT for Individual #195 appeared to have a good knowledge base of her history, personality, and past medical status. ▪ Individual #195's LAR was able to attend the meeting via conference call and frequently gave input into the team's discussions and recommendations. ▪ Individual #195's team had drafted the IRRF and the IHCP prior to the ISP.	

#	Provision	Assessment of Status	Compliance
		Problematic areas needing focus or improvement included: ▪ Based on information discussed at Individual #290's ISP meeting, disciplines were not sufficiently collaborating in an integrated manner to address his areas of risk. Individual #290's team identified him as being at high risk for falls. He had experienced falls out of his wheelchair, some of which had resulted in injuries. The team discussed a previous attempt to request approval to move the clasp of his seatbelt to the back of his chair, but the Human Rights Committee did not approve the restriction. The Human Rights Committee's disapproval seemed appropriate, given that the team did not appear to have exhausted other alternatives. Although there clearly was good reason for concern about his safety, the team did not engage in an integrated discussion about alternatives to restrictive practices. Specifically, Behavioral Health Services staff did not offer suggestions regarding ways to potentially reduce Individual #290's efforts to unlatch his seatbelt, or increase his compliance with keeping it buckled. No one on the team sought Behavioral Health Services staff's advice, or recommended completion of a structured functional behavior assessment to determine the function of the behavior. ▪ Moreover, Individual #290's draft ISP indicated that he was "noted to have over 100 seizures within the past 12 months," and this was part of the justification for enhanced level of supervision when he was away from his home. However, the team did not define or discuss in the draft ISP what "enhanced supervision" would entail (e.g., line of sight, within arms reach, number of other individuals under supervision, etc.). ▪ During his ISP meeting, Individual #290's team discussed the need for a desensitization plan or other strategies to reduce the need for sedation during dental appointments. Although the team asked the Dentist about the type of procedure Individual #290 needed due to a condition caused by his seizure medications and determined it was a painful procedure, the team did not further consider whether Individual #290 was cooperative with less intrusive dental work and/or oral care, and if not, whether development of a desensitization plan or other strategies would be appropriate. In fact, his draft ISP indicated his behavior during previous dental work was noted to be "fair-poor… and [he] was uncooperative during the exam." ▪ For Individual #290, the team did not discuss measurable goals for the IHCP. As a result, it was unclear how the team would know whether or not the supports developed were benefitting the individual. In other words, it was unclear how the team would know whether Individual #290 was doing better or worse, or remaining stable. ▪ Individual #290's PBSP had been discontinued in 2011 because his hitting behavior had decreased, and the team indicated they were monitoring his behavior informally. However, throughout the ISP meeting, Individual #290 hit the direct support professional who was with him. He also had three incidents of peer-to-peer aggression. As discussed above, he also was regularly unbuckling his seat belt, which placed him at risk for falls. Individual #290 also engaged in behaviors such as throwing his glasses across the room, and laughing when staff picked them up (indicating a potential attention-seeking function). It was unclear why the team was not requiring more formal involvement of Behavioral Health Services staff, and/or considering implementation of formal behavioral strategies. ▪ The IRRFs for Individual #290 and Individual #195 did not include some relevant clinical information in order to designate appropriate risk levels. For example, lab values or ranges were not consistently included in the IRRF's risk categories to indicate if the status of a particular health issue had improved	

#	Provision	Assessment of Status	Compliance
		or worsened over the past year as compared to the previous year. ▪ In addition, the IHCP for Individual #195 did not include nursing assessments that would be required by the nursing protocols for health issues, such as constipation and skin integrity. ▪ For Individual #195, the discussions regarding her visual acuity (she was noted to be blind) was incongruent with some of her supports, such as the use of a light board, or her preference to watch TV and game shows. ▪ The SAPs for Individual #195 regarding holding a napkin and holding a coin purse lacked association with functionality. ▪ 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 195'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 IDT indicated that the family for Individual #195 had not been involved. However, the ISP indicated that she enjoys her relationship with her family without any further information to support how this was determined. ▪ In discussing Individual #195's injuries during the past year, the IDT indicated that there were no trends identified. However, from the injuries listed in the ISP, there was clearly a trend of injuries (three of four listed) that involved her left wrist and hand, but the IDT did not identify or assess the trend. From the Monitoring Team's observations and record reviews, some positive steps were noted regarding the process, structure and format of the ISP meetings. However, more efforts are needed to ensure that the risk levels are accurate and supported by clinical data, that the IHCPs reflect supports of the necessary clinical intensity in alignment with the appropriately designated risk levels, that objectives included are functional and/or measurable, that adequate preventative measures are discussed and are included in the integrated health care plans, and teams clearly document this process. In addition, LBSSLC should continue to provide training and mentoring for the IDTs regarding the At-Risk process. The Facility remained out of compliance with this provision.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of	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 the ADOP reviewed a 100% sample of Individual Support Plan Addendums (ISPAs) each month to determine if the IDTs addressed changes of status (CoS) within five days. CoS were identified through the Morning Provider meeting tracking each month and the start of the five-day period was calculated from the date the CoS was identified. Examples of CoSs monitored included hospitalizations, significant diagnostic testing findings, multiple appointment refusals, and increased maladaptive behaviors. Using this criteria to measure compliance, the Facility's findings are noted below:	Noncompliance

#	Provision	Assessment of Status	Compliance

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.

	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14
Number of change of status meetings requested	10	7	14	7	7	6
Number of change of status meetings which occurred within five days	9	7	13	6	6	6
Compliance	90.0%	100.0%	92.9%	85.7%	85.7%	100.0%
Facility six-month compliance:						92.4%

- In addition, the Facility presented data regarding the Provider Meeting tracking system to determine the number of ISPAs requested, the number of ISPAs received and reviewed at the provider meeting, and the number of ISPAs whose recommendations were accepted or deemed clinically appropriate. The data indicated that the percentage of interventions deemed clinically appropriate varied from month to month, and reflected a significant decrease when compared to data from the previous six-month period, which was 83%. The Facility indicated that the decrease was actually a positive change in that it reflected an increase in the critical review of the ISPA recommendations.

Month	ISPAs requested	ISPAs received	ISPA recommendations accepted	Percentage deemed clinically appropriate
Nov-13	8	6	6	75%
Dec-13	7	7	6	86%
Jan-14	14	14	12	86%
Feb-14	7	6	3	43%
Mar-14	7	6	6	86%
Apr-14	6	6	1	17%

Self-rating:
The Facility reported that: "based upon the findings of the self-assessment this provision is not in compliance as evidenced by data indicating that while improvement has been made with IDTs addressing changes of status within 5 days, the supports and interventions being implemented are not sufficient to address the risks resulting from the change in status. Action Plans for Section I.2 address the identified issues related to the quality of the supports and interventions being put in place to address risks associated with changes of

#	Provision	Assessment of Status	Compliance
		status." Based on a review of records for 21 individuals determined to be at risk (i.e., Individual #304, Individual #68, and Individual #269 for aspiration; Individual #322, Individual #288, and Individual #131 for behavioral issues; Individual #181, Individual #225, and Individual #242 for fluid imbalance issues; Individual #223, Individual #161, and Individual #30 for gastrointestinal issues; Individual #293, Individual #317, and Individual #323 for infections; Individual #276, Individual #76, and Individual #136 for weight issues; and Individual #175, Individual #179, and Individual #111 for constipation.), 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; ▪ When recommendations for further assessment were found on the Risk Action Plans/IHCPs, the date of completion was frequently left blank, or the dates that were listed on the Action Plans did not correspond to dates on the Integrated Risk Rating forms, ISPs, or ISP addendums. Thus, it was impossible to determine what precipitated the recommended assessment, and if it was actually timely completed. <u>Nursing Assessments</u> Based on a review of 21 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 #304, Individual #68, and Individual #269 for aspiration; Individual #322, Individual #288, and Individual #131 for behavioral issues; Individual #181, Individual #225, and Individual #242 for fluid imbalance issues; Individual #223, Individual #161, and Individual #30 for gastrointestinal issues; Individual #293, Individual #317, and Individual #323 for infections; Individual #276, Individual #76, and Individual #136 for weight issues; and Individual #175, Individual #179, and Individual #111 for constipation. More specific details are provided with regard to Section M.2. In addition, a review of the most current quarterly or annual Comprehensive Nursing Reviews for the above 21 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 Review form. Although not consistent, the Monitoring Team found that since the last review, more progress had been made regarding the use of data from the current quarter as compared to the previous quarter in the analysis of the high and medium health/mental health indicators in a number of the nursing summaries. However, overall, none of the Annual/Quarterly Nursing Review summaries reviewed actually included an adequate analysis of the individuals' health/mental health issues between quarters, indicating if the health issues were improving, maintaining, or getting worse. In addition, due to the ongoing	

#	Provision	Assessment of Status	Compliance
		lack of implementation of the nursing protocols for existing conditions/diagnoses, appropriate clinical nursing assessments were not consistently being conducted for the individuals, and this resulted in an absence of objective clinical data generated to even allow a complete and thorough analysis of the health/mental health issues to occur. 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 21 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. <u>Medical Assessments</u> Six records were reviewed to determine adequacy of risk assessment and completeness of risk reduction plans. These included the records for: Individual #171, Individual #68, Individual #161, Individual #113, Individual #181, and Individual #74. The following provides more detailed information about the findings of the reviews: ▪ Individual #74 was hospitalized twice for respiratory distress in 2013. Diagnoses included viral bronchitis and pneumonia. The PCP attended the ISP meeting. The individual had Barrett's esophagus with dysplasia, was followed by a gastroenterologist, and required an ablative procedure for treatment of the Barrett's esophagus/ dysplasia. The history included dysphagia, gastroparesis, chronic gastritis, silent aspiration, and hiatal hernia. A discussion of risks and benefits of other treatment options for this individual were not submitted. In 2014, this individual was then hospitalized for UTI and seizures. An ISPA occurred while the individual was hospitalized, but the PCP did not attend. The individual had complex urological dysfunction, including a neurogenic bladder, and required intermittent catheterization. This occurred twice daily. The ISPA did not address ways to minimize a repeat UTI. Discussion of adequacy of hydration, hygiene, technique of catheterization, as well as monitoring/retraining of technique did not occur in the ISPA meeting, or was not documented. Because of the prior episodes of respiratory distress, this individual received suction tooth brushing. Due to the risk of aspiration, nursing was assigned the task of completing this procedure for the individual. It was documented in an ISPA that the individual underwent general anesthesia in a hospital setting for dental care. Oral hygiene was considered poor. However, it was noted that behavior in the dental chair was good, and the reason for the general anesthesia remained unclear when the individual was compliant with oral hygiene. A frequent prophylaxis in the dental chair might have prevented the need for deep scaling, but this was not addressed.	

#	Provision	Assessment of Status	Compliance
		▪ The PCP for Individual #181 attended the most recent ISP meeting. The individual had type III periodontal disease (i.e., intense gingival inflammation, moderate bone loss, light to moderate mobility), and received dental prophylaxis every six months under TIVA/general anesthesia. There was no mention of the need for dental desensitization or other plan for tooth brushing. The IRRF did not mention this. It was noted that the IRRF of 6/4/14 also indicated under the polypharmacy section that there were no side effects due to Trileptal, but this medication had to be decreased due to persistent hyponatremia (dating at least from January 2014) and eventually stopped. ▪ Individual #113 had an ISP meeting that the PCP attended, but the individual also had numerous ISPA meetings. This individual received suction tooth brushing by nursing. The individual was combative during tooth brushing. Type III periodontal disease was present, and the individual was to receive treatment under general anesthesia. There was no mention in the IRRF of the need for a desensitization program, or behavioral strategy to improve compliance with tooth brushing as an initial step to reduce gingival inflammation and potentially eventually reduce the need for general anesthesia. A BSP was in place, but did not appear to provide specific steps for the behaviors associated with suction tooth brushing and the steps to be taken by nursing to improve the individual's compliance. No other strategies or desensitization plan were in place. An ISPA of 5/22/14 documented that a dental SAP was discontinued due to lack of progress and combativeness, but there was no information concerning the need for a desensitization program/additional BSP addendum, etc. The individual had a dislodged feeding tube (most if not all times due to the individual removing the tube) on 10/3/13, 10/30/13, 11/3/13, 11/22/13, 12/19/13, and 1/30/14. On 11/4/13, the PCP requested an IDT meeting to address this issue. An ISPA from 12/20/13 and an ISPA from 1/30/14 addressed this concern. An ISPA following the PCP request in 11/2013 was not submitted. The two ISPAs for the feeding tube self-removal had appropriate recommendations specific to the individual. There were two additional ISPAs submitted (dated 5/7/14 and 5/15/14). These ISPAs included specific recommendations appropriate to the concern (i.e., falls, behaviors causing self-injury, sunburn, etc.). These two ISPAs demonstrated interdisciplinary discussion and understanding of the concerns to be addressed. There were three to four recommendations from each of these ISPAs, which appeared appropriate in resolving the challenges discussed. ▪ On 2/12/14, Individual #171 was hospitalized for nausea and vomiting. Three submitted ISPA meetings prior to this hospitalization (i.e., 10/8/13, 11/7/13, and 11/14/13) addressed diets and vomiting. Eleven recommendations were made from these ISPAs. Post-hospitalization, an ISPA occurred within two days to address continued vomiting. Three recommendations were made. The individual was followed closely by the IDT and PNMT, and ISPA meetings occurred monthly from February through May 2014. One additional recommendation was made. Another involved discussion of placement of a gastrostomy-jejunostomy (G/J) tube, but no final decision had been made according to the submitted documents through 5/14/14. The PCP attended the ISP of 5/14/14. This case demonstrated a highly responsive IDT, with multiple ISPA meetings, and timely response to the hospitalization. Information concerning benefits/risks of a G/J tube placement was not submitted.	

#	Provision	Assessment of Status	Compliance
		In summary, for this sample of individuals, medical care appeared appropriate and timely. The record of clinical decision-making was not always well documented, especially concerning risks and benefits of various treatment options. These should be located in the annual medical assessment/IRRF and/or ISP. Depending on the concern, a discussion might be appropriately recorded at an Ethics Committee meeting. Most of the areas of need appeared to be in the non-medical areas, such as aggressive evaluation for dental desensitization. A recently implemented Facility-wide CAP for this area might assist the IDTs. The quality of the ISPAs varied, with some having several practical recommendations, and others not addressing preventive steps. The Facility indicated that it was not in compliance with the requirements of the Settlement Agreement for this area. This was consistent with the findings of the Monitoring Team.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that	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 continued to be difficult, which was consistent with the findings of the Monitoring Team for this area, as discussed below. The Facility's record reviews indicated that action steps referring to long standing processes, such as documentation on the Food/Fluid sheets, Bowel Management Records, and PNMP data sheets, were able to be verified and were initiated within 14 days of the IHCP's development in nine of 15 (60%) records, and that there was some improvement with documentation of the action steps in the IHCP regarding the Direct Support Professional Treatment Records in six of 15 (40%). However, action steps assigned to LVNs and RNs providing direct care, such as vital signs every shift, were unable to be verified on a consistent basis in the Integrated Progress Notes. <u>Self Rating</u> The Facility's Self-Assessment indicated that: "based upon the findings of the self-assessment this provision is not in compliance as evidenced by data indicating that the integrated health care plans did not contain required elements and lack of evidence to show implementation within 14 days. Action plans for Section I.3 address quality and implementation of the integrated health care plans." Based on a review of 21 records for individuals determined to be at risk (i.e., Individual #304, Individual #68, and Individual #269 for aspiration; Individual #322, Individual #288, and Individual #131 for behavioral issues; Individual #181, Individual #225, and Individual #242 for fluid imbalance issues; Individual #223, Individual #161, and Individual #30 for gastrointestinal issues; Individual #293, Individual #317, and Individual #323 for infections; Individual #276, Individual #76, and Individual #136 for weight issues; and Individual #175, Individual #179, and Individual #111 for constipation), there was documentation that the Facility: ▪ Established an appropriate plan within fourteen days of the plan's finalization, for each individual, as	Noncompliance

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	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.	appropriate, in one of the cases reviewed (5%) (i.e., Individual #225). Although all 21 individuals (100%) were found to have a care plan addressing their high or medium health/mental risk indicator, only one sufficiently addressed the health risk in accordance with applicable nursing protocols. ▪ Implemented a plan within fourteen days for each individual, as appropriate in one (5%) of the cases reviewed (i.e., Individual #225). The 21 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 for 20 of the 21 reviewed. In addition, a number of the action steps in the 20 IHCPs were nonspecific and thus, could not be verified. ▪ Implemented a plan that met the needs identified by the IDT assessment in one of these cases (5%) (i.e., Individual #225). ▪ Included preventative interventions in the plan to minimize the condition of risk in one of the cases (5%) (i.e., Individual #225). Although some generic interventions were found in some other IHCPs addressing, for example, the need to encourage adequate fluids or 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 one of the cases (5%) (i.e., Individual #225). ▪ Integrated the IHCP into the ISPs in 21 of the 21 cases (100%). ▪ None (0%) of the plans reviewed showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ One of the plans (5%) (i.e., Individual #225) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan. ▪ One of the plans (5%) consistently included the specific clinical indicators to be monitored (i.e., Individual #225). ▪ The frequency of monitoring was included in the plans for one of the individuals (5%) (i.e., Individual #225). Although the other 20 plans contained a heading addressing "Monitoring Frequency," the frequency was either noted generally as ongoing, daily or weekly without the specific shift or day included to ensure accountability, or it was not addressed. LBSSLC should continue to focus its efforts on the process of developing specific and clinically appropriate IHCPs. The one IHCP that was found to be in compliance should be used as an example to illustrate for nursing staff how the Nursing Protocols should be used to direct clinical care. The nursing protocols that were found in the other 20 IHCPs were noted to be implemented only in the event of an acute issue related to the high/medium health risk indictor. It was very troubling at this juncture of the Settlement Agreement review process that only one IHCP included clinically appropriate nursing protocols that required nursing staff to conduct regular nursing assessments for high and medium health risks, particularly because the other 20 IHCPs were also for individuals that had already experienced health issues related to their elevated health/mental health risk ratings.	

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		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 7/9/14 Pharmacy and Therapeutics (P&T) Committee Meeting; o Alphabetical list of individuals psychiatrically hospitalized during the last year; o A table entitled: "Comparative Polypharmacy," which provided historical data for the following categories: • Individuals on one psychotropic medication; • Individuals on two psychotropic medications; • Individuals on three psychotropic medications; • Individuals on four psychotropic medications; • Individuals on five psychotropic medications; • Individuals on six psychotropic medications; • Individuals on two antipsychotic medications; • Individuals on two or more mood stabilizers; • Individuals on two antidepressants; • Individuals receiving benzodiazepines; • Individuals on conventional antipsychotics; • Individuals on Mellaril; and • Individuals on Atarax; o 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, including: 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;

	○ Curriculum vitae (CV) of Allan Hanretta, M.D., Ph.D.; ○ CV of Boris Porto, M.D.; ○ CV of Shiraz Vahora, M.D.; ○ Overview of Psychiatrists' weekly schedule, undated; ○ Reiss Screening spreadsheet; ○ Job description of Psychiatrist III, undated; ○ Minutes, supporting documents, and attachments for the "Monthly Facility Review of Psychoactive Medication Polypharmacy" meetings for the past six months; ○ List of individuals who have Psychiatric Support Plans; ○ For the following individuals the Facility selected in response to the Monitoring Team's pre-review document request and considered to be psychiatrically stable: Individual #82, Individual #83, Individual #202, Individual #266, Individual #67, Individual #84, Individual #68, Individual #255, Individual #25, and Individual #114, the following sections of the medical record: • Demographic Information (e.g., Profile Sheet – Photograph and Identifying Information Sheet); • Social History Evaluation; • Individual Support Plan (ISP) section; • Positive Behavior Support Plan (PBSP) section, including Addendums; • Psychological Assessment; • Functional Assessment; • Annual Medical Summary, including: 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; • Neurology Consultation section; • Documentation and consultations regarding the use of pre-treatment sedation medication (i.e., Treatment Plan, Guardian Approval, Human Rights Committee (HRC) Approval, etc.); and • Human Rights section, including a copy of the signed consents; ○ The same set of records was requested during the Monitoring Team's onsite review for the following individuals: Individual #33, Individual #137, Individual #126, Individual #4, Individual #239, Individual #380, Individual #213, Individual #1, and Individual #8; ○ Documentation for the following episodes in which chemical restraint (including the dates and hours of restraint) was administered: Individual #4 (4/7/14 at 1:45 p.m., and 5/14/14 at 4:45 a.m.); Individual #187 (6/3/14 at 9:34 p.m., and 6/3/14 at 10:48 a.m.);

	and Individual #299 (5/4/14 at 7:47 a.m.); o List of individuals who received pre-treatment sedation for medical and/or dental appointments for the prior six months; o The utilization data for dental pre-treatment sedation and Intravenous (IV) or general anesthesia, for the prior six months; o Spreadsheet of individuals listing the status of CPA completion as of 6/30/14; and o MOSES/DISCUS side effect scales for the following five individuals prescribed Reglan: Individual #323, Individual #312, Individual #176, Individual #135, and Individual #199. ▪ **Interviews with:** o Shiraj Vahora, M.D., Staff Psychiatrist, Allan Hanretta, M.D., Ph.D., and Edie McFadden, R.N., on 7/7/14, 7/8/14, and 7/10/14; o Becky Crawford, BCBA, Director of Behavioral Health Services; and James Forbes, BCBA, on 7/7/14; o Dr. William Shipley, Director of Dental Services, on 7/7/14; o John Todd, R.PH., Clinical Pharmacist, on 7/7/14; o Sheila Powell, Human Rights Officer, on 7/9/14; o Raul Trevino, Program Compliance Monitor for Psychiatry; Allan Hanretta, M.D., Ph.D., Shiraj Vahora, M.D.; and Edie McFadden, R.N., on 7/8/14 to review the Facility Self-Assessment; o Edie McFadden, RN (Psychiatric Nurse), on 1/7/14; and o Dr. Glenn Shipley, Medical Director, on 7/10/14. ▪ **Observations of**: o Polypharmacy Committee Meeting, on 7/9/14; o P&T Committee Meeting, on 7/9/14; o Psychiatric Clinics at 514 South Cedar (Birch), on 7/8/14; o Psychiatry Clinics on 521 North Cedar (Canna), on 7/9/14; o Neurology Clinic with Dr. Daniel Hurst, on 7/9/14; o Neurology Consultation with Dr. John DeToledo, on 7/10/14; o ISP meeting for Individual #251, on 7/9/14; o Human Rights Committee Meeting, on 7/8/14; and o During the Psychiatric Clinic and the Neurology Clinic, as well as the visits to the residences and day/vocational programs at LBSSLC, the following individuals were observed: Individual #240, Individual #75, Individual #251, Individual #65, Individual #108, Individual #8, Individual #239, Individual #276, Individual #91, Individual #279, Individual #140, Individual #1, Individual #202, Individual #213, Individual #222, Individual #83, Individual #116, Individual #227, Individual #88, Individual #22, Individual #119, Individual #34, Individual #290, Individual #102, Individual #197, Individual #283, Individual #269, Individual #250, Individual #70, Individual #184, and Individual #146.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section J, dated 5/28/14. 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 7/8/14, during the Monitoring Team's onsite review, these materials, including the Facility Self-Assessment, were reviewed with the two staff Psychiatrists, the Psychiatric Nurse, and the Program Compliance Monitor (PCM) 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 (QA) reviews consisted of the Psychiatric Nurse, the two Staff Psychiatrists, 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 the other Psychiatrist treated. The PCM randomly selected the two records 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 (i.e., 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 128 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:

- The Facility used monitoring/auditing tools:
  - The monitoring/audit tools the Facility used to conduct its self-assessment included the "Section J – Psychiatric Care and Services Monitoring Tool," finalized by the DADS State Office on 2/19/13.
  - 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 (i.e., 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 instructions 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, which the Director of Psychiatry moderated. 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 Psychiatrists. o The staff responsible for conducting the audits/monitoring had experience in relevant clinical/programmatic area(s). However, the Facility did not have a formal mechanism for determining their competence to conduct the audits. 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. o 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 the degree of 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 the two Psychiatrists and the PCM attended. ▪ 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, 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: o On a positive note, the Facility Self-Assessment consistently presented the Facility's findings in a simple, straightforward "yes/no" dichotomous manner, with the exception of the spreadsheets referenced above. Results on the spreadsheets were reported as completion rates, which were then translated into percentages. o Of concern, the reviews primarily focused on the presence or absence of items. 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. o 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 staff member also attended selected meetings of the Psychiatry Department to familiarize himself with the psychiatric treatment process at LBSSLC. ▪ 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 consistent with those of the Monitoring Team. ▪ The Facility Self-Assessment identified areas where more improvement was needed. This observation was true for the one provision 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; as well as the new initiative to develop Desensitization Plans to decrease the reliance on anesthesia). 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 last review, there had been significant changes in the staffing of the Department of Psychiatry. A previous staff Psychiatrist had become the Director of Psychiatry, after the departure of the previous Director. The Facility had been able to add a new full-time Psychiatrist, so there were two full-time Psychiatrists who were both Board Certified, as was the Consulting Psychiatrist, who continued four hours per week to update the CPAs. In addition, the full-time

	Psychiatric Nurse continued to be a valuable asset and the Psychiatric Clerk position also had been filled. The CPA completion rate continued at 100 percent, and the Psychiatrists had attended the ISPs of the individuals they followed at a monthly rate of 100 percent, except for February, when it dropped to 92 percent. The problems with ISP documentation identified in the Monitoring Team's prior report had been rectified through close cooperation with the ISP team. Over the prior six months, eight individuals had been admitted to the Facility, all of whom had significant psychiatric and behavioral issues. For these individuals, community supports available had been insufficient to meet their needs. As might be expected, these individuals were admitted on multiple psychotropic medications. One individual had been prescribed seven psychotropic medications, while others had been prescribed five psychoactive medications. The Psychiatrists had begun to carefully decrease these medications. The rate of active polypharmacy had increased from 14 to 16 percent, which was in large part due to previously admitted individuals who had been there for greater than one year, migrating from the New Admissions category to the Active Polypharmacy List. The Psychiatrists had begun to perform the DISCUS evaluations themselves, rather than have the nurses perform them. These examinations were done in conjunction with the Quarterly Psychiatric Reviews. The rate of chemical restraint for the most recent six-month period was significantly less than the prior six-month period, despite the admission of eight individuals with problematic behavioral presentations in this timeframe. The Psychiatrists had begun to increase the routine daily medications for individuals who appeared to be entering the manic phase of their Bipolar Disorder and then decrease the dose after the crisis had passed. This was a reasonable clinical intervention, which might have contributed to the decrease in frequency with which chemical restraint was used at the Facility. There also had been an improvement in the quality of the review of the chemical restraint documentation by the Clinical Pharmacist and the Psychiatrist. During the Monitoring Team's onsite review, there was a review of the Facility's new initiative to improve the process of developing Desensitization Plans and other strategies to reduce the need for pre-treatment sedation for medical and dental procedures. The Facility had gathered together a multi-disciplinary team to reformulate and improve this initiative from the ground up.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	In the interval since the prior review, Dr. Richard Weddige, the Director of Psychiatry, has left the Facility. Dr. Shiraj Vahora continued at LBSSLC on a full-time basis. The American Board of Psychiatry and Neurology certified Dr. Vahora in both Adult Psychiatry and Geriatric Psychiatry. Dr. Vahora joined the Department in September 2012.	Substantial Compliance

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		Dr. Allan Hanretta was also Board Certified in Adult Psychiatry and also had a Ph.D. in Pharmacology. On 4/1/14, he joined the LBSSLC Department on a full-time basis. Prior to that, he had worked in the Texas Criminal Justice System for eight years. His career was in academic Psychiatry at the Texas Tech Health Sciences Center, as an Associate Professor in the Department of Neuropsychiatry. As a Resident in Psychiatry at Texas Tech, Dr. Hanretta did both a rotation and an elective at LBSSLC. Dr. Hanretta also had some exposure to clinical work with individuals who had intellectual disabilities/ developmental disabilities (ID/DD) when he worked in the Criminal Justice System. In October 2013, Edie McFadden, RN, joined the Department of Psychiatry as a full-time Psychiatric Nurse, having previously worked for four years in the QA Department at LBSSLC. She had seven years of experience working with individuals who had ID/DD when she worked in the Criminal Justice System. Dr. Boris Porto continued to work at the Facility as a Consultant for four hours per week. He was Board Certified in both Adult and Child and Adolescent Psychiatry by the American Board of Psychiatry and Neurology. His experience with individuals with ID/DD has been described in the Monitoring Team's previous reports. The Facility was found to be in substantial compliance with this provision, as the Psychiatrists were all Board Certified in Adult Psychiatry. In addition, the Psychiatrists and the Psychiatric Nurse had prior clinical experience working with individuals who have ID/DD.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	A total of 128 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 maintained an initiative to complete a thorough CPA that would comply with the terms of the Settlement Agreement for all of	Substantial Compliance

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		the individuals prescribed psychotropic medication. The Department of Psychiatry maintained data related to its progress in completing the CPAs for those individuals prescribed psychotropic medication. Review of this spreadsheet entitled: "Psychiatric Assessments (Active List)," indicated that an initial or updated CPA had been completed for all of the 128 individuals 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%) 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. Since the prior review, there had been two modifications of an individual's psychiatric diagnosis. These changes involved adding the diagnosis of "Tic Disorder" for Individual #155, and the diagnosis of "Pica" for Individual #284. These changes were confirmed by review of the Department's "Dx Changes" flow sheet and in the 7/7/14 interview with the members of the Psychiatry Department. 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 being attributed to environmental and/or behavioral factors in the Psychology section of the individual's record. The Psychiatry Department, working in conjunction with the Department of Behavioral Services, had effectively addressed this problem through the systemic methods discussed in detail with regard to 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	

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		prescribed psychotropic medication. In addition, 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 full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	The individual interviews with the Psychiatrists, and the direct observations of the Psychiatric Clinics, as well as the review of the records of 19 individuals prescribed psychotropic medication did not reveal any evidence that psychotropic medication was being overtly used for the convenience of the staff, or as a form of punishment. A member of the Monitoring Team was able to directly observe approximately 24 percent 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 status of the Facility's efforts to monitor for the side effects of psychoactive medications is described with regard to Section J.12. 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 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 Department, this problem had been eliminated in the clinical documentation of the records of 19 (100%) of the individuals receiving psychotropic medication. This is further discussed with regard to Sections J.8 and J.9. The quality of the 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	Substantial Compliance

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		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 the data related to the five most recent episodes of chemical restraint data was reviewed:	

INDIVIDUAL #	DATE	TIME	MEDICATION
Individual #4 (Episode A)	4/7/14	1:45 p.m.	Ativan 2 milligrams (mg) plus Haldol 5mg IM
Individual #299	5/4/14	7:47 a.m.	Ativan 1mg plus Haldol 5mg IM
Individual #4 (Episode B)	5/14/14	4:45 a.m.	Ativan 2mg plus Haldol 5mg IM
Individual #187 (Episode A)	6/3/14	9:34 p.m.	Ativan 2mg IM
Individual #187 (Episode B)	6/3/14	10:48 a.m.	Ativan 2mg (route not specified)

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. The documentation for Individual #4 (Episode A) indicated that this individual was aggressive and agitated prior to the restraint, and also indicated that he was entering the manic phase of his Bipolar Disorder, as illustrated by the following excerpt from the documentation dated 4/7/14:

  DESCRIPTION OF BEHAVIORS PRIOR TO RESTRAINT: DESCRIBE THE INDIVIDUAL'S ENVIRONMENT, ACTIONS, AND INTERACTIONS WITH OTHERS IN THE TIME BEFORE YOU BEGAN TAKING STEPS TO AVOID THE USE OF RESTRAINT

  Individual #4:
  "[Individual #4] was screaming, kicking, spitting, slapping, and flopping to the floor. Head banging on walls, floor. [He] would not let nurse look at him. ***Had been agitated since the morning. Appears to be entering cycle."***

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		However, as illustrated above, the last two sentences of this description were written with a darker pen and appeared to be in a different handwriting. The analysis of the documentation for the remaining four episodes was as follows: Individual #4 – Episode B: *"Displaying physical aggression (hitting, kicking, spitting, and [illegible word] at staff and peers. All attempts to redirect failed and three prior restraints failed. Individual #4 is still showing high aggression towards staff and peers. Chemical ordered and approved."* Individual #299: *"Individual #299 was running through the home throwing, pushing staff and grabbing staff, screaming, yelling, and falling to floor."* Individual #187: *"Physical aggression, attempted UAD [unauthorized departure] chemical given at 10:49 pm."* Individual #187 – Episode B: *"Physical aggression/UAD (unintelligible word) chemical given at 9:32 pm."* The review of this section of the chemical restraint documentation found that it was adequate for the two episodes involving Individual #4, but not the other three (40%). ▪ 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 adequately described the interventions 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 Individual #187 (Episodes A and B), the documentation indicated that the individual refused the vital signs. The documentation went on to describe the individual's mental status and level of physical agitation. Thus, this review found that in all of the five (100%) incidents reviewed, the individual's physiological status was assessed, and if this was not possible, there was a description of the individual's general level of alertness and physical activity. ▪ 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	

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		adequate description of the antecedents, and an overall summary of the events. This information provided the detail concerning the antecedent circumstances that was frequently missing in the initial description of antecedent events that followed the initial prompt to describe the circumstances that led up to the restraint, as described above. ▪ The Chemical Restraint Clinical Review Form was completed for all five (100%) individuals in a timely manner (i.e., within 10 days). Each of the five Clinical Review Forms contained comments from the Pharmacist and Psychiatrist related to 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 10 pages of specific, detailed information related to the incident, as described above. Both the Pharmacy and Psychiatric Reviews contained significantly more detailed information than those found in prior reviews. Thus, the essential five elements of the documentation needed to verify the appropriate utilization of chemical restraint were adequately completed for all of these individuals, with the exception of the section following the initial prompt to describe the context for the episode of chemical restraint, which was found to be adequate for two of the five (40%) individuals. However, the deficits in the initial description of the setting of these events 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 section were found to be informative in providing the context for the restraint in all five (100%) of these episodes. There was also an attempt to monitor, at a minimum, the individuals' mental status and level of physical activity for the two episodes during which the individual was too aggressive to monitor all of the physiological parameters. This 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. The final section of the documentation, which provided the summaries and opinions of the Psychiatrist and the Clinical Pharmacist, also had been significantly expanded. 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. The issues related to the use of chemical restraints are also reviewed and discussed in other sections of this report.	

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		During the Monitoring Team's onsite review, the staff Psychiatrists reported that they had begun to increase the daily medications of individuals who have a Bipolar Disorder when it becomes apparent that they are entering the manic phase of their Bipolar illness. Later, when the acute phase of the illness has spontaneously resolved, they will then decrease the medication. This was a reasonable clinical intervention, which might have contributed to the decrease in frequency with which chemical restraint was used at the Facility. 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, which was frequently related to an underlying Bipolar Disorder. The review of the most recent six months of chemical restraint utilization indicated a significant decrease in the frequency with which chemical restraint was required. This may, in part, be due to these interventions. The Facility was found to be in substantial compliance with this provision, as the improvements in chemical restraint documentation were significant and sufficiently clarified the nature of the events leading up to the interventions in a manner. This removed any doubt that they were being used for punishment or for the convenience of staff.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	The Human Rights Officer maintained a comprehensive spreadsheet concerning the use of pre-treatment sedation. This document listed all individuals for whom the Interdisciplinary Team (IDT) had sought approval from the HRC to use pre-treatment sedation and/or anesthesia, as well as whether the medication was used for a dental or medical procedure, or both. 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 this information was updated weekly, and the document was scanned on 7/8/14. Following a meeting of the Desensitization Workgroup in March of this year, the nomenclature for these categories had been changed to: ▪ Name; ▪ Dental Physical/Mechanical Restraint; ▪ Dental Chemical Restraint; ▪ Medical Physical/Mechanical Restraint; ▪ Medical Chemical Restraint; ▪ HRC Approval Expires; and ▪ Procedures: Routine or Treatment Specific. The heading entitled "Dental Chemical Restraint" was further clarified in the right-hand column, where it was noted that the method of sedation would either be "Total Intravenous Anesthesia" (TIVA) or oral pre-treatment sedation. The heading entitled	Noncompliance

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		"Medical Chemical Restraint" applied only to oral pre-treatment sedation for medical procedures, which was also specified in the right-hand column. The column entitled "Dental Chemical Restraint" listed 121 individuals. The column entitled "Medical Chemical Restraint" (previously "Medical Sedation") listed 13 individuals, as compared to 15 at the time of the Monitoring Team's last review, 23 at the prior review, and 41 at the review prior to that. The right-hand column of this spreadsheet also indicated whether there was a specific consent for TIVA. This column contained comments related to 114 individuals, which indicated that consent for TIVA was in place for dental procedures. Thirty-two of these individuals had a further notation that the TIVA should be administered at the UMC (University Medical Center). The prior Director of Dental Services had 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. This documentation listed six administrations of medication for medical procedures, as compared to 15 for the six months prior to the Monitoring Team's last review, and 16 in the six months prior to that. The six administrations during the past six months were given to a total of three individuals. (One individual received four of the six administrations, for four different procedures.) The medication used for the six administrations of pre-treatment sedation included: Ativan 2mg (four times), Ativan 1mg (one time), and Zyprexa 5mg (one time). During the prior two six-month periods (one year), there had been no oral administrations of pre-treatment sedation for dental procedures. This was compared to 78 individuals for whom "inhaled general anesthesia" was utilized from 9/1/13 to 4/30/14, as based on the report by the dental specialist who performed these procedures. The Facility's census at the time of the Monitoring Team's onsite review consisted of 204 individuals. The census had fluctuated over the prior six months, due to admissions and discharges. Utilizing the current census of 204 as a general number on which to base calculations, this would indicate that, currently, the IDTs had sought Human Rights approval to use anesthesia for 114 individuals (56%) of the total population of LBSSLC,	

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		and during the aforementioned six-month period, anesthesia had been administered to 78 individuals (38% of the population) to accomplish a dental procedure. In comparison, over the last year, no individuals had been administered oral pre-treatment sedation for dental procedures, and there had been little progress in developing pre-treatment Sedation Plans. The Facility recognized that these rates of general anesthesia were high compared to that utilized for similar populations and had developed a multidisciplinary team to completely redo the dental desensitization initiative from the ground up. During the current onsite review, the members of the Facility's interdisciplinary team met with several members of the Monitoring Team to provide a detailed overview of this initiative. Thus, although the finding of noncompliance is carried forward from the prior review, the Facility appeared to be embarking on a strategic plan that will likely produce positive results in meeting the requirements of this provision of the Settlement Agreement.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	At the time of the Monitoring Team's prior reviews, the Director of Psychiatry had completed an analysis of the time commitment required of the Psychiatry Department to provide ongoing, routine psychiatric services to the individuals at LBSSLC, including fulfilling the requirements of the Settlement Agreement. A discussion of these calculations with the Director of Psychiatry indicated he had taken into account the time needed to prepare and complete the CPEs, attend the ISP meetings of the individuals prescribed psychotropic medication, and other activities required by the Settlement Agreement, as well as maintain the ongoing day-to-day psychiatric treatment of these individuals. He concluded that two full-time Psychiatrists should be sufficient to provide services to the individuals who received psychotropic medication at LBSSLC. On 7/7/14, this subject was discussed again with the members of the Psychiatry Department. As indicated with regard to Section J.1, the number of full-time Psychiatrists continued to be 2.1 full-time equivalents, and the workload was essentially the same as it was at the time of the Monitoring Team's last review. At the time of the Monitoring Team's current review, LBSSLC employed two full-time Psychiatrists. A total of 128 individuals were receiving psychotropic medications. Thus, each of the full-time Psychiatrists was responsible for the psychiatric care of approximately 60 individuals. As discussed in prior Monitoring Team reports, the Facility continued to employ the part-time Psychiatrist that had been added for four hours per week. This Psychiatrist did not have an active caseload of individuals, but rather, his time was devoted to performing second-opinion consultations, and annual updates of the CPAs. In addition to the two Staff Psychiatrists, the Facility also employed one full-time Psychiatric Nurse to help coordinate the psychiatric care of the 128 individuals	Substantial Compliance

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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>prescribed psychotropic medication. The Facility also had added a full-time Psychiatry Clerk to assist with the data collection related to meeting the requirements of the Settlement Agreement. This position had been vacant for four months (from 1/14 to 4/14). Thus, the total composition of the Psychiatry Department at LBSSLC continued to provide sufficient resources to meet this requirement of the Settlement Agreement.

The Facility was found to continue to be in substantial compliance with this provision of the Settlement Agreement. It employed a sufficient number of skilled Psychiatrists to provide appropriate clinical services to the individuals at LBSSLC.</td><td></td></tr>
<tr><td>J6</td><td>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.</td><td>The Facility had maintained the initiative to complete a thorough CPA for each individual receiving psychotropic medication that they believed would meet the standards set forth in the Settlement Agreement. The review of the medical records of 19 individuals receiving psychotropic medication identified a complete, annually updated CPA for all of the 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 completion rate status of the CPAs, indicated that all 128 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.

In the prior six months, eight individuals had been admitted to the Facility from the community, all of which were prescribed psychotropic medications. The CPAs for these eight individuals were requested and reviewed. This review found that all eight CPAs had been performed in a timely manner, and the content met the criteria specified in the Settlement Agreement. The specific information related to the completion of these CPAs is as follows:

NEW ADMISSIONS SINCE JANUARY 2014

<table><tr><th>INDIVIDUAL #</th><th>CPA COMPLETION DATE*</th></tr><tr><td>Individual #105</td><td>1/13/14</td></tr><tr><td>Individual #102</td><td>1/13/14</td></tr></table></td><td>Substantial Compliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		<table><tr><td>Individual #134</td><td>1/14/14</td></tr><tr><td>Individual #142</td><td>2/10/14</td></tr><tr><td>Individual #152</td><td>2/13/14</td></tr><tr><td>Individual #187</td><td>2/25/14</td></tr><tr><td>Individual #227</td><td>5/6/14</td></tr><tr><td>Individual #234</td><td>5/12/14</td></tr></table> *All of these were completed either on the date of admission, or shortly thereafter. This timely response appeared to have, in part, been due to the information contained in the pre-admission meetings. 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. In addition, based on data the Facility provided, CPAs had been completed within the past year for 100 percent of the individuals prescribed psychotropic medication at the Facility. 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.	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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J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	The integration between Psychiatry and 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 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 7/8/14 and 7/9/14 were similar to those that had been observed during the Monitoring Team's previous onsite reviews. 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, a Behavioral Health Services Provider, 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. The recent data the Psychiatry Department gathered indicated that, either the Psychiatrist or the Psychiatric Nurse attended the ISP meeting for the individuals receiving psychiatric services, at the following monthly rates from January through June	Substantial Compliance

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		2014: January: 100 percent; February: 92 percent; March: 100 percent; April: 100 percent; May: 100 percent; and June: 100 percent. (The above listing equates to a monthly average of 99%.) As indicated in the Monitoring Team's prior reviews, the Psychiatry Department had developed the Psychoactive Medication Treatment Plan (PMTP) to provide the necessary elements of individuals' Treatment Plan that were both necessary for an adequate review of the Plan by the entire IDT, and 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 was subsequently expanded and utilized for the purposes of providing information to the IDT as part of the ISP preparation process, in addition to the CPA. The Psychiatry Department was initially 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 IDT to the most recent CPA, which also covered the relevant information in more detail. Within the past six months, it had become possible for the Psychiatry Department to insert their documentation into the final ISP. As noted above, the Facility data indicated that the Psychiatrists had begun to routinely 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. The Psychiatrists indicated they had been directed to be present throughout the entire ISP meeting. The review of the records of the 19 individuals in this sample indicated the PMTP was completed and referenced in the ISP documentation for all 19 (100%) individuals. One of the primary mechanisms the Department used to convey their information to the ISP Team was the PMTP. The sections of that document, which were updated annually, are listed below: ▪ Demographic Information; ▪ Psychiatric Diagnosis; ▪ Symptoms of Diagnosis;	

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		▪ Target Symptoms Monitored; ▪ Derivation of Symptoms (including a 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; ▪ Psychoactive Medication (which contained the description of the medication, including the rationale for its use, and both the realized and potential side effects); ▪ Risk of Medication (which described overall risk presented by the medication); ▪ Risk of Illness (which described risk of harm to self or others presented by the illness); ▪ Non-pharmacological Treatment (which described behavioral and other non-pharmacological interventions that would be considered less intrusive); ▪ Risk Versus Benefit Discussion (which included overall discussion of the risk-versus-benefit equation); ▪ Past Pharmacotherapy (which described the results of past trials of psychotropic medication); and ▪ Future Plans (which described future plans regarding medication, as well as a community placement discussion). These documents were fully completed for each individual in the sample of 19 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. At the time of the Monitoring Team's prior review the format, which previously had been found to be effective, was no longer being utilized, and it was not clear why these changes had been made. Within the last six months, however, the Facility had returned to the prior format, which provided more information. The Behavioral Health Services section of the current Integrated Risk Rating Form (IRRF) contained the following outline: ***BEHAVIORAL HEALTH HISTORY*** *(including historical data if applicable)* <u>*Psychiatry:*</u> ▪ *Demographics:* ▪ *Diagnosis:*	

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		▪ *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* *The current psychiatric treatment is the least intrusive and most positive intervention to treat condition based on:* ▪ *The risk of illness is greater than the risk of medication: ___Yes ___No* ▪ *Benefits of the medications are greater than any potential adverse effects from the medication: ___Yes ___No* ▪ *Non-pharmacological intervention/treatment alone would not suffice for individual's needs:* *___Yes ___No* *<u>Behavioral Health</u>:* ▪ *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.* ***CURRENT SUPPORTS*** *<u>Psychiatry</u>:* ▪ *1) 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.*	

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		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.* ▪ *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*	

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		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 narrative section of the ISP discussion of the Psychiatrist's plan also had been expanded and included: 1. The rationale for determining that the proposed psychiatric treatments represented 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 monitored to ensure that the interventions are effective, and the incorporation of data into the discussion that would support the conclusions of these discussions; and 4. A discussion of both the potential and realized side effects of the medication, in addition to the benefits. The Monitoring Team's current review found that the narrative contained in the Psychiatry section of the ISP, coupled with the Behavioral Health Services section of the IRRF, met the requirement of this provision for 17 of the 19 (89%) individuals reviewed. The exceptions were the 4/8/14 ISP for Individual #83, and the 4/30/14 ISP for Individual #114. The narrative section of both of these ISPs only referred the reader to the PMTP and the CPA. Although they did affirm the team reviewed the PMTP in the ISP meeting, there was little or no description of the content of those discussions. This was not the case in the other 17 records, which contained a more complete narrative	

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		discussion, in addition to the material in the IRRF. Of interest is the observation that the detail provided in the narrative Psychiatry sections of the ISPs had become more detailed as time progressed (over the last six months). The reviews of the nine ISPs resulting from meetings that occurred in May and June of 2014 showed they contained incrementally more information than those that had taken place earlier in the six-month period, although those were adequate. This would suggest that the quality of these documents continued to improve. Thus, the deficits identified in the Monitoring Team's prior review had been rectified, and the Facility was found to be in substantial compliance with this provision. Specifically, at the time of the prior report, the Facility appeared to rely almost completely on the material contained in the IRRF and had reduced their narrative comments to a minimum in many of the ISPs reviewed. As noted above, the Facility had returned to providing more complete narrative summaries in the ISP to augment the information contained in the IRRF. The narrative summaries also contained the important description of the discussion that occurred during the actual ISP meeting, which was not present in the IRRF.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the	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 the 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/behavioral basis and/or as being related to environmental factors. It is entirely feasible that a given behavior could be co-determined by both biological and behavioral factors. However, the dual description of the behavior as both a target of the psychotropic mediation, 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 the records of 19 individuals prescribed psychotropic medication indicated the Facility had effectively rectified this problem through combined assessment and case formulation. None of the records included in this sample contained a contradictory reference to a behavior solely being present on a behavioral basis in the Behavioral Health Services section of the record, and then referenced as a target	Substantial Compliance

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	degree possible.	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 Services 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 link 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." The Behavioral Health Services Department had developed "Psychiatric Support Plans" for individuals whose aberrant behavior had been determined to derive primarily, if not exclusively, from their Axis I psychiatric disorder. The list of these individuals, which was requested during the Monitoring Team's onsite review, identified 16 individuals. The spreadsheet also contained the dates these Plans were approved by the Behavioral Support Committee, the Facility Director, and the consent from the guardian or LAR. It also listed the timelines and dates of completion for the competency-based training of the staff on the implementation of these Plans. There was also a column entitled	

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		"Readability – Flesch – Kincaid Grade Level," which indicated that the grade level necessary for reading these plans ranged from a low of 3.9 to a high of 6.9 (times two). During the review, a request was also made for the template was used to develop these Plans, as well as two completed Plans. The review of these Plans found that they were detailed and individualized to address the individuals' specific psychiatric diagnosis and related symptoms, and were not generic Plans. This subject is also discussed with regard to Section K. At the time of the Monitoring Team's prior review, it was noted that there continued to be insufficient discussion in the ISPs of the teams' deliberations with regard to whether the use of psychotropic medications represented the least intrusive approach to address the individuals' target behaviors. As 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 earlier onsite reviews, members of the Psychiatry Department indicated that the staff that prepared the final ISP documentation could not accommodate the inclusion of the detailed documentation described in this section of the Settlement Agreement, due to concerns about length. The Department also did not want to place the burden of summarizing this complex clinical information on the QIDP staff, who prepared the final ISP documentation. Accordingly, the Department had developed the PMTP, 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. These 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 utilized. The PMTP also included a section that discussed the Psychiatrist's recommendations 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 99 percent for the prior six months. The current review of the sample of 19 individual records, determined that for 18 of the 19 (95%) individual records there was documentation that the Psychiatrist had attended the ISP meetings, and the ISP documentation for all of these individuals contained	

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		evidence of the collaboration between the Psychiatry Department and Behavioral Health Services. In addition, the Psychiatry Department's internal tracking system indicated that during the January to June 2014 timeframe, a Psychiatrist had attended 99 percent of ISP meetings of individuals prescribed psychotropic medication. Thus, there was evidence the Psychiatrists had been routinely attending the ISP meetings of the individuals prescribed psychotropic medication. The ISP documentation also routinely contained a declarative statement affirming the IDT had reviewed the PMTP. As discussed with regard to Section J.8, the documentation related to the discussion of this material in the ISP documentation had improved and the corresponding information in the IRRF and narrative sections of the ISP was found to be comprehensive and met the requirements of this provision for 17 of the 19 individual records reviewed. The documentation of teams' review of the PMTPs for these individuals not only indicated that the PMTP had been reviewed, but also included a synopsis of the discussion of the material contained in the PMTP. The 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, as the Psychiatry Department had been able to restore the corollary information in the IRRF and narrative section of the ISP to the quality observed in the Monitoring Team's earlier review, and the deficits seen at the time of the last review had been rectified.	
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 sub-section of the CPA, as well as the "Psychiatric Consultation – Diagnostic and Treatment Analysis," which contained a specific sub-section on "Risk vs. Benefit." In addition, the Psychiatry Department, working in conjunction with the Department of Behavioral Services, had developed and implemented the PMTP, 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	Substantial Compliance

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		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 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 individual medication 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 19 (100%) individual records contained in the review sample. The documentation included a discussion of both the potential and realized side effects of the medication, as well as the benefits. In those situations where the individual was already receiving the medication, the actual benefits were described, and if the medication had not been started and/or the effects had not yet been realized, the expected benefits were discussed, as well as the expected timelines for realizing those benefits. These discussions, and the related documentation, appeared in the CPAs, the PMTP, 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 biological determined factors, behavioral sources, or a combination of both. The PMTP contained a discussion regarding the role of behavioral strategies that 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 7/9/14, a member of the Monitoring Team interviewed the Human Rights Officer. The member of the Monitoring Team also observed the HRC meeting on that day. During the meetings the Monitoring Team observed during previous onsite reviews, the reviews the Committee conducted were very detailed, and are described in those reports. There were instances in which the HRC rejected Behavioral Plans because of insufficient information, and/or requested additional information from the Treatment Team before they would consider approving the Plan. During the 7/9/14 interview with the Human Rights Officer, she indicated there had been occasions when the HRC requested the prescribing Psychiatrist attend the meeting to present additional information regarding the risk-versus-benefit considerations, as well as additional justification for the medication. She also indicated that the Psychiatrists always responded positively to these requests. The interview with the	

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		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 in individuals' ISPs and/ IRRFs, 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 full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	This provision relates to the degree of inter-class and intra-class polypharmacy, as well as the attempts to reduce polypharmacy. LBSSLC maintained tabular data that illustrated the yearly reductions in the rates of polypharmacy, dating back to 2005. This data clearly illustrated a consistent, marked reduction in the rates of polypharmacy. The current version of this document illustrated continued progress in reducing the frequency of polypharmacy with psychotropic medication. The following summarizes the past and current status: ▪ The number of individuals prescribed <u>six or more</u> psychotropic medications had been maintained at zero since 2008. However, an individual recently admitted from the community was prescribed six psychotropic medications. The number prescribed five psychotropic medications had decreased from seven in 2005 to a range of zero to six since that time, with the current frequency of six. 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 13. 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 the Monitoring Team's subsequent reviews. The number at the time of the current review was 18. ▪ The data also substantiated improvement with regard to intra-class polypharmacy. The most significant decline 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 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 five reviews, and was zero at the time of both the current and prior reviews. The review of the documentation from the "Monthly Facility Review of Psychoactive Medication Polypharmacy Meetings" from January 2014 to June 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	Substantial Compliance

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		meetings, was as follows: the Medical Director, Clinical Pharmacist, PCM for Psychiatry, Psychiatric Nurse, Psychiatry Clerk, and the two staff Psychiatrists. On 7/10/14, 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 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 essential to their stability. LBSSLC continued to admit individuals from community-based residential programs, correctional facilities, 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 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 in simplifying these complicated medication regimens was reviewed. 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 indicates 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 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	

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		stability. The third category was the aforementioned group of individuals admitted from the community on multiple psychotropic medications. At the 7/10/14 Polypharmacy Committee Meeting, the data presented was organized according to these three categories. Detailed information was presented for each individual, including the current psychotropic medications, the psychiatric diagnosis, a summary of their clinical status, the rationale for the existing medications, and the plans for any future reductions in these medications. This detailed information was both discussed at the meeting and contained in the minutes of the meeting. ▪ The category of Active polypharmacy contained this information for 21 (16%) of the total 128 individuals receiving psychotropic medications. However, it should be noted that seven of these 21 (33%) individuals were receiving only three psychotropic medications; and an additional four were receiving two psychotropic medications, but both were anti-psychotic agents and, thus, represented intra-class polypharmacy. ▪ As of the 7/10/14 meeting, there were 10 individuals in the New Admission category (as compared to one at the time of the Monitoring Team's last review). This equates to eight percent of the total of 128 individuals receiving psychotropic medications. There had been eight new admissions since January 2014. In addition, one individual who had been admitted at the end of 2013 only entered the Polypharmacy category later, when a third medication was added. The tenth individual had been admitted over six months ago, but less than one year ago. ▪ The third category labeled "Stable Polypharmacy" contained the same basic information as the other summaries, as well as an additional section entitled "Clinical Justification." This section reviewed the historical and current clinical status of the 12 (9%) 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 12 individuals. Based on this review, the type of detailed, historical, empirical data required to substantiate clinical efficacy was present for all (100%) of these 12 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 prior onsite review, the Director of Psychiatry indicated that the Psychiatric Clerk, working in conjunction with the other members of the Psychiatry	

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		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. The Psychiatric Nurse had assumed the responsibility for maintaining this database. In summary, at the time of the 7/10/14 Polypharmacy Committee Meeting, 43 of the 128 (34%) of individuals prescribed psychotropic medication at LBSSLC, met the criteria for polypharmacy. ▪ Among these 43 individuals 21 of 128 (16%) had been placed in the "Active" category, which meant that the Psychiatry Team was still actively addressing the individual's medications. ▪ There were 10 (8%) individuals in the "New Admissions" category who had been admitted within the last year. Thus, the Facility was still engaged in the process of challenging their medications, as noted above. ▪ The final category of "Stable" polypharmacy included 12 of 128 (9%) 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 10 individuals admitted to LBSSLC from the community on multiple psychotropic medications within the last year, and the 12 individuals for whom the empirical evidence was sufficiently detailed to support the contention that their prescribed medications were necessary, there remained 21 individuals for whom current justification for their psychotropic medications could not be determined. This equated to 16 percent of the 128 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 addition, they were not clinically stable, and presented with complex psychiatric disorders. The Facility was still actively working to adjust their medications to improve the quality of life for these individuals. The 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 July 2013 review, to 14 percent at the time of the prior review, and sixteen percent at the time of the current review. This increase was primarily related to the migration of individuals who had been admitted to the Facility on multiple psychotropic	

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		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 to sequentially assess the efficacy of multiple psychotropic medications. In addition, some individuals who previously had been considered to be "stable," had an exacerbation of their psychiatric illness, which required additional medication. 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 continued 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 requires systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication, with the DISCUS and the monitoring of more general systemic side effects related to psychotropic medication with the MOSES every six months (per the Healthcare Guidelines). Another component of this review was also the latency between the time that the Nurse completed the evaluation and the prescribing practitioner reviewed and signed the documentation. The nursing staff performed the MOSES evaluations. The staff Psychiatrists performed the DISCUS evaluations on the individuals they followed in conjunction with the Quarterly Psychiatric Reviews. The review of the sample of the records of 19 individuals prescribed psychotropic medication indicated the MOSES evaluations were current (i.e., completed within the last six months), and had been performed every six months for all 19 (100%) individuals. The review of these documents during the current review indicated the Facility performed the MOSES on all individuals for whom they were required in the months of January and July. This schedule 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 reviewed the MOSES evaluation in a timely manner (i.e., within 14 calendar days) for 12 (63%) of these individuals. The data related to the seven individuals for whom there had been a delay, is as follows: MOSES EVALUATION Intervals Between Evaluation and Review by Prescriber	Substantial Compliance

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INDIVIDUAL #	EVALUATION DATE	DATE REVIEWED BY PRESCRIBER	INTERVAL BETWEEN EVALUATION AND PRESCRIBER SIGNATURE (# DAYS GREATER THAN THE 14 ALLOTTED)
Individual #82	1/14/14	2/4/14	21 (7)
Individual #114	1/23/14	2/22/14	30 (16)
Individual #68	1/17/14	2/4/14	18 (4)
Individual #266	2/12/14	Prescriber signed, but not dated	
Individual #202	2/12/14	Prescriber signed, but not dated	
Individual #33	1/22/14	2/12/14	21 (7)
Individual #137	1/23/14	2/21/14	29 (14)

The average number of days that exceeded the 14 days allotted was 9.6, with a range of four to 16.

The purpose of the DISCUS is to detect the emergence of motor side effects related to the use of antipsychotic medication. The review of the records of the sample of 19 individuals indicated the DISCUS was current, and had been performed quarterly for the past year for all (100%) of the individuals. The review of the DISCUS evaluations with regard to the interval between the evaluation and the review by the prescriber had been completed in less than 14 days for 18 of the 19 (95%) individuals. The exception was Individual #68, for whom there was an interval of 20 days between the 11/26/13 evaluation and the 12/16/13 review by the prescriber. The requirement that the DISCUS be reviewed and signed by the prescriber is now moot, because the prescribing Psychiatrists began performing the DISCUS evaluation themselves within the last three months. These evaluations were performed in conjunction with the individual's Quarterly Psychiatric Review, as the Psychiatrist evaluates each individual as part of the Quarterly Review process.

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 similar to those of antipsychotic agents. The Psychiatrist currently performed the DISCUS for those individuals prescribed Reglan, and the Nurse

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		Case Manager performed the MOSES evaluations. Historically, the Psychiatric Nurse had performed the DISCUS evaluations for these individuals. 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 #199, Individual #135, Individual #176, and Individual #312. Review of the records of these individuals indicated that the MOSES evaluations had been performed as required for four of the five (80%) individuals. The exception was Individual #323, where there was a gap between the 7/8/13 and 5/8/14 evaluations. All of the evaluations had been reviewed in a timely manner for four of the five (80%) individuals. The exception was the 1/22/14 evaluation for Individual #312, for whom there was a gap of greater than 14 days until the review on 2/25/14. The Psychiatrist also performed the DISCUS for individuals prescribed Reglan. These evaluations were performed in conjunction with the Quarterly Psychiatric Reviews, even though they were not actually followed by the Psychiatrist. These evaluations were performed in the individual's residence when the Psychiatrist was performing the Quarterly Reviews for the individuals prescribed psychotropic medications. 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 all (100%) five individuals in the sample. In summary, the current review found that for the sample of 19 individuals: ▪ The MOSES evaluations were completed every six months, as required by the Settlement Agreement for 100 percent of the individuals in the sample; ▪ There was a delay in the prescriber review of the MOSES evaluation of greater than 14 days for five individuals, with an average of an additional 9.6 days beyond the allotted 14 days (range = four to 16 days). In addition, the second signature page was signed, but not dated, for an additional two individuals. A timely review was noted for 12 of the 19 individuals in the sample (63%) ▪ The DISCUS evaluations were completed every three months, as specified in the Settlement Agreement for 100 percent of the individuals in the sample; ▪ There was a delay in the review of the DISCUS for one individual that occurred in November 2013, which would indicate a completion range of 95 percent (18 of 19) for the last 12 months. As noted above, the Psychiatrists had begun to perform the DISCUS evaluations themselves, which will eliminate any delay	

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		between the performance of the evaluation and the review by the prescriber; ▪ The MOSES evaluations had been performed as required by the Settlement Agreement for four of the five (80%) individuals in the sample of individuals receiving Reglan; ▪ The MOSES evaluation had been reviewed in a timely manner for four of the five (80%) individuals in the sample of individuals prescribed Reglan; ▪ The DISCUS evaluation had been performed quarterly for all five (100%) of the individuals in the sample; ▪ The DISCUS evaluations had been reviewed in a timely manner for all five (100%) of the individuals in the Reglan sample. The Psychiatrists also had begun to perform the DISCUS evaluations for those individuals prescribed Reglan. The finding of substantial compliance was carried forward from the prior review, due to the 100 percent completion rate of both the MOSES and the DISCUS for those individuals in the sample of 19 individuals prescribed psychotropic medications. However, deficits were noted in the timely review of the January 2014 MOSES evaluations. The next six-month assessment of the MOSES for these individuals would be scheduled to occur in July 2014, and, thus, were not available at the time of the Monitoring Team's review. To maintain the substantial compliance rating in the next review, the Facility will need to implement mechanisms to ensure the timely review of the MOSES evaluations in the future.	
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 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 128 (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 Psychoactive Medication 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.	Substantial Compliance

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	this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	This section of the Settlement Agreement also addresses the need to identify "the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatments' efficacy." These "symptoms or behavioral characteristics" were referred to in LBSSLC documentation as the "target behaviors" of the psychotropic medication. A persistent problem with the documentation in the LBSSLC records had been the dual identification of a specific behavior as being both a "target behavior" of the prescribed psychotropic medication, and also as being present on a learned or behavioral basis. Collaboration between the Psychiatry Department and the Behavioral Health Services department 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 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 Services staff, had developed an empirical system that would allow them to collectively make objective assessments of a specific medication's efficacy over time. The Quarterly Psychoactive Medication Review Forms carried forward six months of behavioral data, presented in tabular form; and the Behavioral Health Services 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-	

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		Psycho-Social-Spiritual Formulation section of the CPA, and then in more specific detail in the "Psychiatric Consultation – Diagnostic and Treatment Analysis," as well as the Annual Psychoactive Medication Treatment Plan. 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 Services 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 Clinics, as well as informal discussions between the Behavioral Health Services Providers, Behavioral Health Services 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 Psychoactive Medication Review forms included a discussion of the timelines when positive effects of a 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 should also 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 included the following information:	

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		Medication Change Form *Physician:* *Month/Year:* *Patient Name* | *Medication Being Altered* | *Date of Change* | *Current Dose* | *Increased to* | *Decreased to* | *Rationale* | | | | | | | | | | | | | | 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 they be contacted by a member of the IDT 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 all 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 the Monitoring Team observed during 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 that required periodic monitoring of blood levels, such as a mood stabilizer, these would also be reported. The results of the most recent MOSES/DISCUS evaluations were reported, as well as any significant medical changes or events, including the individual's seizure status, if applicable, and whether the individual 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 staff reviewed the relevant medical and laboratory data. The Psychiatrist chaired the meeting and provided insights on the current issues and guided the discussion as to whether any medication or programmatic changes might	

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		be beneficial. The direct support professional provided insights into the individual's interactions in the residences. The QIDP also 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 7/8/14 and 7/9/14. 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 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 provided 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 Psychiatrists were observed and followed 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. The individual also would be reviewed monthly, or more frequently, if they were not considered to be stable, and/or if it were determined 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 (IPN), as described below. A listing of the documents produced for these various 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, dictated IPN; ▪ Dictated IPN: These were completed for encounters that occurred on an as-needed basis, and essentially represented briefer notes for less significant situations than those that would have precipitated a Psychiatric Consultation. The individual was usually seen, but might not have been, depending on the rationale (i.e., a note commenting on an elevated blood level and the response would not have involved seeing the individual); ▪ Psychiatric Consultation – Diagnostic and Treatment Analysis: The individual was usually not seen. This was a summary document that covered the following	

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		topics: o Medications with rationale: o Diagnosis/symptoms/target symptoms; o Derivation; o Risk of illness; and o Benefit of pharmacological therapy (including past history); and ▪ The PMTP (updated annually in conjunction with the ISP) 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 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 the Psychiatry Department and the Behavioral Health Services Provider also rectified the problem of the dual classification of behavior described in the Monitoring Team's previous reports. Documentation reviewed showed 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	The review of the Rights/Consents sections of the records for the sample of 19 individuals receiving psychotropic medication indicated that 14 of the 19 individuals had a Guardian of the Person. Those individuals without a guardian relied on the Facility Director to review the material concerning the risk-versus-benefit considerations related to the utilization of psychotropic medication, and then provide the necessary consent. The review of the individual records indicated consents for the use of psychotropic medications were present in the individual records for all (100%) 19 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	Substantial Compliance

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	procedures and shall identify associated risks.	estimated that the team was successful in reaching the guardian in this manner approximately 70 to 80 percent of the time, but no precise records were maintained. If the telephone call were not successful in establishing direct communication with the guardian, a message was then left, asking them to contact the Psychiatry Team. 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 accomplished through written documentation. All consents for psychotropic medication were updated yearly. The annual consent process was accomplished by mailing documents to the guardian. Members of the Psychiatry Department attend the Pre-Admission Meeting for individuals who are being admitted to the Facility from the community. The guardians typically either attend these meetings, or participate via a Conference Call. The initial consents for psychotropic medication were obtained as part of this process. A recent sample of the documents sent to the guardian as part of this process was requested. The specific Informed Consent packets for the individuals reviewed were those of Individual #187 (6/17/14), Individual #40 (6/15/14), Individual #232 (6/13/14), and Individual #165 (6/25/14). 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 the 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	

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		purpose of this document was to ensure that risk-versus-benefit considerations were coordinated with other treatment methods and available to the IDT at the time of the annual ISP 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. 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 review in the ISP 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.	Based on the Monitoring Team's observation of the Neurology Clinics on 7/9/14 and 7/10/14, the Neurologist, the two staff Psychiatrists, the Medical Director, the individuals' Primary Care Provider (PCP), the Clinical Pharmacist, and other members of the professional team, all attended the Neurology Clinic. This was also consistent with observations made during the Monitoring Team's previous reviews. A member of the residential nursing staff accompanied the individual to the Clinic, and an additional nurse assigned to the Clinic helped to coordinate the flow of the individual reviews. The individual's primary nurse presented the relevant history, and the individual's clinical files were also available to the Neurologist. A discussion followed the review of each case presentation. These discussions were quite detailed, and involved the Neurologist, Psychiatrist, and the PCP. Also, where appropriate, there was a discussion of the relevant published literature. The presence of the Psychiatrist and a brief synopsis of the discussion were documented in the Neurologist's Note. The consistency of this process was verified through a review of the Neurology sections of four records within the sample 19 (21%) individuals who required and received neurological consultation within the last year. The review of records indicated that during this time period, one of the two Consulting Neurologists reviewed the following four individuals: Individual #137, Individual #239, Individual #266, and Individual #82. The Neurology Consultation Note documented the attendance of the Psychiatrist in all of these records, with the exception of the 11/20/13 Neurology	Substantial Compliance

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		Consultation for Individual #266. The attendance of the Psychiatrist at the Neurology Clinics of the individuals who received psychotropic medication also had been verified in each of the Monitoring Team's previous reports. Of note, during the 7/10/14 discussion with the Medical Director, he indicated that there are 91 individuals receiving anticonvulsant medication, and 30 individuals who have been successfully tapered off of anticonvulsant medication. The corresponding Neurological Consultation Note for the four individuals in the subsample alluded to the psychotropic medications. The summary describing the substance of the Neurology Consultations was discussed in the Psychiatry section of the record. There was also an ongoing longitudinal summary of each neurological consultation in the individual's annual medical summaries. These summaries were not purged, and contained valuable longitudinal information, which extended back for several years in some cases. The language of this provision specifically indicates only that the coordination of treatment between Psychiatry and Neurology is maintained for those individuals prescribed anticonvulsant medication for the dual treatment of both a seizure disorder and a psychiatric disorder, such as a mood disorder. The Psychiatry Department identified 11 individuals for whom this criterion would be applicable. Those individuals (and the date of the most recent Neurology Consultation) were as follows: MEDICATIONS BEING UTILIZED FOR BOTH SEIZURE DISORDER AND PSYCHIATRIC SYMPTOMS **INDIVIDUAL #** / **HOME** / **MEDICATION** / **DATE OF LAST NEUROLOGY CLINIC VISIT** / **NEUROLOGY CLINIC FOLLOW-UP DUE DATE** Individual #187 / 521 / Tegretol / 5/21/14 / Six months Individual #299 / 526 / Valproic Acid (VPA) and Lamictal / 4/23/14 / Six months Individual #82 / 521 / VPA / 5/23/14 / Three months Individual #45 / 523 / VPA / 7/10/13 7/9/14* / One year Individual #190 / 526 / VPA / 5/21/14 / Two months	

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Individual #124	525	Tegretol	4/23/14	One year
Individual #105	527	VPA	6/11/14	Two months
Individual #143	518	VPA	12/23/13	One year
Individual #242	525	Lamictal	6/11/14	One year
Individual #33	513	VPA & Lamictal	7/24/13 6/24/14*	One year
Individual #51	518	VPA	1/22/14 6/25/14*	Six months

*Seen on that date, but Note not yet available.

The review of the documentation produced by the Psychiatry Department related to each of these consultations confirmed active collaboration between the Departments of Psychiatry and Neurology for each of those individuals.

The Facility exceeded this specific requirement of the Settlement Agreement by attempting to attend the Neurology appointments for all of the individuals who were jointly followed by both the Psychiatry and Neurology Departments.

In summary, the collaboration between the Neurology and Psychiatry Departments was observed in the Neurology Clinic during the Monitoring Team's current and previous onsite reviews. The review of the related documentation confirmed the presence of the Psychiatrist at these meetings. In addition, documentation that appeared in the Neurology Consultation Notes, the Psychiatry section of the record, and the Annual Medical Summary, documented the ongoing collaboration between Psychiatry, Neurology, and Primary Care.

The Medical Director at LBSSLC previously was asked if the Facility had engaged in an empirical analysis to determine if there was enough neurological consultation time available to provide adequate services to the individuals served. During the 7/10/14 interview with the Medical Director, he indicated that such a specific calculation did not exist, but that instead, the Facility relied on the feedback of the Consulting Neurologist, as well as the other clinicians who were actively involved in the neurological consultation process, to determine if adequate consultation time existed. His impression was that, based on this feedback, there had been adequate time, but that if circumstances were to change in the future, it would be relatively easy to add additional neurological consultation time. Currently, one Consulting Neurologist provided neurological

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		consultation two afternoons per month, and a second Consultant provided an additional afternoon per month. Both Neurologists were members of the Texas Tech Neurology Department. The contract to provide neurological services at LBSSLC was with the Texas Tech Health Center and was not a direct contract with the Neurologists. The first Consultant's primary focus was on the treatment of individuals with seizure disorders, while the newest Consultant's focus was on other neurological issues, such as movement disorders, changes in an individual's mental status, and the range of other neurological problems that can develop in individuals with intellectual disabilities. The newest Consultant also presented an hour-long Continuing Medical Education program at the beginning of each Clinic. The observations of the Neurology Clinics during the Monitoring Team's current and prior reviews, coupled with the extensive review of the related documentation described above, suggested that there was adequate neurological consultation time available to meet the needs of the individuals who resided at LBSSLC. In light of the above observations, the Facility remained in substantial compliance with this provision.	

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of the Following Documents**: o Section K Presentation Book, developed by Jim Forbes, Assistant Director of Programs; o Monthly PBSP Progress Note (April 2014), as provided during psychiatric clinic at Cedar (on 7/9/14), for Individual #119; o Completed SAP Treatment Integrity Monitoring forms (and related SAP), as completed during onsite integrity probe at the Workshop (on 7/9/14), for Individual #267; o Completed SAP Treatment Integrity Monitoring forms (and related SAP), as completed during onsite integrity probe at Oak (on 7/9/14) for Individual #235; o PBSP provided during PBSP competency integrity check, as completed at Rose (on 7/9/14), for Individual #91; o PBSP and data cards, as provided during PBSP training at Aspen (on 7/8/14), for Individual #179; o Internal Behavior Support Committee (BSC) and External Peer Review Meeting Notes; o Monthly PBSP Progress Note, Positive Behavior Support Plan, and Structural and Functional Assessment (SFA) as provided during the BSC for Individual #273; 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 #70, Individual #154, Individual #213, Individual #235, Individual #73, Individual #68, Individual #167, Individual #254, Individual #280, Individual #273, Individual #241, and Individual #320; o For Sections K.4 and K.5, SFA, Structural and Functional Assessment - Review (SFAR), and/or Structural and Functional Assessment – Consolidated Report, as provided, for: Individual #70, Individual #154, Individual #213, Individual #235, Individual #73, Individual #68, Individual #167, Individual #254, Individual #280, Individual #273, Individual #241, and Individual #320; o For Sections 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 #146, Individual #4, Individual #223, Individual #70, Individual #154, Individual #213, Individual #235, Individual #34, Individual #254, Individual #284, Individual #321, Individual #171, Individual #73, Individual #68, Individual #167, Individual #8, Individual #280, Individual #273, Individual #242, and Individual #266; o For Section K.7, Psychological Assessments (i.e., 30-day Psychological Assessments, 30-day Psychological Summary, 30-day Behavioral Health Assessment, Behavioral Health 30-day Assessment, and/or Behavioral Health Assessment), as available for: Individual #91, Individual #102, Individual #104, Individual #134, Individual #142, Individual #152, Individual #187, Individual #227, and Individual #234; o For Section K.8, Counseling skill acquisition programs, monthly progress notes, and session notes, as available for: Individual #7, Individual #173, and Individual #34;

	○ For Section K.9, Positive Behavior Support Plans, as available for: Individual #70, Individual #154, Individual #213, Individual #235, Individual #73, Individual #68, Individual #167, Individual #254, Individual #280, Individual #273, Individual #241, and Individual #320; ○ For Section K.9, Behavior Support Peer Review Committee approval/review sheet, Informed Consent for a Positive Behavior Support Plan form, Human Rights Committee (HRC) Review of PBSPs and/or Crisis Intervention Plans (CIP), as provided for: Individual #70, Individual #235, Individual #73, Individual #68, Individual #280, Individual #241, and Individual #320; ○ For Section K.10, Monthly PBSP Progress Notes, for three consecutive months, as provided, for: Individual #70, Individual #154, Individual #213, Individual #235, Individual #73, Individual #68, Individual #167, Individual #254, Individual #280, Individual #273, Individual #241, and Individual #320; ○ For Section K.10, Quarterly Psycho-Active Medication Review, as provided, for: Individual #70, Individual #154, Individual #213, Individual #235, Individual #73, Individual #68, Individual #167, Individual #254, Individual #280, Individual #273, Individual #241, and Individual #320; ○ For Section K.11, Positive Behavior Support Plans, as available for: Individual #70, Individual #154, Individual #213, Individual #235, Individual #34, Individual #254, Individual #284, Individual #73, Individual #68, Individual #167, Individual #8, Individual #280, Individual #273, Individual #142, Individual #266, Individual #241, and Individual #320; and ○ For Section K.12, Staff training documentation, requested from the Competency and Training Department and/or Behavioral Health Services, as provided, for: Individual #70, Individual #154, Individual #213, Individual #235, Individual #73, Individual #68, Individual #167, Individual #254, Individual #280, Individual #273, Individual #241, and Individual #320. ▪ **Interviews and Meetings with the following**: ○ Jim Forbes, Assistant Director of Programs, and Beckie Crawford, Director of Behavioral Health Services, on 7/7/14 and 7/8/14; ○ Stephanie Brasfield, Director of Residential Services, and Roshadi Moore, Active Treatment Supervisor, on 7/8/14 and 7/9/14; ○ Sandi Soliz, QIDP Coordinator, Section F meeting, on 7/8/14; ○ Desensitization Work Group meeting, on 7/9/14; ○ Marty Jones, Integrated Program Developer, and Regan Harrison, Integrated Program Developer, on 7/9/14; ○ Laura Anciso, Director of Vocational and Day Programs, and Rosie Driver, Supportive Employment Coordinator, on 7/10/14; ○ Raul Jaime Trevino, QA Program Compliance Monitor (Section K), and Marilyn Foster, QA Program Compliance Monitor (Section S), on 7/10/14; ○ Peggy Brown, Administrative Assistant, Behavioral Health Services, on 7/10/14; ○ Stephanie Brasfield, Director of Residential Services, on 7/10/14; and,

	○ Beckie Crawford, Director of Behavioral Health Services, on 7/11/14. ▪ **Observations Conducted**: ○ PBSP competency-based training at Aspen (513), on 7/8/14; ○ PBSP Competency Integrity Check at Rose (525), on 7/9/14; ○ PBSP Competency Integrity Check at Workshop, on 7/9/14; ○ Psychiatric Clinic at Canna (521), on 7/9/14; ○ Desensitization Committee Meeting, on 7/9/14; ○ ISP Preparation Meeting for Individual #75, on 7/10/14; ○ BSC Peer Review Meeting, on 7/10/14; ○ Onsite direct observation and/or interaction with direct support professionals, and other professionals were conducted throughout the morning and/or afternoon hours at the following sites: ▪ Large Workshop, on 7/7/14; ▪ Small Workshop, on 7/7/14; ▪ Educational Building, on 7/7/14; ▪ Lily (524), on 7/7/14; ▪ Zinnia (528), on 7/7/14; ▪ Iris (527), on 7/7/14; ▪ Tulip (526), on 7/7/14; ▪ Aspen (513), on 7/8/14; ▪ Willow (520), on 7/8/14; ▪ Oak (518), on 7/8/14; ▪ Maple (517), on 7/8/14; ▪ Rose (525), on 7/8/14; ▪ Violet (523), on 7/8/14 and 7/9/14; ▪ Fir (516), on 7/10/14; ▪ Elm (515), on 7/10/14; and, ▪ Birch (514), on 7/10/14.
	Facility Self-Assessment: Lubbock State Supported Living Center submitted a Self-Assessment for Section K, dated 6/20/14. 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.9, and K.11. This finding was not consistent with the Monitoring Team's current findings. That is, the Monitoring Team found the Facility to be in substantial compliance with only two (i.e., K.2 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: ▪ As noted in previous Monitoring reports, the monitoring/audit tools the Program Compliance Monitor used in the past 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). However, as noted in the Monitoring Team's last report, these tools were utilized sporadically and had not been completed since June or July 2013. However, at that time, it was reported that the PBSP competency-integrity check, including estimates of inter-rater reliability, was utilized in June, July, August, September, and November 2013. In addition, at the time of the Monitoring Team's last visit, discussions reflected an interest by the Facility in reviving the monthly use of the PBSP progress note quality checklist. Currently, it appeared that the Facility had re-started the use of the PBSP progress note quality checklist as well as other quality checks since the Monitoring Team's last visit. More specifically, according to provided documentation, in addition to continuing to utilize the PBSP competency-integrity checks, the Facility re-initiated the use of the PBSP Progress Note Review rubric (in February) as well as the PBSP Checklist and Structural and Functional Assessment Checklist (in April 2014). Documentation also evidenced the completion of inter-rater reliability on each of these completed quality checklists as well. ▪ As described in the Monitoring Team's previous report, the prescribed self-assessment process (as completed monthly by the PCM) appeared to include the random selection of four individuals who had an ISP within the last two months and had a PBSP. Once identified, the PCM and Behavior Services staff would concurrently review the identified documents using specific quality rubrics, including estimation of inter-rater reliability. Although verbal reports indicated an expectation of four checklists completed across each of these documents (as identified above), provided documentation reflected that this expectation was not met in approximately 50% of the months reported. This included self-reported data from January to May 2014 for PBSP competency-integrity checks and PBSP progress notes, as well as from April and May 2014 for both PBSP review and SFA checklists. Discussion during the onsite visit indicated that the quality of the Behavior Health Assessments as well as competency-based trainings of PBSP might be targeted in the future. ▪ The self-assessment process also appeared to prescribe monthly meetings in which the PCM and the Director of Behavioral Health Services discussed ongoing monitoring. Provided documentation (meeting minutes) reflected monthly meetings between January and May 2014, including the review of quality scores from completed checklists as well as related inter-rater reliability estimates. In addition, provided documentation revealed review of this data through completed Quarterly QA Section Monitoring Results/Analysis. ▪ The self-assessment process, in addition to the work supported by the PCM, also included efforts of the Behavior Services Department utilizing other relevant data sources and/or indicators and outcome measures. For example, the current self-assessment contained many informal review processes, including review of Behavioral Health 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 competency-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

	or 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. Indeed, recent integration of additional quality rubrics into monthly monitoring was viewed as progress. However, the Facility still did not appear to have an electronic database where scores could be entered and stored, as well as utilized to develop reports and graphs to assist with ongoing analysis.
	Summary of Monitor's Assessment: Since the Monitoring Team's last review, Behavioral Health Specialists' progress in their pursuit of certification as Board Certified Behavior Analysts (BCBAs) continued as three Specialists had completed coursework and supervision requirements and planned to take the BCBA exam in August 2014. However, a personnel change within the Behavioral Health Services Department resulted in the reduction of BCBAs from six to five. Other changes in this Department included the promotion of the former Director and the hiring of a qualified internal BCBA as the new Director. The ongoing supervision of the new Director by the former Director appeared likely to maintain continuity of psychological care throughout the Facility. Although the internal peer review process continued to reflect consistent, ongoing, and active review of behavioral programming, the previously noted progress evidenced through external peer review did not maintain since the Monitoring Team's last visit. That is, consistent monthly external peer reviews did not occur, thus evidencing less than satisfactory maintenance of ongoing critical review. The Facility's continued efforts were noted in promoting more accurate data through more rigorous monitoring of the data collection system. However, concerns were noted with how this data was monitored through the use of Monthly PBSP Progress notes. That is, concerns remained with regard to the adequacy of operational definitions for replacement behaviors, consistency between the notes and the current PBSP, consistent inclusion of inter-observer agreement (IOA) data, and the timeliness and adequacy of review. Progress was noted in updating psychological assessments using the Behavioral Health Assessment format. As previously noted and currently observed, the majority of scores from standardized tests of intelligence and tests of adaptive behavior remained outdated. However, since the Monitoring Team's last visit, the Facility reinitiated completion of standardized test of intelligence as well as adaptive behavior. Indeed, standardized test of intelligence and/or tests of adaptive behavior were completed for 21 individuals. A decline in the number of Structural and Functional Assessment (SFA)/ Structural and Functional Assessment Report (SFARs) updated annually was noted. In addition, almost half of the individuals residing at the Facility still had SFAs completed in the outdated format. Continued efforts are required to update these assessments using the most current format and to ensure their adequate completion, including emphasis on ensuring descriptive assessment methods, functionally equivalent replacement behaviors, and the consistent incorporation of data.

	Documentation revealed that all newly admitted individuals had a psychological assessment completed within 30 days of admission. However, several were incomplete, utilized the previous format, and/or contained outdated tests of intelligence and adaptive behavior. Since the Monitoring Team's last visit, the Facility had made efforts to upgrade the counseling SAPs. These revisions were an improvement compared to previously reviewed documents. The next step, as the Facility identified, was to ensure an adequate data collection system (i.e., use of counseling data cards), including ongoing monitoring of progress. Progress in the development of quality PBSPs continued to be noted. Indeed, the Facility was successful in maintaining progress in ensuring that PBSPs were written so that direct support professionals could understand them effectively. However, concerns were noted with regard to the quality of operational definitions for replacement behaviors, identification of functionally equivalent replacement behaviors, and inclusion of baseline data for target and replacement behaviors, as well as the need to conspicuously identify if SAPs were in place (or not) to teach replacement behaviors and provide clarity and specification with regard to reducing the intensity of interventions. The overall quality of the graphic display of data that was observed at the Monitoring Team's last visit continued to be noted. However, concerns were evident with regard to the availability of up-to-date data, accurate data (especially as identified in quarterly psychiatric notes), and the integration of IOA data in monthly PBSP notes. A member of the Monitoring Team's direct observation of staff training on a PBSP reflected elements of effective competency-based training. However, review of provided documentation led to concerns with regard to the adequate documentation of staff training on PBSPs, the timeliness of these trainings, the annual training of PBSPs, and, based on this documentation, concerns regarding adherence to the guidelines for PBSP Competency-Based Training.

#	Provision	Assessment of Status	Compliance
K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to	At the time of the Monitoring Team's current visit, five Behavioral Health Specialists within the Behavioral Health Services Department were Board Certified Behavior Analysts (BCBA). More specifically, of the 11 Behavioral Health providers, including the Director, five (45%) were currently BCBAs. This reflected a decrease in the number of BCBAs on staff since the Monitoring Team's last visit. That is, at the time of the previous visit, six (55%) of the 11 Behavior Health Specialists were BCBAs. Based on current verbal reports, the Director did not carry a formal caseload. Consequently, 10 of the 11 providers in the Department currently carried caseloads and developed PBSPs and, of these 10, four (40%) providers were BCBAs.	Noncompliance

	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.	According to summary data presented within the Section K Action Plan, at the time of the current onsite visit, three Behavior Health Specialists had completed all coursework and supervision requirements, and were planning to take the exam in August 2014. One staff was currently enrolled in classes and receiving supervision. In addition, one recently hired Behavior Health Specialist had not yet begun expected coursework and necessary supervision, but was planning to enroll in classes. The Facility was rated as being in noncompliance with this provision because the professionals in the Behavioral Health 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. Currently, only five 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.	A significant change in the administrative structure of the Behavioral Health Services Department occurred since the Monitoring Team's last visit. More specifically, Jim Forbes, M.Ed., BCBA, previous Director of Behavioral Health Services, had been promoted to Assistant Director of Programs, and Beckie Crawford, BCBA, was promoted to Director of Behavioral Health Services. Based on verbal report, the new Director of Behavioral Health Services started within her current position effective 7/1/14. According to provided documentation, Rebecca "Beckie" Crawford, M.S., BCBA, the new Director of Behavioral Health Services, held a Master of Science degree in Psychology and received her BCBA in 2012. She had been employed at LBSSLC since 2003 in a variety of positions including direct support professional (two years), QIDP (four years), Associate Psychologist (three years), and Behavior Analyst (two years). Throughout these positions, she appeared to have had extensive experience supporting individuals with intellectual, mental, and physical disabilities. Based on the recent hiring of a qualified Director of Behavioral Health Services as well as the continued supervision by the previous Director, it appears that the Facility was maintaining a consistent level of psychological care throughout the Facility. Consequently, the Facility remained in substantial compliance with this provision.	Substantial Compliance
K3	Commencing within six months of	As noted in the Monitoring Team's previous reports, LBSSLC had an internal peer review	Noncompliance

	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.	system that occurred through the weekly meetings of the BSC. At the time of the Monitoring Team's previous visit, it was noted that the recently revised LBSSLC policy, "Positive Behavior Support Behavioral Health Services," revised 12/5/13, did not include attendance criteria as identified in previous Monitoring Team reports. In an effort to examine the current nature of the internal peer review system, provided minutes from BSC meetings held since the Monitoring Team's last visit, between January and June 2014, were reviewed. This sample included meeting minutes across a 24-week period from 1/13/14 to 6/23/13. Based on this review, it appeared that the BSC met at least once each week for 21 (88%) of the 24 possible weeks. It should be noted that an additional BSC meeting was held during the third week of January. Based on the number of actual BSC meetings (N=22), meeting minutes revealed that the Director (previous or current) and/or Assistant Director of Behavioral Health Services, both of whom were BCBAs, were in attendance for 19 (86%) of the BSC meetings. Closer examination revealed that three or more BCBAs were in attendance at 22 (100%) of the meetings. Overall, at least one Behavioral Health Specialists was in attendance at 16 (73%) of the meetings, and two or more Behavioral Health Services Assistants were in attendance at six (27%) 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 were in attendance at 17 (77%), 22 (100%), and six (27%) of meetings, respectively. Based on the findings noted above, adherence to the weekly BSC schedule, as well as supervision by the Director or Assistant Director of Behavioral Health Services at those meetings appeared satisfactory. In addition, attendance by at least three BCBAs was also viewed as positive. BSC meeting minutes evidenced detailed peer review and critique, including the provision of specific feedback and recommendations, of several documents, including PBSP monthly notes (including graphs), SFAs, Consolidated SFA, SFA Review, PBSPs, Crisis Intervention Restraint Plans (CIRPs), Psychiatric Support Plans, and Protective Mechanical Restraint. Overall, meetings minutes consistently demonstrated an ongoing active, critical review of behavioral programming. According to data provided within the Section K Presentation Book, based on the PBSP Master List, as of 5/31/14, 103 (86.6%) of 119 PBSPs had been annually reviewed and approved by the BSC. According to dates found within a more recently updated PBSP Master List, dated 7/9/14, it appeared that 89 (76%) of 117 PBSPs had been annually reviewed and approved by the BSC prior to their expiration date. More specifically, provided summary data indicated that 28 PBSPs had BSC approvals that had expired. It should be noted that the majority of these expired BSC approvals appeared to be from May and June 2014.	

		As reported in the Monitoring Team's previous reports, faculty (including a BCBA-D) and students from Texas Tech University supported the Facility through consultation, implementation of intensive projects aimed at improving behavior services (e.g., monitoring of data collection), and participation in BSC. When this BCBA-D was in attendance at BSC meetings, the Facility viewed his participation as a form of external peer review. As reported in the Monitoring Team's previous report, this BCBA-D attended only one (5%) of the BSC meetings held between 6/6/13 and 10/31/13. Currently, based on provided BSC meeting minutes (as described above), it appeared that this BCBA-D did not attend any of the BSC meetings held between 1/13/14 and 6/26/14. Consequently, the Facility appeared to have discontinued this form of external peer review. The internal peer review process continued to be supplemented by the utilization of an external peer review process. As noted in the Monitoring Team's previous report, external peer review was obtained through the participation of external reviewers, including BCBAs, from State Office or other Texas SSLCs primarily through phone conferences. However, written reviews and participation of external reviewers at BSC meetings also had been provided as evidence of external review in the past. Based on provided external peer review meeting minutes/summary sheets, since the Monitoring Team's last review (i.e., for meetings held between January and June 2014), it appeared that at least one external peer review involving Behavioral Health Providers, including BCBAs, from other SSLCs and/or State Office, was held in five (83%) of the six months within this period. The exception included the external peer review held in June 2014. More specifically, documentation offered as evidence of external peer review for June 2014 directed the Monitoring Team to "… refer to internal peer review meeting notes on June 26, 2014." Notes from this BSC meeting, however, did not evidence any external reviewers in attendance. Consequently, it was unclear to the Monitoring Team how this BSC meeting reflected evidence of external peer review. Documentation revealed that two meetings were held in March 2014 – this included: 1) a teleconference between the Director and the State Office Discipline Coordinator held to discuss inter-rater reliability procedures; and 2) a written case review completed by the State Office Discipline Coordinator. It should be noted that the planning meeting on 3/14/14 appeared to target preparations to adhere to requirements of the recently revised Behavioral Health Services Positive Behavior Support policy (12/5/13). However, it was unclear if other individuals, in addition to the State Office Discipline Coordinator and Director of Behavioral Health Services, participated in this consortium (if others were in attendance, they were not identified). Additional documentation indicated that a quarterly inter-rater reliability check, involving an external peer reviewer, was completed on an individual supported by the Facility in April 2014. Overall, based on the seven external peer review meeting minutes/summary sheets	

		provided as evidence of external peer review, documentation revealed that AUSSLC, ABSSLC, CCSSLC, and the State Office Discipline Coordinator participated as external reviewers in two (29%), two (29%), one (14%), and six (86%) reviews, respectively. It should be noted that representatives from AUSSLC were not identified as BCBAs, and that the only external BCBA involved in reviews in March, April, and May was the State Office Discipline Coordinator. That is, when examining the nature of external review as facilitated by peers, it appeared that only two (29%) of the case reviews included BCBAs from other SSLCs. Closer examination revealed that, of the seven external peer review meeting minutes/summary sheets provided as evidence of external peer review, only five (71%) included case reviews of individuals supported by the Facility conducted by BCBAs. These five case reviews targeted three individuals served by the Facility (i.e., three of the reviews were centered on the same individual). The Director of Behavior Health Services or the Behavioral Health Specialists/BCBA responsible for presenting the identified case participated in all (100%) of these reviews. Provided documentation appeared to evidence 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 recommendations. Based on documentation, it appeared that the peer reviewer examined behavioral programming, including SFAs, PBSPs, Psychological Assessments, and progress notes (behavior data/graphs), and actively engaged in discussion and provided feedback. Overall, compared to previously reported findings, it appeared that the current involvement of other SSLCs, including BCBAs, in the external peer review process had diminished significantly. More specifically, as noted in the Monitoring Team's previous report, five (83%) of the six external reviews (not including BSC meetings) were completed by BCBAs from one or more SSLCs, in addition to the State Office Discipline Coordinator. Currently, as noted above, it appeared that only two (29%) of the case reviews completed since the Monitoring Team's last visit were completed by BCBAs from other SSLCs. And, compared to the last review that found six different individuals targeted across six different reviews, the current documentation only found three individuals targeted across five different reviews (across a six-month period). And, although only a limited number of individuals were reviewed, it appeared that three consecutive monthly reviews focused on issues related to a single individual (i.e., Individual #235) and that some of the recommendations/discussion related to behavioral programming made over that time were incorporated into proposed strategies that the committee subsequently reviewed. It should be noted that the Committee's follow-up on previously made recommendations should be more conspicuously identified in meeting minutes. Provided documentation did not evidence consistent monthly external peer reviews (i.e., evidence provided for June was found to	

		be inadequate). Consequently, the external peer review process appeared less than satisfactory and did not suggest that same level of review had been maintained. Overall, the Facility continued to maintain an effective internal peer review process through the BSC. However, although the external peer review provided some valuable feedback when cases were reviewed, the inadequacy of consistent monthly external peer review suggested that previously observed levels of review had not been consistently maintained over time. Based on the findings presented above, the Facility was not in substantial compliance with this provision of the Settlement Agreement.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	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. Although this collaboration appeared to have ended since the Monitoring Team's last visit, similar efforts directed toward fostering the effective completion of data cards had been maintained by the Behavioral Health Services Assistants. In addition, the collected data reportedly was enhanced by a more rigorous definition used when determining if data cards were turned in. That is, according to current verbal reports, each card collected was not scored as completed unless some data was recorded. The Monitoring Team viewed this change as an improvement as, in the past, blank data cards might have been accepted and scored completed as long as the cards were simply turned in. Currently, based on data provided within Section K of the Facility's Self-Assessment (dated 6/20/14), the Facility continued to monitor compliance rates (of turning in completed cards). Provided documentation reflected significant efforts at ongoing monitoring of data card completion/receipt between February and May 2014. That is, the daily receipt of data cards (total number of staff and total number of cards received) for each shift across programs appeared to be collected. Closer examination of the collected data revealed that every residential program had daily data collected from February through May, with the exception of two programs that appeared to have data collect only in May. Summary data provided within the Section K Self-Assessment illustrated the averaged percentage of data cards turned in by program (collapsed across February, March, and April 2014). Summary data indicated that 12 (80%) of the programs exceeded 80% of cards completed per month (on average). As described in the Monitoring Team's previous reports, the Facility had collaborated with Texas Tech University to improve the quality of monthly PBSP progress notes by developing the PBSP Progress Note Review rubric to examine the quality of monthly PBSP progress notes. And, although this project appeared effective, it was noted at the time of the Monitoring Team's previous review to have been discontinued. However,	Noncompliance

		verbal reports from the Director of Behavioral Health Services indicated that the PCM and Behavioral Health Services would likely re-implement this rubric as part of the QA process to assess the quality of monthly PBSP progress notes going forward. Currently, verbal reports and provided documentation indicated that use of this rubric (the PBSP Progress Note Checklist) had been re-started through the collaboration of the PCM. That is, documentation presented within the Section K Presentation Book evidenced examples of completed checklists from January, February, and March 2014. Summary data from the use of these checklists was provided within the Section K Self-Assessment and indicated that monthly samples of PBSP progress notes was examined by the PCM and Behavioral Health Services Staff. This data reflected small samples (n=3) completed each month from January through April 2014 with ratings by Behavioral Health Services staff as well as the PCM typically above 90%. However, lower ratings (i.e., 74% and 71% for Behavioral Health Services staff and PCM, respectively) were observed in April 2014. Overall, inter-rater reliability estimates were consistently above 93% reflecting good correspondence between raters. 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 and PBSPs for 12 individuals was selected. This sample was selected from those who had an ISP meeting within the past six months, with two exceptions (i.e., Individual #241 and Individual #320), as well as from those who were rated at medium or high behavioral health risk (on the Integrated Risk Ratings summary, dated 6/10/14) and included individuals from across most residential programs in an effort to ensure a representative sample. Based on the PBSP Master List, dated 7/9/14, this sample of 12 individuals reflected 10% of total number (N=117) of individuals with active PBSPs. This review included the examination of the current PBSP as well as Monthly PBSP Progress Notes from April, May, and June 2014, as available. Review of provided documentation indicated: ▪ Monthly PBSP Progress Notes were completed across April, May, and June for 12 (100%) individuals; ▪ At least one target behavior and at least one replacement behavior were displayed in monthly PBSP progress notes for 12 (100%) of the individuals sampled. However, a target behavior was defined, but not graphed for Individual #213, and a replacement/alternative behavior was defined, but not graphed for Individual #154 and Individual #235. Consequently, only nine (75%) individuals appeared to have monthly notes that adequately displayed target and replacement behaviors; ▪ Adequate operational definitions for target and/or replacement behaviors were found on monthly PBSP progress notes for 10 (83%) of the individuals sampled. Exceptions included the monthly notes for Individual #254 and Individual #213, where target and replacement behaviors were not adequately identified and/or defined, respectively. Consequently, only 10 (83%) individuals appeared to	

		have monthly notes that adequately identified and/or defined target and/or replacement behaviors; ▪ Target and replacement behaviors were consistent across the PBSP and monthly PBSP progress notes for seven (58%) of the individuals sampled. It should be noted that, in some cases, the Monitoring Team could not determine if target and/or replacement behaviors were consistent across documents as it appeared that a revised plan was recently implemented and the previous plan was not available (i.e., Individual #235, Individual #73, and Individual #280). However, in some cases it appeared that target or replacement behaviors were graphed, but not identified and/or defined within the PBSP (i.e., Individual #254 and Individual #320); ▪ Inclusion of monthly IOA estimates, including actual data, were found in the monthly notes for April, May, and June in eight (67%), seven (58%), and seven (58%) of the individuals sampled, respectively. 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 the monthly notes for April, May, and June in 10 (83%), 11 (92%) and 10 (83%) of the individuals sampled, respectively. 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 12 (100%) of the individuals sampled; ▪ Monthly notes appeared to be completed and reviewed in a timely fashion (within 30 days) for nine (75%) of the individuals sampled. The exceptions were notes for Individual #213 and Individual #273. It could not be determined when two out of the three monthly notes for Individual #235 were completed (the signature and date were not included on the copy); ▪ Overall, the clinical notes appeared to be descriptive, integrative, and offered clinical insight (beyond the graphed data) in the monthly notes for nine (75%) of the individuals. Exceptions included the seemingly cryptic and, at times, incomprehensible narrative for Individual #73, as well as inadequate comments for Individual #167 and Individual #273. Based upon the current review of sampled Monthly PBSP Progress Notes, concerns remained with regard to the adequacy of operational definitions for replacement behaviors, consistency between the notes and the current PBSP, consistent inclusion of IOA data, and the timeliness and adequacy of review. Data provided within the Self-Assessment for Section K.4 also evidenced concern with regard to the adequacy of completion of monthly PBSP progress notes. More specifically, the Facility continued to monitor the number of monthly PBSP progress notes completed	

		per month and provided summary data of the number of PBSP progress notes completed per month between November 2013 and April 2014, reflecting a troubling decreasing trend. Data revealed that percentage of completed progress notes dropped from almost 100% in November 2013 to under 60% in April 2014. Relatedly, less than 20% of these monthly notes (completed between January and April 2014) were completed by a BCBA. Overall, consistent with the findings reported above (based on the current sample) as well as recent data reported by the Facility, concerns with regard to the number and quality of monthly PBSP progress notes remained. Indeed, due to these concerns, starting in June 2014, the Facility reported initiating mandatory monthly meetings targeting the completion of monthly PBSP progress notes for Behavior Services staff not completing notes within 20 days of the month. Verbal reports from the previous Director of Behavioral Health Services indicated that this approach appeared initially effective. 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 Revision/Update/New PBSP" section of the PBSPs 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 12 PBSPs reviewed, two appeared to be revised due to changes observed in behavioral functioning (i.e., Individual #235 and Individual #280). Overall, based on the sample, the practice of revising PBSPs appeared, at times, related to observations of behavioral functioning. However, for most individuals sampled, revisions continued to appear primarily rooted within the ISP meeting schedule. As reported in the Monitoring Team's last report, the Facility developed and utilized CIPs. 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 April, May, and June 2014) were reviewed. This included the CIPs and monthly PBSP progress notes for Individual #213 and Individual #320. Based on data listed with "Crisis Intervention Restraint Plans," dated 12/1/13 through 5/31/14, this sample reflected 25% of the total (N=8) 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 (i.e., identified and graphed, as appropriate) for the individuals sampled. Overall, although progress was noted in regard to methods used for data collection, including the completion of data cards, concerns remained with ensuring the adequate completion and quality of the monthly PBSP notes. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure adequate definitions for replacement behaviors are included in monthly notes, consistency between PBSPs and monthly notes, consistent reporting of IOA and integrity	

		data each month (as required), 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 continued to be 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 were completed to examine individuals 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 SFAs. As presented in the Monitoring Team's previous reports, the SFA was 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. At the time of the Monitoring Team's last visit, on 12/20/13, the Facility formally implemented the new Behavioral Health Services policy, dated 12/6/13. 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 the SFA and the SFAR. The latter 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 the various factors that might necessitate a re-evaluation and subsequent completion of a more current SFA. In addition, the Structural and Functional Assessment Checklist, revised 10/23/13, had been developed to assist in ensuring SFAs were adequately developed. In addition to the new format for SFA, an additional 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 found to be lacking. These new formats and related implications for the current review are discussed below.	Noncompliance

		Currently, according to the PBSP Master List, dated 7/9/14, approximately 92 (79%) individuals with PBSPs had an SFA or SFAR completed within one year of BSC approval of the PBSP. It should be noted that seven assessments were reportedly completed and pending review. Overall, this current finding reflected a substantial decline in completion of these assessments compared to findings noted during the Monitoring Team's previous visit. More specifically, as noted in the previous report, 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. In an effort to more closely examine the nature of current functional assessments, provided SFAs, SFARs, and/or Consolidated SFAs for 12 individuals was reviewed. This sample was selected from those who had an ISP meeting within the past six months, with two exceptions (i.e., Individual #241 and Individual #320), as well as those who were rated at medium or high risk with regard to behavioral health (on the Integrated Risk Ratings, dated 6/10/14) and included individuals from across most residential programs in an effort to ensure a representative sample. Based on the PBSP Master List, dated 7/9/14, this sample of 12 individuals reflected 10% of total number (N=117) of active PBSPs. Review of provided assessments revealed that a SFA, SFAR, and/or Consolidated SFA was/were completed within the last 12 months for nine (75%) of those sampled. Closer examination of the most recently dated assessments revealed that, of the 12 individuals selected: 1) an SFA completed using the older format was provided for four (33%) individuals (i.e., Individual #213, Individual #254, Individual #241, and Individual #320); 2) an SFA completed using the most recently revised format was provided for five (42%) of the individuals (i.e., Individual #235, Individual #73, Individual #68, Individual #167, and Individual #20); and, 3) a Consolidated SFAR was completed for two (17%) individuals (i.e., Individual #70 and Individual #154). Overall, seven (58%) were completed using the most current SFA or Consolidated SFA format. 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 51.3% of current SFAs were in the current format. It should be noted that SFARs were completed for all (100%) of the individuals sampled. Closer inspection revealed that, at the time of the onsite visit, nine (75%) had been completed within the last 12 months. The exceptions included SFARs for Individual #68, Individual #254, and Individual #273, which were completed on 5/2/13 (referenced SFA dated 4/30/12), 4/8/13 (referenced SFA completed on 4/30/12), and 3/26/13 (referenced SFA dated 9/7/12), respectively. It should be noted that the Facility indicated that as SFAs were adequately upgraded (i.e., concurrent with the development or revision of PBSPs), SFARs were no longer going to be completed (as discussed below).	

		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 SFAs in the most recent format as well as completing Consolidated SFAs, only those assessments completed using these most current formats were examined. Indeed, based on documentation provided within Section K.5 of the Presentation Book, as the Facility completes upgraded SFAs concurrent with the development or revision of PBSPs, SFARs are no longer going to be permitted. Consequently, the current review focused more closely on examining only SFAs or Consolidated SFAs for individuals within the current sample that had been completed more recently (i.e., within the last 18 months), including SFAs or Consolidated SFAs completed between January 2013 and June 2014. Consequently, the current review examined the SFAs for three individuals (i.e., Individual #235, Individual #73, and Individual #280) as well as the Consolidated SFAs for two individuals (i.e., Individual #70 and Individual #154). Review of the five sampled SFAs or Consolidated SFAs indicated that four (80%) reported using standardized methods, including interviews, rating scales, and/or direct observation, widely accepted within behavior analysis. The exception was the Consolidated report for Individual #154 that primarily used previous reports as well as other permanent products (e.g., progress notes). In this case, the use of ratings scales, interviews, or more descriptive methods, like direct observation, were not conspicuously identified as sources of information. Of these five assessments, five (100%) included operational definitions of target behaviors, as well as potential precursor behaviors. 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. However, only three (60%) identified functionally equivalent replacement behaviors. The exceptions were assessments that did not identify any replacement behaviors (i.e., Individual #235) and where the replacement behavior did not appear to be functionally equivalent to potential underlying functions (i.e., Individual #73). In addition, five (100%) referenced the individual's response to current and/or previous interventions. However, only two (40%) included the use of data (or referenced data) to support their conclusions about previous interventions, including those for Individual #70 and Individual #280. Relatedly, only three (60%) included IOA and treatment integrity data. All five (100%) included information describing any necessary accommodations and relevant recommendations, as well as 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, however, that concerns (as noted above) remained with the adequacy of these assessments.	

		As reported in Section K.5 of the Facility's Self- Assessment, starting in April 2014, the PCM and Behavioral Service staff began conducting quality reviews of SFAs using the SFA Checklist. These reviews included conducting inter-rater reliability estimates. Three examples of completed Checklists were provided for review in the Section K Presentation Book. Summary data revealed an average score of 93.2% and 100% for PCM and Behavioral Services staff, respectively, on completed reviews (n=3) for the month of April. The inter-rater reliability of these reviews was reportedly 93.3%. Overall, it was found that there continued to be a substantial number of individuals with PBSPs that did not yet have current SFAs or SFARs, including upgraded SFAs. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility continue to focus on upgrading SFAs, including emphasis on ensuring descriptive assessment methods, functionally equivalent replacement behaviors, when appropriate, and the consistent incorporation of data (e.g., when discussing effectiveness of previous interventions, IOA and competency-integrity data).	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	As noted in the Monitoring Team's previous report, the Facility had implemented a new Behavioral Health Services policy (revised 12/5/13). In this new policy, a new assessment, the Behavioral Health Assessment, was detailed and a new format was prescribed. The new policy indicated behavioral health providers must review this assessment annually and as needed. Questions posed in the Monitoring Team's previous report regarding how the IDT would identify or determine if a change in functioning was "clinically significant," as well as how the behavioral health provider would determine which standardized assessments would be acceptable and when these assessments would need to be completed when reassessing intellectual and/or adaptive ability appeared to remain. This 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 204 individuals at the time of the current onsite visit, this sample reflected approximately 10% of the total number of psychological assessments.	Noncompliance

		Based on the current sample (as described above), of the Behavioral Health Assessments reviewed, 20 (100%) were updated within the last 12 months. However, one assessment (i.e., for Individual #146) was missing the summary and recommendations sections of the report and, consequently, did not appear fully completed. It should be noted that 20 (100%) of the assessments were completed using the new Behavioral Health Assessment format, dated 8/30/13. This was a substantial improvement compared to the assessments sampled during the Monitoring Team's last review. At that time, only 10 (50%) were completed using the new format. In addition, 20 (100%) of the assessments appeared completed prior to the ISP meeting. These findings were consistent with summary data the Facility provided. That is, provided data, as listed on one of the tracking spreadsheets (i.e., Psychological/Behavioral Health Assessments, dated 6/26/14), revealed that 112 assessments had been completed since 12/28/13, and that only four (less than 2%) assessments were out-of-date. Off-site comparison of this summary data with sampled documentation reflected 95% correspondence between the dates listed on the tracking data sheet and dates listed on the sampled documents. The one exception was the date listed on the assessment (3/11/14) for Individual #68 that was inconsistent with the date listed on the database (4/11/14). Provided documentation revealed that, of the behavioral health assessments reviewed, 19 (95%) of the sampled individuals had an ICAP evaluation completed within the last three years. The exception was Individual #171 (i.e., ICAP was dated 6/17/11, and a more current ICAP was not provided). It was unclear why more recently completed ICAPs, dated 4/17/14 and 5/13/14, were not included in the Behavioral Health Assessments completed for Individual #70 and Individual #68, respectively. 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, 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 #73). Of the 20 individuals sampled, only seven (35%) reported findings based on intellectual testing completed within the last five years. The exceptions included assessments for 13 individuals that contained testing results that were five or more years old (i.e., Individual #146, Individual #4, Individual #154, Individual #213, Individual #254, Individual #284, Individual #321, Individual #171, Individual #73, Individual #167, Individual #8, Individual #273, and Individual #242). Of the 20 sampled Behavioral Health Assessments, tests of adaptive functioning (i.e., Vineland Adaptive Behavior Scales or AAMD) were reported in 19 (95%) assessments. The exception included the assessment for Individual #321, 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 #146, Individual #154, Individual #213, Individual #254, Individual #284, Individual #321, Individual #171, Individual #73, Individual #8, Individual #273, and Individual #242). The Monitoring Team's previous report noted that since February 2013, no new testing (i.e., standardized tests of intelligence and/or tests of adaptive behavior) had been completed. However, at the time of the previous visit, verbal reports from the Director of Behavioral Health Services indicated an expectation that more rigorous standardized testing would be initiated. Currently, based on verbal report and provided documentation, it appeared that completion of standardized tests of intelligence as well as tests of adaptive behavior was reinitiated. More specifically, based on summary data (Record of Psychological Testing, provided in the Section K Presentation Book), it appeared that since the Monitoring Team's last visit, standardized tests of intelligence and/or adaptive behavior were completed for 21 individuals. Off-site comparison of this summary data with sampled documentation (i.e., Individual #266) reflected 100% correspondence between the dates listed on the tracking data sheet and dates listed on the sampled assessment. It should be noted that in May 2014, the Behavioral Health Assessment Quality Checklist was developed and initiated. According to verbal reports, it was expected that a random sample of assessments would be reviewed monthly using this checklist to examine ongoing quality of completion. Examples of completed checklists from April, May, and June 2014 were provided for review. Overall, progress was evident in completing Behavioral Health Assessments as well as initiating the updating of standardized tests of intelligence and adaptive behavior. As noted above, 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 continue efforts at updating standardized tests of intelligence and adaptive behavior, including ensuring that recent testing results are adequately described/summarized to facilitate the potential treatment utility of Behavioral Health Assessments.	
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of	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. Provided documentation (i.e., Admission Activity, dated 11/15/13 to 5/15/14) indicated that 10 individuals were admitted or re-admitted to the Facility during this time period. It should be noted that one of these individuals (i.e., Individual #94) was only placed in the community for approximately seven days before she was re-admitted to the Facility. Consequently, she was not included within the current sample	Noncompliance

	each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	as described below. As noted in Monitoring Team's previous report, the psychological assessment for Individual #91, who was admitted on 12/11/13, was not provided at the time of the last review. Consequently, this individual was included in the current sample. In total, the current sample included nine individuals. Based upon review of provided psychological assessments, it appeared that nine (100%) were completed within 30 days of admission and prior to the ISP meeting. Of these, seven (78%) had an ICAP completed within the last three years. The exceptions were assessments that did not include any detailed information regarding ICAP testing (i.e., Individual #152 and Individual #187). In addition, six (67%) included results of previously completed standardized tests of intelligence. The exceptions included three assessments that did not include any detailed information regarding intelligence testing (i.e., Individual #104, Individual #152, and Individual #187). Of these six, only four (67%) had testing completed within the last five years. The exceptions included Individual #134 and Individual #227. Of the nine individuals, six (67%) had assessments that included results of previously completed standardized tests of adaptive behavior (i.e., not including the ICAP). The exceptions were Individual #152, Individual #187, and Individual #227. Of these six, however, only three (50%) had adaptive testing completed within the last five years. Overall, of the nine assessments in the sample, only four (44%) had standardized tests of intelligence completed within the last five years (these included Individual #102, Individual #91, Individual #142, and Individual #234) and only three (33%) had tests of adaptive behavior completed within the last five years (these included Individual #91, Individual #102, and Individual #142). Upon review of the above sample, it was noted that six (67%) were completed using the new Behavioral Health Assessment format. However, it was noted that utilizing the newer format did not increase the likelihood that important elements prescribed within the assessment would be included. More specifically, although two of the sampled assessments were completed using the new format, they did not include any specific information regarding previous (or current) cognitive and adaptive testing. These included the Behavioral Health Assessments for Individual #152 and Individual #187. And, at times, more current testing information, when available, appeared misplaced within the assessment. That is, the most recent testing results were not placed within the Cognitive and Adaptive Functioning section of Evaluation/Assessment Results (Section V). It should be noted that the results reported above (based on the current sample) did not similarly reflect data the Facility provided within Section K.7 of the Presentation Book. That is, summary information the Facility presented stated: "9 of 9 (100%) of new admissions … had Behavioral Health Assessments completed within 30 days of their admission date." Although, the Monitoring Team found that all nine (100%) of the sampled individuals had some form of psychological assessment completed within 30	

		days of their admission date, two (22%) of these were not completed utilizing the new Behavioral Health Assessment format. In addition, documentation in the Presentation Book indicated that: "9 of 9 (100%) of those individuals have intelligence testing current within 5 years" as well as "5 of 9 (55.6%) of those individuals have assessments of adaptive behavior current within 5 years other than the ICAP." These statements were not consistent with the findings reported above based on documentation provided for review. More specifically, as noted above, of the nine assessments sampled, only four (44%) and three (33%) had standardized tests of intelligence and tests of adaptive behavior completed within the last five years, respectively. However, closer inspection of additional documentation (Record of Psychological Testing as provided within the Section K Presentation Book) appeared to indicate that more recent standardized tests of intelligence and tests of adaptive behavior had been completed in May 2014. That is, these testing results were obtained after the Behavioral Health Assessments (i.e., those provided for review) were written. Based on summary data (listing of dates), this appeared to be the case for five of the nine individuals sampled (i.e., Individual #134, Individual #152, Individual #187, Individual #227, and Individual #104). Unfortunately, the Behavioral Health Assessment completed at the time of the admission and provided for review by the Monitoring Team did not have this information detailing the more current testing results. Lastly, as described previously in the current report with regard to Section K.6 of the Settlement Agreement, provided dates as listed on tracking spreadsheets (i.e., Psychological/Behavioral Health Assessments, dated 6/26/14) revealed that 112 Psychological/Behavioral Health assessments had been completed since 12/28/13, and that only four (less than 2%) assessments were out-of-date. Off-site comparison of this summary data with sampled documentation (as described with regard to Section K.6) reflected 95% correspondence between the dates listed on the tracking data sheet and dates listed on the sampled documents. Off-site comparison of this summary data with sampled documentation (as described here) reflected 100% correspondence between the dates listed on the tracking data sheet and the dated listed on the sampled documents. Consequently, the Monitoring Team had confidence that this tracking sheet accurately reflected the date when the assessments were completed. However, as observed here, new testing results were not necessarily integrated into these assessments. If this new information was integrated into Behavioral Health Assessments, these revised assessments were not provided for review. Overall, documentation revealed that all new admissions had a psychological assessment completed within 30 days of admission. However, as noted above, several were incomplete, utilized the previous format, and/or 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 summary data provided within the Section K Self-Assessment, as of 5/29/14, it appeared that three community-based counselors provided counseling services to seven individuals. As reported, seven individuals received counseling from Licensed Professional Counselors and a Licensed Marriage and Family Counselor. Consequently, all seven reportedly were receiving counseling services by appropriately credentialed counselors. Statements found within Section K.8 of the Presentation Book revealed that the Facility's "… overall approach to counseling is in process of review and revision, with additional changes in procedures to be developed." Statements included with documents provided as part of the Section VIII document request revealed that: "counseling skill acquisition programs were recently revised and are in various stages of implementation. Consequently, weekly session notes and progress notes are not yet available." As a result, the Monitoring Team determined that the only documentation available to currently review included Counseling Skill Acquisition Programs. According to statements in the Self-Assessment, the Facility upgraded counseling SAPs by focusing on: 1) more individualized treatment; 2) adding discriminative stimuli in the objective and methodology; 3) more individualized and specific operational definitions; and 4) clarifying the methodology. As noted in the Monitoring Team's previous report, counseling SAPs were developed to add more structure and rigor to these therapeutic supports to aid in more effective service delivery and ongoing progress monitoring. Indeed, as described within the SAPs, they were designed for the counselor to implement them during counseling sessions as well as IDT member or direct support staff out of session. As noted above, the Facility identified seven individuals who were currently receiving counseling supports. This included Individual #88, Individual #7, Individual #173, Individual #34, Individual #124, Individual #121, and Individual #197. Descriptions the Facility provided suggested that all (100%) seven had recently revised or developed counseling SAPs. This was partially evidenced by the fact that four were actually dated (on 4/30/14), and exceptions included SAPs that were not dated for Individual #88, Individual #124, and Individual #197. It should be noted that, although some of these SAPs were dated, there was no evidence provided that they were actually currently implemented. In an effort to examine the upgrades as described above as well as the nature of these counseling SAPs in general, a sample of the SAPs the Facility provided were reviewed. That is, provided counseling skill acquisition programs were reviewed for three of the individuals currently identified as receiving counseling supports. This sample represented 43% of those individuals (N=7) receiving counseling services. Of the three individuals, the following was found:	Noncompliance

		▪ Three (100%) had a counseling skill acquisition program that provided a reason for revision as well as identified a rational the program; ▪ Three (100%) had a counseling skill acquisition program in which one or more treatment objectives were identified; ▪ Three (100%) had a counseling skill acquisition program in which one or more replacement behaviors were identified; ▪ Three (100%) had a counseling skill acquisition program in which one or more replacement behaviors were operationally defined; ▪ 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 counseling sessions; and ▪ Three (100%) had a counseling skill acquisition program that specified data collection and measurement procedures. Overall, since the Monitoring Team's last visit, it appeared that the Facility had made efforts to upgrade the counseling SAPs. These revisions appeared to be an improvement compared to previously reviewed documents. The next step, as already identified by the Facility, was to ensure an adequate data collection system (i.e., use of counseling data cards), including ongoing monitoring. It should be noted that, in addition to the counseling SAPs described above, the Facility also provided Counseling Generalization Skill Acquisition Programs for review. That is, counseling generalization SAPs were developed for five (71%) of the individuals currently receiving counseling supports. However, the Facility indicated that counseling generalization SAPs were " in development" for Individual #88 and Individual #124, and as a result, were not available for review. Examination of available counseling generalization SAPs revealed they were structured similarly to the SAPs typically implemented within residential programs. Consequently, these SAPs were reviewed with regard to Section S.1 of the Settlement Agreement. 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 revised the previous policy (i.e., 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, revised 12/5/13. 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 move forward with implementing the revised counseling SAPs and counseling generalization SAPs as well as develop and ensure adequate data collection and review procedures.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	It an attempt to examine the current status of active PBSPs, a sample of 12 individuals was identified. This sample was selected from those who had an ISP meeting within the past six months, with two exceptions (i.e., Individual #241 and Individual #320) as well as from those who were rated at medium or high risk with regard to behavioral health (on the Integrated Risk Ratings summary, dated 6/10/14), and included individuals from across most residential programs in an effort to ensure a representative sample. Based on the PBSP Master List, dated 7/9/14, this sample of 12 individuals reflected 10% of total number (N=117) of active PBSPs. This review included the examination of the current PBSP as well as SFAs and/or SFARs. Based on review of 12 individuals, the following was found: ▪ Of the 12 individuals sampled, 12 (100%) had PBSPs completed using the most recent PBSP format; ▪ Nine (75%) conspicuously identified their development based on the findings of a completed SFA, SFAR, or Consolidated SFA. The exceptions included plans for Individual #154, Individual #235, and Individual #73; ▪ 12 (100%) included a rationale for development or revision of the PBSP; ▪ 12 (100%) included one or more operational definitions of target behavior(s); ▪ 12 (100%) included one or more operational definitions of replacement behavior(s). However, of these, six included inadequate definitions for identified replacement behaviors (i.e., Individual #154, Individual #213, Individual #235, Individual #68, Individual #167, and Individual #273). As a result, six (50%) included adequate operational definitions for replacement behaviors; ▪ 12 (100%) included a purpose(s) of the plan, including proposed underlying function(s) of target behaviors. However, of these, two did not propose underlying function for all target behaviors, including, for example, very dangerous responses such as pica and self-injury (i.e., Individual #70 and Individual #213). As a result, 10 (83%) adequately identified proposed underlying functions of target behaviors; ▪ 12 (100%) included behavioral objectives for one or more target behaviors. However, of these, one included inadequate objectives for target behaviors (i.e., Individual #68). As a result, 11 (92%) included adequate behavioral objectives	Noncompliance

		for target behaviors; ▪ 12 (100%) included behavioral objectives for one or more replacement behaviors. However, of these, three included incomplete objectives (i.e., Individual #213, Individual #235, and Individual #73). Consequently, nine (75%) included adequate behavioral objectives for replacement behaviors; ▪ Nine (75%) included baseline data for one or more target behavior(s). The exceptions included Individual #280, Individual #68, and Individual #154; ▪ Nine (75%) included baseline data for one or more replacement behavior(s). The exceptions were Individual #154, Individual #213, and Individual #280; ▪ Seven (58%) conspicuously identified the use (or not) of SAPs to formally address the acquisition of replacement or alternative behaviors. The exceptions were Individual #70, Individual #235, Individual #254, Individual #273, and Individual #241. Consequently, it was only clear in five (42%) of the sampled plans whether or not SAPs were in place to support the acquisition of needed replacement or alternative responses; ▪ 11 (92%) described potential establishing operations (typically identified and/or described using layman terms). The exception was the PBSP for Individual #273, where these could not be identified; ▪ 12 (100%) included antecedent-based or preventative strategies; ▪ 12 (100%) included strategies to promote replacement or alternative behavior; ▪ 12 (100%) included consequence-based strategies or interventions aimed at weakening target behaviors; ▪ 12 (100%) appeared to include the use of positive reinforcement. Most of the PBSPs appeared to identify potentially robust individualized reinforcers; ▪ 12 (100%) included descriptions of data collection procedures; ▪ 11 (92%) included descriptions of plans to reduce the intensity of intervention(s). The exception was the PBSP for Individual #235 that did not include any information within this section. Of the 11, seven had identified the intervention and included some objective criteria to reduce its intensity. The exceptions were Individual #70, Individual #213, Individual #254, and Individual #320. Consequently, seven (64%) included adequate descriptions of plans to reduce the intensity of the interventions; ▪ 12 (100%) included grade level readability estimates all below a 7.0 grade level; ▪ 12 (100%) included the formatting and directions for conducting competency-integrity checks; and ▪ 11 (92%) were signed and dated. The exception was the PBSP for Individual #235. Overall, consistent with findings from the Monitoring Team's previous report, PBSPs remained similarly formatted and appeared relatively concise and user-friendly. In addition, the PBSPs continued to include many of the necessary elements for effective behavioral programming. However, as noted above, concerns regarding the adequacy of	

		these elements across many of the sampled plans remained. One concern not fully described above included whether or not functionally equivalent replacement behaviors were identified in the PBSPs. For nine (75%) of the PBSPs reviewed, it appeared that the replacement behavior appeared to be functionally equivalent to the identified function. The replacement behavior(s) identified in the remaining three plans, however, although meaningful, did not appear to target important functions of target behavior identified in the PBSP. These exceptions included replacement behaviors identified in the PBSPs for Individual #73, Individual #273, and Individual #320. As discussed with regard to Section C.4 of the Settlement Agreement, since the last Monitoring Team visit, the Facility had made substantial efforts to address issues related to medical and dental desensitization programming. That is, over the past six months, the Facility had re-initiated its efforts to develop dental and medical desensitization programs. In an effort to examine the nature of these supports, a sample of formal plans recently developed for five (45%) of the 11 individuals from the pilot group were examined. This sample included two PBSPs (Individual #38 and Individual #264) and three SAPs (Individual #51, Individual #272, and Individual #109). The identified SAPs are discussed with regard to Section S.1 of the Settlement Agreement. Current review of the two PBSPs noted that each PBSP identified target behavior(s) related to dental and/or medical appointments, and contained specific antecedent- and/or consequent-based interventions designed to reinforce more appropriate and adaptive behavior that would likely facilitate more successful clinical appointments. However, concerns were noted with several elements within the PBSPs. These concerns were not dissimilar to those noted above. For example, operational definitions for target (anxiety) and replacement behaviors (appropriate participation in appointments) were found to be inadequate (i.e., too broad, not specific enough to be accurately measured) for Individual #38. In addition, the prescribed strategies for relaxation therapy for Individual #38 appeared to require more detailed instructions as well as more specification regarding related data collection. Similar concerns were noted with regard to the adequacy of the operational definition for Individual # #264. Overall, these strategies appeared appropriate to support desensitization efforts without requiring more technical and comprehensive skill acquisition programming. With additional "fine tuning," these supplemental strategies as prescribed within PBSPs would likely be helpful alternatives to promote more adaptive behavior that would ultimately reduce the need for restraints during clinical appointments. Based on verbal report and provided documentation, it appeared that the PBSP Checklist, a quality rubric developed to examine the quality of PBSPs, had been initiated in April 2014. More specifically, a small sample of PBSPs (n=3) were examined by Behavioral Health Services staff as well as the Section K PCM and estimated ratings of their quality as well as inter-rater reliability were completed. Examples of these completed rubrics were provided for review in the Section K Presentation Book. Provided summary data	

		revealed an averaged quality rating of 89.3% and 94% by Behavioral Health Services staff and the PCM, respectively. In addition, inter-rater reliability was reported as 92.3%, which reflected good correspondence between raters. Provided documentation also indicated efforts by the Facility in improving the operational definitions and behavior objectives for replacement behaviors as targeted in the PBSPs and SAPs. This documentation included Action Steps and correspondence with Behavior Health Services staff identifying these issues. In addition, documentation reflected efforts to identify (and make more conspicuous) whether or not a SAP was in place to teach replacement behavior(s). This documentation included examples of three PBSPs where this information was conspicuously identified. 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 7/8/14, were examined. To confirm the accuracy of the Master List, dates recorded on the Master List were compared to dates on corresponding documents (e.g., Behavior Support Peer Review Committee approval/review sheet, Informed Consent for a Positive Behavior Support Plan form, and/or HRC Review of PBSPs and/or SPCIs form) during a brief onsite review. A sample of seven individuals, from the larger sample of individuals selected (as described with regard to Section K.9), was selected and 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. Based on the PBSP Master List, this sample of seven individuals reflected 6% of total number (N=117) of active PBSPs. Correspondence checks indicated 100% agreement between dates on selected documentation and dates on the PBSP Master List. According to the dates, necessary consents were obtained prior to the implementation of the PBSP for six (86%) of the individuals sampled. The exception was Individual #235. More specifically, provided documentation (PBSP) for Individual #235 did not indicate a start date and was not signed/dated by the author. It should be noted that approvals and consents for this PBSP were very recently received (within one week of the onsite visit) and the plan might not have been trained and implemented yet. In addition, it could not be determined if this PBSP was implemented within 14 days of receiving necessary consent from the guardian. Consequently, it appeared that six (86%) of the PBSPs were implemented within 14 days of receiving necessary consent from the guardian or approval from the Director. The Monitoring Team recognized that the timing of the onsite visit and document request in relation to the receipt of the approvals/consents as well as likely planned training for Individual #235 accounted for the unavailability of evidence. Based on data reported on the current PBSP Master List (dated 7/8/14), 115 (98%) of all	

		active PBSPs met the 14-day criteria (i.e., that the PBSP was implemented within 14 days of consent or Director approval). Data recorded on the Master List also indicated that 79 (68%) of all active PBSPs received necessary consent within 30 days of BSC approval. This was somewhat inconsistent with the current findings that indicated seven (100%) of those sampled received necessary consents within 30 days of BSC approval. Review of the sampled individuals also indicated that HRC approval was received as required for two (100%) of the PBSPs as required (i.e., Individual #70 and Individual #280). Lastly, data on the Master List also indicated that 90 (77%) of the PBSPs were current with one year of receipt of the Director's approval. Findings from the current sample indicated that six (86%) of the PBSPs were current within one year of the receipt of the Director's approval. The exception included the PBSP for Individual #68 that was last updated on 5/6/13. 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 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.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	As previously discussed with regard to Section K.4 of the Settlement Agreement, a sample of 12 individuals were selected and their current PBSP as well as Monthly PBSP Progress Notes, for three consecutive months were examined. Based on the PBSP Master List, dated 7/9/14, this sample of 12 individuals reflected 10% of total number (N=117) of individuals with active PBSPs. This review included the examination of the current PBSP as well as Monthly PBSP Progress Notes from April, May, and June 2014, as available. Currently, monthly PBSP Progress Notes were completed for 12 (100%) of the individuals sampled. At least one target behavior and at least one replacement behavior were adequately displayed in monthly PBSP progress notes for 12 (100%) of the individuals sampled. Adequate operational definitions for target and/or replacement behaviors were found on monthly PBSP progress notes for 10 (83%) of those sampled. In addition, target and replacement behaviors were consistent across the PBSP and monthly PBSP progress notes for seven (58%) of the individuals sampled. Monthly notes contained timely target and/or replacement behavior data for 12 (100%) of the individuals, and appeared to be completed in a timely fashion (within 30 days) for nine (75%) 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 nine (75%) of the individuals. Overall, concerns remained with regard to the adequacy of operational definitions, consistency between the PBSP and the Monthly PBSP Progress Notes, consistent reporting of IOA and competency-integrity data, and	Noncompliance

		their timely completion, including a thoughtful and insightful review of individual progress. Indeed, as noted with regard to Section K.4 of the Settlement Agreement, the Facility recently noted the need for additional oversight and support in the successful completion of monthly PBSP progress notes and had implemented new supports to ensure their adequacy. Closer review of graphic displays of data reflected maintained progress, and some improvement, 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 individualized data paths, at times in combined graphs, for 12 (100%) of the notes reviewed. Indeed, 12 (100%) of the sampled individuals had graphs that were easily interpretable. Of those sampled, 12 (100%) included data on both target and replacement behavior(s). In addition, the inclusion of condition change lines or other demarcations on graphs to illustrate changes in programming or other variables improved as these notations were noted within 10 (83%) of the individuals' sampled monthly notes. This was an improvement compared to the findings in the Monitoring Team's previous report at which time notations were found in only 69% of the individuals' monthly notes. The current exceptions included Individual #167 and Individual #254, where these interpretive aids were not utilized. Overall, the graphic displays were satisfactory. It should be noted, however, that concerns still remained with monthly PBSP progress notes (more information is provided with regard to Section K.4 of the Settlement Agreement). As noted in the Monitoring Team's last report, and previously highlighted with regard to Section K.4 of the Settlement Agreement, the completion of monthly IOA probes as well as the inclusion of IOA estimates within PBSP Monthly Notes was expected for each individual with a PBSP. Based on the review of the current sample, inclusion of monthly IOA estimates, including actual data, were found in the monthly notes for April, May, and June 2014 in only eight (67%), seven (58%), and seven (58%) of the individuals sampled, respectively. Overall, monthly IOA estimates were found in all three monthly notes for only five (42%) of the individuals sampled. It should be noted that this finding appeared somewhat lower compared to the estimate of 54% that was found in the previous sample as noted in the Monitoring Team's last report. The Monitoring Team's previous reports documented the Facility's progress at collecting IOA data. At the time of the last onsite visit, the Facility reported completing 1540 IOA probes between 5/1/13 and 11/30/13, with an average of 220 IOA probes conducted per month (range of 155 to 275 probes completed each month). It was reported that these probes estimated an average agreement of 91% (range of 79% to 98%). As noted in the previous report, this reflected a continued improvement in the completion of IOA probes, including improved agreement, over time. Currently, as reported by the Facility in the Section K of the Self-Assessment, 936 IOA probes were completed between	

		11/1/13 and 4/30/14. During that time period, the Facility reported completing an average of 156 IOA probes per month. Graphic display of the percentage of IOA probes completed per PBSP indicated that at least one IOA probe was completed for each PBSP per month from November 2013 to March 2104. Recent data from April indicated a slight reduction in the percentage of completed IOA probes. This data indicated that approximately 85% of PBPSs had at least one IOA probe completed monthly. Although this reflected a decrease, the Facility appeared to be completing more IOA probes than expected in the three of the five previous months. Provided data also reflected estimated average agreement at or above 95% from November 2013 to April 2014. Overall, although the total number of IOA probes completed each month had decreased since the Monitoring Team's last visit, monthly probes appeared to be conducted on a high percentage of PBSPs and agreement scores remained high. It appeared the Facility had initiated a process to monitor ongoing IOA collection by Behavioral Health Services staff. More specifically, IOA tracking reports completed by staff were provided within the Section K Presentation Book. These included samples of summaries of IOA completed by Behavior Health Services staff and entries identifying the individual, shift, date, targeted staff, and IOA score. In some cases, the data on competency-integrity checks was also included. Overall, these reports reflected an ongoing process from December 2013 through May 2014 across many staff. It might be helpful for the Facility to add summary information at the end of each report detailing if specific criteria (e.g., the percentage of plans with IOA probes completed, number of IOA probes completed across shifts) was met. This monthly summary data would likely be helpful when combining all of the monthly data to track trends over time. As noted in the Monitoring Team's previous report, the Facility highlighted the use of Quarterly Psychoactive Mediation Reviews as evidence of the integration of PBSP behavior data and other information (e.g., DISCUS and MOSES findings, lab results, etc.) when evaluating the effectiveness of psychotropic medication. As reported at that time, a sample of Quarterly Psychoactive Mediation Reviews as well as PBSP and Monthly PBSP Progress Notes were reviewed to examine the nature of this process. It was found that the data provided in these quarterly reviews was only consistent with the PBSP and Monthly PBSP Progress Notes for 83% of those sampled. Currently, in an effort to review the continued implementation of this system, a similar sample of Quarterly Psychoactive Mediation Reviews was examined. More specifically, a sample of 12 individuals who had PBSPs was selected and the most recent Quarterly Psychoactive Mediation Review as well as the PBSP and Monthly PBSP Progress Notes were reviewed. Review of the current sample revealed that 12 (100%) individuals had Quarterly Psychoactive Medication Reviews completed since the Monitoring Team's last visit. These reports were dated in April, May, or June 2014. Overall, behavior data was included in 12 (100%) of those sampled. However, the data provided in these reviews only appeared consistent with the PBSP and Monthly PBSP Progress Notes for seven (53%) of the	

		individuals sampled. That is, the data included in the quarterly review for five individuals (i.e., Individual #70, Individual #154, Individual 235, Individual #73, and Individual #68) did not appear to match the data reflected in the PBSP or monthly progress note. In addition, the data provided only appeared complete for 10 (83%) of those sampled. That is, considerable data was missing from the quarterly reports for Individual #213 and Individual #254. In addition, the data displayed in one quarterly review did not appear to match the data presented on the monthly progress note for Individual #235. Overall, concerns remained about the utility of the Quarterly Psychoactive Medication reviews based on the inadequacies noted previously and more recently for the sample reviewed above. It should be noted that it was not always entirely obvious if behaviors were identified as target, replacement, alternative, marker and/or monitored behaviors. It should be noted that the Monitoring Team observed examples of the use of behavioral data across several meetings during the onsite visit. More specifically, during the psychiatric clinic at Canna (on 7/9/14), graphed data was available for the individual that attended the clinic (i.e., Individual #119). Based on the provided graph, however, it was noted that the data/graph was last updated in April 2014. It should be noted, however, the Monitoring Team's observation was of an informal psychiatric clinic held to introduce the new psychiatrist to residents who were not scheduled to attend. Another behavior analyst also was covering the absence of the usual clinician at this meeting. In addition, behavioral data, including graphs, was presented and discussed during the BSC meeting on 7/10/14 with regard to review of the SFA and PBSP for Individual #273. This data appeared to be last updated in May 2014. It was unclear to the Monitoring Team if up-to-date data was necessary at the two meetings described above, especially given the impromptu psychiatric clinic. However, having current data available appeared to be a reasonable expectation given the emphasis on data-based decision-making, especially with regard to critical review of behavioral programming at a scheduled BSC meeting. The overall quality of the graphic display of data that was observed at the Monitoring Team's last visit continued to be noted. However, concerns were noted with regard to the availability of up-to-date data, accurate data (as noted in quarterly psychiatric notes), and the integration of IOA data in monthly PBSPs notes. 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	Previous Monitoring Team reports have documented the Facility's efforts in revising all of PBSPs to more closely adhere to a revised, streamlined PBSP format. Indeed, the Monitoring Team's last two reviews consistently found all of the sampled PBSPs written in this new format. In an effort to determine if this successful conversion has maintained	Substantial Compliance

	PBSPs are written so that they can be understood and implemented by direct care staff.	over time, a sample of 17 individuals who had an ISP meeting within the last six months and who also had a PBSP were selected and their current PBSP was examined. Based on the PBSP Master List, dated 7/9/14, this sample of 17 individuals reflected 15% of total number (N=117) 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 17 (100%) were completed using the most recent streamlined PBSP format. However, as previously discussed with regard to Section K.9 of the Settlement Agreement, one of the sampled PBSPs currently reviewed appeared incomplete (i.e., Individual #235). Overall, this format appeared likely to improve the accessibility, understanding, and implementation by staff. Sampled plans appeared similarly structured, three to five pages in length (average page length of 3.7 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 7/9/14), 100% of the PBSPs (N=117) had readability levels at or below a 7.0 grade level, and analysis indicated an average reading level of 5.9 (range of 3.2 to 7.0). Currently, closer review of the sample of PBSPs revealed that 17 (100%) were scored at or below a 7.0 grade reading level. That is, the sampled PBSPs revealed an average grade reading level of 6 (with a range from 4.2 to 6.9). Overall, since the Monitoring Team's last visit, the Facility continued to maintain 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	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. The current Monitoring visit focused primarily on the review of training and provided training documentation from either the Behavioral Health Services Department or from Competency Training and Development (CTD) Department. It an attempt to examine the current status of training for active PBSPs, a sample of 12 individuals was identified and training documentation for their current PBSPs was requested. This sample was selected from those who had an ISP meeting within the past six months, with two exceptions (i.e., Individual #241 and Individual #320) as well as from those who	Noncompliance

	implementation of those plans.	were rated at medium or high risk with regard to behavioral health (on the Integrated Risk Ratings summary, dated 6/10/14), and included individuals from across most residential programs in an effort to ensure a representative sample. Based on the PBSP Master List, dated 7/9/14, this sample of 12 individuals reflected 10% of total number (N=117) of active PBSPs. Based on review of provided training documentation, concerns were noted with regard to the adequacy of how PBSP trainings were documented. More specifically, of the 12 individuals sampled, only eight (67%) evidenced completion of trainings as documented on PBSP Review Documentation Sheet or Certification of Completion of Competency Based Training – Behavioral Health Services, as provided. Exceptions included individuals that the Facility had identified as not having training documentation available (i.e., Individual #68 and Individual #254) as well as individuals whose documentation, if available, was not provided (i.e., Individual #167 and Individual #280). Of the eight individuals with available training documentation, seven (88%) were dated within the last 12 months. The exception was the training for Individual #273 (dated 5/1/13). Overall, of the 12 individuals sampled, only seven (58%) evidenced the completion of training for the current PBSP within the last year. Of the three training documents with pre-printed staff names, two (67%) appeared to have trained all of the staff listed. Review of provided training documentation also revealed inconsistency in identified dates of implementation or start dates of sampled PBSPs. It was assumed by the Monitoring Team that a "start date" as identified on a PBSP was the date that training was implemented on the current plan, and, consequently, reflected the identified date of when the plan was started. Consequently, the Monitoring Team expected that the start date (as identified on the PBSP) would correspond with the "Competency Based Training/PBSP Implemented" date as recorded on the PBSP Master List (dated 7/9/14). Of the eight PBSPs with available training documentation, six (75%) had start dates that corresponded with PBSP implementation dates on the Master List. The exceptions included Individual #235 and Individual #154. As noted previously with regard to Section K.9 of the Settlement Agreement, it was likely that planned training for Individual #235 might have occurred around the time of the onsite visit, and, consequently, more current training documentation might not have been available. Concerns also were noted with the correspondence between available training documentation and the competency-based training/PBSP implementation dates on the Master List. That is, of the eight PBSPs with available training documentation, five (63%) had training dates (as recorded on training documentation) that corresponded with competency based training/PBSP implementation dates as on the Master List. The exceptions included Individual #213, Individual #235, and Individual #320. Accuracy of the recorded dates on the Master List was critical as these were the dates of comparison used to determine adherence to other important criteria.	

		Documentation also revealed variability in the formats used to track attendance at the trainings. That is, the newer format, entitled "Certification of Completion of Competency-Based Training – Behavioral Health Services," had the names of staff members already printed on the document compared to the older form, entitled PBSP Review Documentation Sheet, where names had to be printed. This newer format appeared to facilitate quicker review and identification of direct support staff who continued to require training. Currently, of the eight PBSPs with available training documentation, three (38%) appeared to be completed using the newer format (with the pre-printed staff names). The exceptions included documentation for Individual #213, Individual #235, Individual #73, Individual #273, and Individual #320. In addition, competency scores were not always recorded on the training documentation. That is, only four (50%) of the provided training documentation included competency scores for staff. The exceptions included Individual #70, Individual #235, Individual #273, and Individual #320. Lastly, it appeared only Behavior Health Assistants conducted the majority of sampled trainings. More specifically, a Behavior Health Specialist conducted only one (13%) of the trainings (i.e., the PBSP training for Individual #70). This was surprising given that Behavior Health Specialists had written all of the PBSPs, and all of the trainings observed during onsite visits included Behavior Health Specialists and Behavior Health Assistants. In addition, trainer initials and/or signatures on provided documentation appeared to indicate that two trainers facilitated only two (25%) of the trainings (i.e., Individual #213 and Individual #241). It should be noted that a second trainer might have been at hand but did not indicate participation through initials or signature on the training documentation. These findings were not consistent with the expected methods the Facility employed to ensure competency-based training. More specifically, the guidelines for PBSP Competency Based Training (revised 3/25/13) indicated that a Behavior Health Specialist/Behavior Analyst and at least one Behavior Health Assistant conduct the training together. As described in the Monitoring Team's previous report, efforts to ensure the quality of competency-based trainings (CBT) by Behavioral Health Services staff included prescribed methods of CBT that 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. As previously noted, it was expected that these methods 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 #179) evidenced the utilization of these prescribed methods. More specifically, three trainers were involved in the observed training, and materials were provided to all participants at the training, including copies of the PBSP as well as data cards. It was observed that the trainers comprehensively reviewed the PBSP, including having the trainees demonstrate data collection as well as antecedent- and consequence-based strategies. Training focused on	

		both the participant's verbal behavior as well as their demonstration of necessary skills. Throughout the training, the instructors were likely to ask "explain to me why _____," "show me how you would _____," etc. In addition, multiple opportunities were provided for staff to demonstrate skills and interact with the trainers and each other as the large group was broken down into three smaller groups (with a trainer for each group). It was obvious to the Monitoring Team that the instructors were focused on the competencies of the staff and their accurate demonstration of required skills. The Monitoring Team's previous reports have consistently noted that competency-based trainings reportedly were provided for very high percentages of PBSPs. That is, the Monitoring Team's past reports have highlighted data recorded by the Facility in PBSP Master Lists, dated 7/11/13 and 12/12/13, that revealed 97% and 99% of PBSPs were implemented following competency-based training, respectively. As reported within the Section K Self-Assessment, as of 5/29/14, 89.1% of PBSPs had initial competency-based training current within one year. This percentage appeared to decline over time as data reported in the Section K Presentation Book revealed that, as of 6/26/14, 80.6% of PBSPs had initial competency-based training current within one year. 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 new policy entitled the "Pulled Staff/Transfer Staff Process," dated 12/11/13. This policy remained in effect. At the time of the last review, although procedures were in place to facilitate the training of these pulled staff, it did not appear the Facility had processes in place to estimate the quality of the training these individuals received. Currently, it appeared the Facility had initiated completing competency-integrity checks on a sample of pulled staff to estimate their competency in implementing PBSPs. Provided documentation, including examples of pulled staff member orientation pages as well as competency-integrity checks, reflected this process of targeted quality checks of pulled staff's competency as related to PBSPs. Summary data contained in the Facility Self-Assessment reflected the completion and monitoring of competency-integrity checks completed in March and April 2014 on a small sample of pulled staff each month (n=7). Average scores on these checks by pulled staff were comparable to scores from non-pulled staff (i.e., over 90%). Going forward, the Facility might want to increase sample size of pulled staff so it is proportional to the number of pulled staff typically utilized per month. As presented with regard to Section K.4 of the Settlement Agreement, inclusion of monthly competency-integrity estimates were found in the sampled monthly notes of 10 (83%), 11 (92%) and 10 (83%) individuals sampled across April, May, and June 2014, respectively. Closer examination revealed the inclusion of competency integrity estimates was found in all three monthly notes for five (42%) individuals. This appeared to reflect a decrease in reporting of these estimates compared to the findings reported in the Monitoring Team's previous report. At that time, inclusion of competency integrity	

		estimates was found in all three monthly notes for eight (73%) of the individuals sampled. Overall, it appeared that previously noted increasing consistency of the integrity estimates within monthly notes was not maintained. 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 in this new format. Indeed, this was consistent with findings from the current review of sampled PBSPs. The Monitoring Team's previous reports reflected progress over time in the completion of competency-integrity checks. Currently, summary data provided in the Section K Self-Assessment indicated that approximately 769 competency-integrity checks were completed between November 2013 and April 2104. These checks produced an estimated average monthly integrity score of 98.8% (ranging between 98.3% to 99.2%) based on approximately 128 checks, on average, completed each month (ranging from 120 to 132). These findings were consistent with scores reported in the Monitoring Team's previous report. That is previous data indicated 893 competency-integrity checks were conducted between May and November 2013 which 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. As noted in previous Monitoring Team reports, a data management system had been developed to manage and monitor trainings, including the training of new hires as well as other Facility staff, and was overseen by CTD. As reported in the last few reports, this system appeared likely to be helpful in managing data related to trainings across campus. Verbal reports at the time of the Monitoring Team's last review indicated data was just being inputted into the database, and that ongoing efforts would be necessary to fully populate the database. Currently, provided documentation suggested that trainings in November and December 2013 had been inputted into this system. However, documentation revealed that data had not been entered since February 2014 due to staffing vacancies. Consequently, it appeared that the Behavioral Health Services Department developed and implemented a separate database for tracking PBSP training. A few examples that were provided for review revealed that this new system could be very helpful in monitoring training. Unfortunately, if these training reports were available at the time of the onsite visit, they were not provided in response to the Monitoring Team's request for training documentation for sampled individuals. Overall, given the concerns noted above with regard to the adequacy of training documentation, including ensuring an effective method to track and monitor the nature	

		of training (e.g., who trained, what direct support professionals were trained, scores, etc.), 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, or the newly created department database, 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 of Behavioral Health Services, LBSSLC employed 10 other Behavioral Health Specialists. Of these 11 staff, five (45%) were currently BCBAs. In addition, LBSSLC currently employed seven Behavioral Health Assistants, one of which was the Assistant to the Director of Behavioral Health Services. Currently, there were no vacant positions in the Behavioral Health Services Department. At the time of the current onsite visit, reports indicated that LBSSLC currently served 204 individuals. Based on this current census, and the recognition that the Director did not carry a formal caseload, an approximate average ratio of 1:20 Behavioral Health Specialist-to-individual served was determined. With six Behavioral Health Assistants currently supporting 10 Behavior Health Specialists with caseloads, 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 Health 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.	Noncompliance

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, titles, and degrees; o Name and CV of Medical Director, if new since the last visit; o Name and degrees of all PCPs new to the Facility since last Monitoring Team visit; o Number of individuals on each PCP's caseload; o Employees listed under Medical Department completing CPR training certification with dates of completion, and dates of expiration; o Copy of any in-service for PCP training on ICD and DSM diagnostic criteria in last six months; o For the past six months, copy of Continuing Medical Education (CME) for each primary care provider, list of CME credits according to topics reviewed, and list per PCP of total CME credits during this time period; o Copy of any clinical guidelines developed and implemented since last Monitoring Team 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: Individual #105, Individual #45, Individual #310, Individual #222, Individual #131, Individual # 192, Individual #114, Individual #197, Individual #323, Individual #181, Individual #60, Individual #108, Individual #28, Individual #112, Individual #25, Individual #7, Individual #190, Individual #213, and Individual #146; o For any medical staff meetings (i.e., morning medical meetings, etc.) copy of all minutes, handouts, logs from Infirmary, hospitalizations, and 24-hour reports discussed, for the week prior to the Monitoring Team's visit; o Most recent results/report of the Facility-wide medical review system, including copy of any non-facility physician review reports or data since the Monitoring Team's last visit, with separate reports/data of external medical peer review audits from internal medical peer review audits (both general medical and medical management audits), including information concerning number of corrective action plans, and QA Department follow-up of these corrective action plans; o List of individuals who died since the Monitoring Team's last visit. For each individual, submitted information included date of death, death certificate, whether autopsy was done (and if so, copy of autopsy report), medical problem list current at time of death, and for seven days prior to death or hospitalization, all clinical documentation including nursing and physician notes, and all diagnostic studies including radiologic and laboratory. Submitted requested information included location at time of death, whether

	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: Individual #324, Individual #204, and Individual #52; o Mortality Reviews (i.e., clinical, administrative, and nursing reports) since Monitoring Team's last visit; o Corrective actions related to Mortality Reviews (including status reports on previous recommendations made prior to last Monitoring Team visit which had follow-up closure or action steps completed); o Notes and orders for any DNRs and rescinding of DNRs; o Current DNR list with reason/criteria for DNR; o List of death reports (i.e., clinical/administrative) that remain incomplete/outstanding; o Twenty most recent annual medical assessments and physical examinations and prior annual assessment and examination; o Specialty clinic schedule per month for past six months (including the list of appointments made, the list of appointments completed, the list of appointments refused by the individual, the list of appointments missed for 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: ▪ With tracheostomies; ▪ With fractures, date of fracture, type of fracture (i.e., compound, simple, stress, etc.), bone fractured (location); ▪ With injuries requiring visit to ER or hospitalization since the last on site review; ▪ With pica or ingesting inedible object, date of ingestion, object/liquid ingested, whether taken to ER or hospitalized, since the Monitoring Team's last on site review; o Policies or procedures for medical screening and routine evaluations; o For those over 50, date of last colonoscopy, identification of reason for colonoscopy (i.e., preventive versus evaluation of active problem), with reason if not up-to-date;

	○ For those women over 40, date of last mammogram and reason listed if not up-to-date (i.e., guardian refusal, etc.); ○ List of all women age 40 or greater with date of birth; ○ List of all individuals age 50 or greater, with date of birth; ○ Current list of all those with diagnosis of osteopenia/osteoporosis with medications and dosage per person (include calcium, Vitamin D, IV bisphosphonate, etc.), date of last 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; ○ For men with diagnosis of osteopenia/osteoporosis, copy of any lab work testing for secondary causes (from current active record), other information indicating cause (i.e., specific medications, etc.) of osteopenia/osteoporosis; ○ 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 (i.e., specific medications, etc.) of osteopenia/osteoporosis; ○ 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.); ○ For individuals with Down's syndrome, date of last thyroid test; ○ 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 #100, Individual #68, Individual #191, Individual #310, Individual #90, Individual #174, Individual #160, Individual #6, and Individual #293; ○ 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 #55, Individual #312, Individual #313, Individual #270, Individual #139, Individual #134, Individual #104, Individual #191, Individual #115, and Individual #76; ○ For these same 10 most recent hospitalizations that have been completed, copy of Hospital Liaison Nurse documentation of hospitalization; ○ Length of stay for Infirmary admissions for past six months, if applicable; ○ Infectious disease data per quarter by category of infection last two quarters; ○ Summary report or trend analysis of infectious disease/communicable disease last two quarters; ○ Avatar pneumonia tracking forms/ pneumonia data from Avatar database for past six months; ○ For those with diagnosis of pneumonia in last six months and taking food/liquid by mouth,

	type of liquid (amount of thickening), and type of texture of solid food ordered, and last swallow study; o Absolute numbers of new cases (i.e., prior year, by month) for the following: ▪ Pneumonia; ▪ Decubitus ulcers; ▪ UTIs; ▪ 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: ▪ Malignancy; ▪ Cardiovascular disease; ▪ Diabetes mellitus; ▪ Sepsis; ▪ Bowel obstruction or bowel perforation; ▪ 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 #136, Individual #251, Individual #3, Individual #250, and Individual #76; o List of individuals seen by neurologist with dates on which appointments were completed and reason, since the Monitoring Team's last visit, date of prior visit to the neurologist for these same individuals; o List of those with status epilepticus since the last monitoring visit; o List of those going to ER for uncontrolled/prolonged/new onset seizure since last Monitoring Team visit; o List of individuals with refractory seizure disorder; o List of individuals with refractory seizure disorder who are being evaluated for Vagal Nerve Stimulator (VNS) placement and the stage of evaluation; o Numbers and percentage of individuals with diagnosis of seizure disorder on zero, one, two, three, four, and five antiepileptic drugs (AEDs); o Numbers and percentages of persons on older AEDs (i.e., Phenobarbital, Dilantin, Mysoline, and Felbamate); o Since the Monitoring Team's last visit, any Ethics Committee meeting minutes, with attendance rosters, concerning DNR decisions/changes, or other concerns addressed by this committee; o Dates of last two completed annual medical assessments and annual physical examinations for all individuals; o Dates of last two completed quarterly medical reviews/IPN completed for all individuals;

	○ For specialty clinic appointments (on campus and off site), list of appointments that were completed and ones not completed (with reasons); ○ For hospitalizations in prior six months, copies of follow-up ISPA; ○ Number of individuals with VNS in place, date of placement, date of replacement, if applicable; ○ For concerns identified needing closure at morning medical 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.); ○ For the last five pre-treatment sedations administered for a medical procedure, all information related to medical pre-treatment sedation used, including consents, Human Rights Committee (HRC) approval, relevant assessments, ISP entries, any general discussion record, action plan, and IPN entries. Information submitted for following individuals: Individual #151 (3/13/14), Individual #164 (3/11/14), and Individual #115 (2/26/14, 3/7/14, and 4/2/14); ○ Ten most recent PNMT recommendations for which physician orders were written based on those recommendations; ○ ISPA addressing missed appointments or refusals for the past three months (for mammograms, colonoscopies and off-site and on-site consultation appointments); ○ List of missed medical appointments with reasons past six months; ○ Presentation Book for Section L; ○ DADS Preventive Health Care Guidelines, SSLCs, dated August 30, 2011; ○ For women age 21 to 65, list of individuals with date of last pelvic exam (including whether attempted but unsuccessful), date of last pap smear with determination of adequate reading, sufficient sample, etc., (including whether attempted but unsuccessful), if pelvic not done, the reason/indication, and if pap smear not done including the reason/indication. For those with a history of hysterectomy, list of the reasons for the hysterectomy; ○ For the self-assessment process: list of monitoring/audit tools used; for each tool, identification of the total number of the eligible population to be sampled, the number of the sample, clarification of how the sample was chosen, how often the data was collected, the staff that completed the audit/monitor survey/review, and whether any inter-reliability data was obtained/analyzed for the audit/monitoring review; ○ For the self-assessment process: list of databases utilized (other than audit information), including title of each database/chart/table with date range of each database. For data collected periodically rather than continuously, the frequency of the data collection; and ○ For each of the following individuals, copies from the active record: most current annual medical assessment and physical exam, preventive care flow sheet, most current nursing assessment, past one year of IPN, past one year of lab results (i.e., x-rays, scans, MRIs, ultrasound reports), hospital discharge summaries for past one year, ER reports for past one year, consults and procedure reports past one year, DNR forms if applicable, physician orders past one year, most recent ISP and subsequent addendums, most recent Behavior Support Plan (BSP), past three medical quarterly reviews: Individual #171, Individual

	#68, Individual #161, Individual #113, Individual #181, and Individual #74; and ○ Minutes of the medical morning meeting with handouts during the Monitoring Team visit: 7/8/14, 7/9/14, and 7/10/14. ▪ **Interviews with**: ○ Glenn Shipley, DO, MPH, Medical Director; ○ Leah Shults, RN, BSN, Medical Program Compliance Nurse; ○ Resurreccion Barranda, MD, Staff Physician; ○ Ricardo Rodriguez, MD, Staff Physician; and ○ Grazyna Thomas, PA-C, Staff Physician Assistant. ▪ **Observations of**: ○ Individual #258, Individual #37, Individual #136, Individual #195, Individual #181, Individual #211, Individual #104, Individual #167, Individual #62, Individual #21, Individual #215, Individual #280, Individual #323, Individual #312, Individual #226, Individual #6, Individual #43, Individual#293, Individual #317, Individual #161, Individual#225, Individual #176, Individual #171, Individual #196, Individual #191, Individual #89, and Individual #269; ○ Neurology Clinic 7/9/14: Individual #251, Individual #80, Individual #290, Individual #76, Individual #225, and Individual #167; and ○ Morning Provider Meeting of 7/8/14, 7/9/14, and 7/10/14.
	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: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: external and internal general medical audits, external and internal medical management audits, and audits of content of the annual medical assessments and the quarterly medical reviews. ○ The peer review monitoring/audit tools included insufficient indicators to allow the Facility to determine compliance with the Settlement Agreement, especially in the medical management audit. The general medical audit appeared adequate and comprehensive. ○ The monitoring tools included adequate methodologies, such as record reviews. ○ The Self-Assessment identified the sample 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 for most audits. ○ The following staff/positions were responsible for completing the audit tools: PCPs, Medical Compliance Nurse, Clinic Nurse, and RN Clinic Manager. ○ Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the external and internal general medical and medical management audits. ▪ The Facility used some other relevant data sources and/or key indicators/outcome measures to

	show whether or not the intended outcomes of the Settlement Agreement were being reached, such as timely completion of annual medical assessments. The quality of the data maintained in the databases was noted to be complete and accurate, with only minor inconsistencies between databases. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Presented the results of the external and internal peer review audits in bar graphs; o Presented findings consistently based on specific, measurable indicators; and o Consistently measured the quality as well as presence of items. ▪ 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 in need of improvement. For those areas of need, the Facility Self-Assessment provided an analysis of the information, identifying for example corrective action plans to be completed. These were then tracked to completion.
	Summary of Monitor's Assessment: Timely preventive screening and tracking remained a strength of the Medical Department for mammograms, colonoscopies, cervical cancer screening, and DEXA scan completion. Timeliness of quarterly medical reviews had achieved 90 percent. Nutritional assessments provided the needed information concerning dietary and supplemental intake of calcium, as well as daily intake of Vitamin D. The morning provider meeting was efficient and effective and tracked the necessary clinical concerns identified through that meeting. A system was in place to follow through with recommendations for the administrative death reviews. However, although progress had been made with regard to closure of mortality review recommendations, the information presented did not address the recommendation in several cases. The medical services policy and procedure manual appeared to be comprehensive and up-to-date. Legibility was a concern, both in the written orders from the PCPs, and in the Integrated Progress Notes (IPNs), which were also dictated but not immediately available in the record. Internal quality review of abnormal tests/findings or change of status had begun recently, and a larger sample size was needed, along with assistance from the QA Department in developing a robust QI process for this aspect of clinical care. At the morning provider meeting, there appeared to be less emphasis on the PCPs providing a synopsis of current tests completed with results and plans formulated when discussing a change of health status. For individuals hospitalized and already discussed at the morning provider meetings, this would not be necessary However, a brief summary of findings and plans for ER visits and other acute illness, as well as new hospitalizations, and additional comments based on new findings while hospitalized or once released back to LBSSLC would provide assurance of the identification of the clinical steps to be implemented that day or on return to LBSSLC, as well as provide needed information to the attendees of the meeting. The morning meeting would benefit from assuring this component of interdisciplinary discussion occurred for acute health issues. The Monitoring Team determined that the Facility had achieved substantial compliance with Section L.4, and remained in noncompliance with Sections L.1, L.2, and L.3.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different subsections that address various areas of compliance, as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, physician participation in team process, routine care and preventative care, medical management of acute and chronic conditions, and Do Not Resuscitate (DNR) Orders. <u>Staffing and Administration</u> For the census of 206 individuals as of 5/27/14, there were four PCPs responsible for this population. The Medical Director had a caseload of 11. Other PCPs had caseloads ranging from 62 to 68. There was no vacancy in the department. A list was submitted indicating those members of the Medical Department that remained current in CPR certification. The list was scanned on 6/2/14. Of the primary care providers in the department, four of four (100%) were current in CPR. Of the four PCPs in the Medical Department, a list of CME credits was submitted for three of four of these PCPs. This varied from 12 to 32.5 hours. The majority of the topics included areas of importance to primary care and the individuals residing at LBSSLC. Of the total of 60.5 hours of continuing education taken by the PCPs, 53.25 hours appeared to be applicable to the care of individuals residing at LBSSLC. No topics were listed that were specific to intellectual or developmental disabilities. <u>Physician and other Departmental Participation In Team Process</u> ▪ For the three morning medical meetings observed, there was a signed attendance roster in three of three meetings. ▪ For the three morning medical meetings observed, there were five hospitalizations (i.e., Individual #168, Individual #273, Individual #139, Individual #135, and individual #156). ▪ Based on the Monitoring Team's observations and review of documentation: o **On-call PCP participation:** For the three morning medical meetings observed, the on-call PCP (from the prior evening) participated in providing clinical information from the prior evening in three of three meetings. o **Attending PCP participation:** The attending PCP participated in the discussions in health status changes/updates/concerns in three of three meetings. o **Campus 24-hour medical log report**: The Campus 24-hour medical log report was reviewed at three of three morning medical meetings. o **Hospital Nurse Liaison updates:** The Hospital Nurse Liaison reported an update for hospitalizations during the three of three observed meetings. o **Assignment of follow-up to meeting participant:** There were critical clinical questions raised/identified needing closure, which was followed by assignment of the concern for further review. The meeting minutes for one of the three indicated closure, but the Monitoring Team	Noncompliance

#	Provision	Assessment of Status	Compliance
	provision in a separate monitoring plan.	member's observation at the meeting indicated the assignment had occurred without further information indicating closure. Additional information might have been provided after the meeting. o **Assignment of open record review:** There were two assignments for two hospitalizations/ER visits/admissions requesting an open record review. o For **previously assigned open record reviews**, none were presented during the three morning meetings. There were four open record reviews assigned, but not due during this time period. o **Closure discussions**: There were seven prior concerns with assignments for follow-up, which were presented at the medical morning meetings. o **Follow-up requested ISPA reviewed:** There were two brief summaries of ISPAs that had been assigned to IDTs in responding to concerns referred by the medical morning meeting. These were discussed, and one was accepted without change and the morning provider meeting participants made recommendations for one. This ISPA was then followed up two days later with the recommendations included in the ISPA. o **Infection control updates:** During the three medical morning meetings, there were two infection control updates presented. o **Summaries of completed consultations:** During the three medical morning meetings, there were 27 summaries presented concerning completed consultations or updates of status of consultations not completed that had been received o **Dental Department updates**: The Dental Department provided brief updates/information during zero of three medical morning meetings. o **PT/OT/ST and PNMT updates:** The PT, OT, ST, and PNMT presented updates during one of three medical morning meetings. o **Skin integrity updates:** Skin integrity reports/updates were provided at one of three medical morning meetings. o **Discussion of significant weight change:** There was a discussion of individuals with significant weight loss or gain at one of three medical morning meetings. One focus of the morning provider meeting in the past had been the PCP synopsis of current test results, current physical findings, and plans/orders to be completed that day in response to acute problems. Based on this most recent review, this component of critical clinical discussion appeared to be missing. Although there were no new hospital admissions for discussion at the meetings the Monitoring Team observed, there were ER visits and abnormal findings from tests and procedures that would have been appropriately discussed at the morning provider meeting. It is recommended that this discussion of critical clinical review be included for significant change in health status events and significant abnormal findings. Demonstration of discussion of the pertinent clinical background and immediate plans would ensure that care was timely and aggressive, and would provide critical information to other members of the morning provider meeting. <u>Routine Care</u> A list of dates of the last two annual medical assessments and physical exams were submitted in a document entitled 'Tracking Annual Physical Exams." The list totaled 206 individuals. Ten individuals newly admitted within the prior 12 months were omitted, leaving 196 individuals listed. All entries appeared to be complete, and without typographical	

#	Provision	Assessment of Status	Compliance
		error or data entry error. For 196 individuals, there were dates of prior and current annual medical assessments listed. Of these, 156 out of 196 (80%) of the recent annual medical assessments were completed within 365 days of the prior assessment. For 22 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 requested for review. Evaluations were considered timely if the most recent annual medical summary and physical examination evaluation was completed within 365 days of the prior annual evaluation. For two individuals, the current or prior annual medical summary and physical examination evaluation was not submitted, and timeliness for these two could not be determined. For the 20 individuals for which the requested information was complete, compliance was 18 of 20 (90%). The two annual assessments that did not include both current and prior assessments were not further considered in this review. ▪ For the 20 most recent annual medical assessments, there was an interval history included as part of the document in 20 of 20 (100%) reviews. However, for one of 20 the interval history included information occurring prior to the past year. As the interval history should highlight information from the last annual assessment, it is recommended that the Medical Department review this document and provide guidance to the PCPs. ▪ For the 20 most recent annual medical assessments, the major active problems listed had plans of care addressing each of the significant current diagnoses in 20 of 20 (100%) assessments. ▪ For the 20 most recent annual medical assessments, 20 (100%) addressed smoking history. ▪ Family history was adequate/helpful in 11 of 18 (61%) assessments. One individual was adopted and no history was available. Another individual had no family involvement. ▪ A discussion of readiness/requirements for transition to the community was included in 19 of 20 (95%). For the sample reviewed, staff had not removed optional blank spaces or non-applicable areas from the annual medical evaluation template. The template format was difficult to follow at times. For example, the interval history did not include consults in the prior year, but this information was listed in a different section. Clinically, it would have been helpful to have all pertinent information obtained in the prior year located in one area of the document. There was a section listing preferences, strengths, and goals, and, as written had little relationship to the medical assessment. This area might be more helpful if preferences, strengths, etc., were selected that were applicable to the individual's medical care, such as compliance, cooperation, self-administration of medication, etc. Cutting and pasting/repeating this information from the ISP distracted from the clinical information provided prior to this entry and after the entry. This area needed further guidance from the Facility Administration, as well as a review of the location in which it was placed within the document. The benefit of repeating information already provided elsewhere in the ISP without using it in a meaningful way was unclear. As noted above, there are aspects of medical care in which it would be totally appropriate to incorporate individuals' preferences and strengths, but to simply repeat information without addressing its relevance did not seem to have much benefit. As part of the monitoring review process, the Monitoring Team selected the medical records of six individuals to determine compliance with several requirements of Section L.1. These individuals are listed in the documents reviewed section. The reviews selected were based on 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,	

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		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, most recent BSP, last annual ISP and subsequent addendums, labs, X-rays/CT scans, MRI scans, ultrasound scans, other radiographic test results for the prior one year, the Integrated Risk Rating Form (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 six medical records reviewed: ▪ Six of six (100%) annual medical assessments had been completed in the prior 365 days. ▪ Active problem lists appeared to be thorough in one of six (17%). ▪ Five of six (83%) annual medical assessments included smoking history and/or substance abuse history ▪ A family history was documented (or attempts at obtaining this information) in two of six (33%) records. o For one of six, there was minimal information. o For two of six there was reference to no family correspondence, but information concerning attempts was not provided. ▪ Six of six (100%) had information discussing requirements for transition. These six medical records also were reviewed to determine whether the physician IPN note used the SOAP format for acute illness documentation. ▪ In six of six (100%), the SOAP format was used. ▪ Six of six (100%) of SOAP IPNs included the date. ▪ Six of six (100%) of SOAP IPNs included the time. ▪ Six of six (100%) of SOAP IPNs recorded vital signs or referenced vital signs from a prior recent note/entry. *Quarterly Medical Reviews* The Medical Department provided a list of quarterly medical reviews completed each quarter for all individuals. Information for 206 individuals was provided. There were five new admissions that would only have had one quarterly medical review completed. For the six-month interval, the total number of quarterly medical reviews required was 206 plus 201, which equates to 407. Three hundred sixty eight quarterlies were listed, for a compliance rate of 90 percent (368/407). It was noted that this calculation did not account for those individuals that were no longer at the Facility due to transfer, transition to the community, etc. For each month, the list of individuals for which quarterlies were due was provided, along with the date completed. The following provides the number of individuals per month in which a quarterly was due, and the number of quarterlies completed. If a quarterly was overdue or not completed, this was listed on the submitted information.	

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Month	Number of Individuals for Which Quarterly Medical Reviews Were Due	Number of Quarterly Medical Reviews Completed on Time	Percentage of Quarterly Medical Reviews Completed on Time
December 2013	45	44	98%
January 2014	41	41	100%
February 2014	115	112	97%
March 2014	48	32	67%
April 2014	41	41	100%
May 2014	117	98	84%
Total timely reviews	407	368	90%

Contents of 38 quarterly medical reviews (i.e., two most recently completed) from 19 individuals' records were reviewed for completeness. Using a cut-off date of 5/31/14, for the most recent quarterly medical review submitted, 36 of 38 (95%) were completed timely. None were undated.

- A template format was used/completed in 38 of 38 quarterly medical reviews.
- Thirty-eight of 38 (100%) included the date of the quarterly review completion.
- Major diagnoses were listed in 37 of 38 (97%) medical quarterly reviews.
- The last three monthly weights or equivalent information were recorded in 33 of 37 (89%) medical quarterly reviews. One individual was newly admitted for one review and only had one weight available.
- There were brief comments/entries listing numbers of seizures per quarter (if applicable) in 22 of 38 medical quarterly reviews.
- There was documentation of changes in medication in 28 of 38 medical quarterly reviews.
- Important/abnormal labs and drug levels/radiographic test results were documented in 15 of 38 medical quarterly reviews. Sixteen of 38 had additional tests recorded.
- Five individuals had documentation of an ER visit.
    - Five of five included reasons for the ER visit.
- One had no information entered concerning whether an ER visit occurred.
- No individual had documentation of a hospitalization.
- One had no information entered concerning whether a hospitalization occurred.
- Thirty-one of 38 individuals had documentation of consultations completed, listing the specialty.
    - For two of 38, the dates of consultation occurred in a quarter prior to the quarterly medical review being completed. It is recommended that the current quarterly review focus on events and findings occurring in that quarter.

The Medical Department completed a monthly audit on the content of the quarterly medical reviews. Compliance ranged from zero to 100 percent per month for December 2013 through May 1014. At the 6/5/14 medical

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interdepartmental meeting, the minutes indicated that the medical quarterly audit for the prior three months averaged 36 to 40 percent compliance. A copy of the quarterly medical review template and examples were provided as instructions to the PCPs.

For the six medical records reviewed, the three most recent quarterly medical reviews were requested. Three of six (50%) medical records included three quarterly medical reviews that were completed timely without gaps between quarters. For one medical record, no quarterly medical review was submitted. For two of six, the most recent quarterly medical review that was submitted occurred in 2013.

Access to Specialists
The following chart indicates the off-site appointments scheduled, the off-site appointments completed, follow-up appointments scheduled, follow-up appointments completed, and pending appointments based on data the Facility submitted in a document entitled: "Information provided was for appointments from November 2013 through April 2014."

Specialty	Initial Appointment Scheduled	Initial Appointment Completed	Number of Appointments Rescheduled and Completed	Not Rescheduled with Valid Reason	Pending	Percent Completion or Valid Reason Not Completed*
Allergy	4	3	1	0	0	4 (100%)
Allergy and Asthma	9	7	2	0	0	9 (100%)
Dermatology	9	6	0	3	0	9 (100%)
Cardiology	35	26	8	0	1	34 (97%)
Nephrology	12	7	4	1	0	12 (100%)
Ear/Nose/Throat (ENT)	6	5	0	1	0	6 (100%)
ENT surgery	8	6	1	0	0	7 (88%)
Gastroenterology	105	71	22	9	2	102 (97%)
Gynecology	2	2	0	0	0	2 (100%)
Oncology	9	7	2	0	0	9 (100%)
Ophthalmology	28	20	2	5	0	27 (96%)
Internal Medicine	8	6	2	0	0	8 (100%)
Pulmonary	7	6	1	0	0	7 (100%)
Radiology	111	64	35	7	1	106 (95%)
Sleep	1	1	0	0	0	1 (100%)

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studies						
Surgery	21	16	3	2	0	21 (100%)
Orthopedic	17	14	3	0	0	17 (100%)
Urology	49	37	7	5	0	49 (100%)
Vascular	12	4	0	5	0	9 (75%)
Wound	14	13	1	0	0	14 (100%)
Hospital tests	32	22	6	1	2	29 (91%)
Hematology	17	13	3	1	0	17 (100%)
Neurology	17	15	2	0	0	17 (100%)
Rheumatology	1	1	0	0	0	1 (100%)
Total	534	372 (70%)	105 (20%)	40 (7%)	6	517 (97%)

*Due to transition to community, death, family refused to provide consent, or other reason determined by PCP or IDT.

On site, specialty clinics were held to meet the needs of the individuals from November 2013 through May 2014. The following chart provides details of these specialty clinics:

Specialty	Date of Clinic	Appointments Scheduled	Appointments Completed	Documentation that Appointment Rescheduled and Completed or No Longer Indicated
Endocrinology	11/7/13	26	20	1
Endocrinology	12/4/13	20	15	0
Endocrinology	2/26/14	28	27	1
Endocrinology	3/26/14	25	20	0
Endocrinology	4/30/14	22	18	0
Gynecology	12/4/13	8	8	0
Neurology	11/1/13	9	6	3
Neurology	1/17/14	9	9	0
Neurology	1/24/14	10	9	0
Neurology	2/21/14	12	10	1
Neurology	3/7/14	10	10	0
Neurology	4/25/14	11	10	0
Neurology	5/23/14	11	9	0
Neurology	11/20/14	16	13	2
Neurology	12/18/13	12	11	1
Neurology	1/8/14	12	11	1

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Neurology	1/22/14	12	9	3
Neurology	4/23/14	15	14	0
Neurology	5/7/14	12	11	1
Neurology	5/21/14	14	8	0
Vision	11/6/13	19	17	2
Vision	12/13/13	19	15	2
Vision	1/8/14	24	19	4
Vision	1/31/14	27	15	10
Vision	2/12/14	23	14	7
Vision	3/12/14	26	19	5
Vision	4/2/14	19	15	1
Vision	4/4/14	15	11	0
Vision	5/9/14	23	14	0
Podiatry	11/20/13	10	9	1
Podiatry	12/18/13	10	7	3
Podiatry	1/22/14	18	12	6
Podiatry	2/19/14	14	9	5
Podiatry	3/19/14	13	12	1
Podiatry	4/23/14	15	12	2
Podiatry	5/21/14	12	11	0
Total		581	459 (79%)	63 (11%)

The total for completed appointments (i.e., initial and first rescheduled appointment) was 522 of 581 (90%). This was not calculated to include those who missed serial appointments until completing a visit. Also note that for the most recent clinics, a missed appointment would have been rescheduled, but without opportunity for completion as the next clinic had not occurred.

The following lists the most common reasons for the off-site missed appointments:

Reason for Missed Appointment	Number of Missed Appointments
Specialist office canceled	39
Individual hospitalized	7
Individual Refused	21
PCP cancelled	24
State holiday	5
Guardian refusal	7
Administrative reasons - paperwork not prepared, consents not received/completed, conflict in schedule, computer problem, etc.	40
Not Nothing by Mouth (NPO)	6
Inadequate bowel preparation	7

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		From the reasons listed, there were several that were beyond the ability of the Medical Department to control. However, there were others that needed further systems improvements to reduce the missed appointment rate (i.e., State holiday, administrative reasons, not NPO, etc.). Requested were copies of ISPAs addressing missed appointments or refusals in the most recent three months concerning procedures and consultation appointments. Eight ISPAs were submitted involving seven individuals spanning the time period of 12/23/13 through 5/22/14. ▪ Eight of eight (100%) included discussion from several members of the IDT. ▪ Eight of eight (100%) documented decisions/next steps to be taken. o The number of decisions/recommendations varied from one to three per ISPA. The decisions appeared to be person-centered and required the input of those on the IDT with detailed knowledge of the individual's history, preferences, and strengths. The quality of the consultation referrals is reviewed as part of the peer review process. This is discussed in further detail with regard to Sections L.2 and L.3. In addition, the Monitoring Team's findings with regard to the follow–up on consultations are discussed with regard to Section G.2. <u>Preventive Care</u> ▪ Preventive care flow sheets were in place to facilitate tracking of standard testing and evaluations in six of six (100%) records reviewed. ▪ Preventive care flow sheets were up-to-date in five of six (83%) records reviewed. ▪ Current vision screening was documented within the prior 12 months in six of six (100%) records reviewed. ▪ Audiological screening documentation was submitted in zero of six (0%) records reviewed in the prior three years. ▪ The influenza vaccination had been given to six of six (100%) individuals in a timely manner during 2013. ▪ Whether the individual needed to receive varicella vaccine (i.e., depending on birth date, medical history, and immunity status), and whether it was given if indicated, was recorded in six of six (100%) active records reviewed. ▪ Whether the individual needed to receive a hepatitis B vaccine (i.e., depending on immunity status, carrier state, etc.) and whether the series was completed if indicated (or being tracked for completion), was recorded in six of six (100%) active records reviewed. ▪ The medical chart clearly indicated a Tdap had been given to four of six (67%) individuals. o For one individual, the Annual Medical Assessment indicated it had been given, but the Comprehensive Nursing Review indicated a Td had been given. o For one individual, there was a statement that it would be ordered, but it was either not ordered, ordered and the order not completed, or not otherwise documented in the submitted information. ▪ A pneumococcal vaccination had been given to six of six (100%) individuals. ▪ For individuals age 60 or over, a zoster vaccine had been given to two of two (100%) individuals. A list was submitted entitled: "Mammograms Women ages 40 -70 years old" identifying women residing at LBSSLC who	

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		were over the age of 40, along with the date of last mammogram, and the reason, if it was not done or outdated. The DADS SSLCs policy "Preventive Health Care Guidelines," dated 8/30/11 was to be followed. A total of 37 women were identified as being in the age range of 40 to 70. Of the 37 women between the ages of 40 and 70, 14 had reasons not to have a mammogram (i.e., guardian refusal, inability to physically provide proper positioning for the test, etc.). Of the remaining 23 women, 23 had mammograms within the prior year. This was a compliance rate of 100 percent. It was noted that an ultrasound was completed in the past year for five individuals that were unable to complete a mammogram. From the sample of six medical records reviews, there were two females between the ages of 40 and 70. Of these, two females were eligible for a yearly mammogram (i.e., no contraindication or reason for not completing a mammogram). Zero of two had completed a mammogram in the past year and one of two (50%) had completed a mammogram in the past two years. A list was submitted indicating women residing at LBSSLC who were between the ages of 21 and 65, in a document entitled "Pap smear tracking women age 21-65 years old." Forty-nine women were listed in this age group. Six of the 49 had hysterectomies and were not further reviewed. For 43 women eligible for pap smear screening, 40 were current with this preventive screening test for a compliance rate of 93 percent. Additionally, two had been offered repeatedly and/or attempts made repeatedly without success. It would be important to ensure the guardian/legal representative was aware of the repeated refusals and agreed with the decision to not pursue this test, or determine other options. There should be documentation to justify continued efforts to obtain a pap smear or justify alternative decisions agreed upon by the IDT and guardian/family, etc. There was one overdue pap smear. From the sample of six active records reviewed, there was one female between the ages of 21 and 65. Two women were over the age of 65. One of one (100%) female had documentation of cervical cancer screening within the prior three or five years. The Medical Department submitted a list of those individuals over the age of 50 with the date of the last colonoscopy, with the reason for the colonoscopy (i.e., screen or diagnostic testing for signs and symptoms). A total of 91 names were submitted. Of these, two were over the age of 75 and for none there was incomplete data or data entry irregularities. As it takes time to schedule appointments and procedures and have IDT to discuss procedures and potential complications of the prep involved, individuals at age 50 who had not completed a colonoscopy were removed from the list of those for whom a colonoscopy was expected. There were two individuals in this category. Additionally, 12 individuals had clinical contraindications or family/guardian refusals of consent. Of these 12, seven had guardian refusals and for five, it was determined the risk outweighed the benefit. Therefore, the eligible population was 75 individuals. Of these, 75 (100%) completed a colonoscopy within the prior 10 years, and/or had alternate testing and ongoing specialty consultation considered acceptable as clinical equivalents. Of the two individuals over age 75, one of two had completed an appropriate procedure within the prior 10 years. One had a contraindication (i.e., guardian refusal). Of the six active records reviewed, there were five 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. None were	

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		over the age of 75. For four individuals for which a colonoscopy would be expected in the prior 10 years, four of four (100%) were attempted and/or completed. Three of four were successful. One of four had repeated failed attempts and was to be rescheduled in one year. A list of individuals with a diagnosis of osteopenia or osteoporosis was submitted. Identification of the medications and dosages of the medications treating these diagnoses also was requested. Additionally, for all those over 50, a list of the last DEXA scan date and copies of the most recent DEXA scan report were requested. This information was requested, because for those with a diagnosis of osteopenia or osteoporosis, a T score usually would be an important aspect of the work-up provided through a DEXA scan. Additionally, based on the T score, treatment would be ordered to optimally treat the individual. Follow-up DEXAs to determine T scores are indicated at intervals (i.e., every two to three years) to determine effectiveness of treatment. A total of 66 individuals with osteoporosis and 52 individuals with a diagnosis of osteopenia were reviewed. ▪ For those with osteoporosis, 59 had a T score from a DEXA scan submitted. o Seven had reasons not to complete a DEXA scan (i.e., risk outweighed benefits, guardian refusal, etc.). ▪ Fifty-seven of the 59 DEXA scans (97%) were considered current (i.e., completed within the prior three years). ▪ Forty-four of 66 were treated with a bisphosphonate. ▪ Thirteen of 66 were prescribed Prolia. ▪ Thirteen of 66 were prescribed Miacalcin. ▪ The submitted information indicated several individuals were prescribed more than one of these medications. ▪ One of 66 was not treated with additional osteoporosis medication. ▪ Fifty of 66 were treated with calcium supplementation other than a multivitamin. ▪ Sixty-two of 66 were treated with Vitamin D supplementation other than a multivitamin. ▪ For those with osteopenia, 52 of 52 had a T score from a DEXA scan submitted. ▪ Fifty-two of 52 (100%) were considered current (completed within the prior three years). ▪ Forty-six of 52 were treated with a bisphosphonate. o Thirty of 46 with osteopenia were prescribed preventive dosages for osteoporosis. o Sixteen of 46 on bisphosphonate were prescribed treatment dosages for osteoporosis. ▪ One of 52 was treated with Prolia. ▪ Two of 52 were treated with Miacalcin. ▪ Thirty of 52 were prescribed calcium supplementation other than a multivitamin. ▪ Forty-four of 52 were prescribed Vitamin D supplementation other than a multivitamin. For men with a diagnosis of osteoporosis/osteopenia, the Medical Department submitted laboratory results from the current active record as part of the evaluation for secondary causes of osteoporosis. Information was submitted concerning laboratory testing for 10 men with osteoporosis or osteopenia. The following lists the compliance with several recommended tests, based on submitted information: ▪ Two of 10 had a testosterone level recorded. ▪ Three of 10 had renal function recorded. ▪ Two of 10 had liver function recorded. ▪ Seven of 10 had thyroid function recorded,	

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		▪ Four of 10 had a CBC recorded. ▪ Two of 10 had a calcium level recorded. ▪ Eight of 10 had a Vitamin D level recorded. A document listing all individuals with osteoporosis and osteopenia named 81 males with these diagnoses. The above list of lab testing was too incomplete to provide a determination of adequacy of the identification of secondary causes of osteoporosis. The list of all individuals with these diagnoses did list additional contributing secondary causes such as antiepileptic medication, non-ambulatory status, hypogonadal state, psychotropic medication use, etc. However, no information was submitted that all men with a diagnosis of osteoporosis or osteopenia completed the above tests to rule out additional causes. It is likely many of these tests had been completed as part of routine testing, but information was not submitted as requested. For women with a diagnosis of osteoporosis/osteopenia, the Medical Department submitted laboratory results from the current active record as part of the evaluation for secondary causes of osteoporosis. Information was submitted concerning laboratory testing for two women with a diagnosis of osteoporosis or osteopenia. The following lists the compliance with several recommended tests, based on submitted information: ▪ Two of two had renal function recorded. ▪ Two of two had liver function recorded. ▪ Two of two had thyroid function recorded. ▪ One of two had a CBC recorded. ▪ Two of two had a calcium level recorded. ▪ Two of two had a Vitamin D level recorded. A document listing all individuals with osteoporosis and osteopenia named 37 women with these diagnoses. The above list of lab testing was too incomplete to provide a determination of adequacy of the identification of secondary causes of osteoporosis. The list of all individuals with these diagnoses did list additional contributing secondary causes. However, no information was submitted that all women with a diagnosis of osteoporosis or osteopenia completed the above tests to rule out additional causes. It is likely many of these tests had been completed as part of routine testing, but information was not submitted as requested. Twenty Nutrition Service Annual Assessments were reviewed for content concerning calculation of daily calcium and Vitamin D in the diet and supplements. ▪ Nineteen of 20 included the daily amount of calcium available in the offered diet. ▪ Nineteen of 19 included the amount of calcium in the daily multivitamin/mineral supplement, when prescribed. ▪ Nineteen of 19 included the amount of Vitamin D in the daily multivitamin/mineral supplement, when prescribed. ▪ Fourteen of 14 included the total daily supplementation of calcium other than in a multivitamin/mineral supplement. o Six were not prescribed calcium supplementation. ▪ Nineteen of 19 included the total daily supplementation of Vitamin D other than in a multivitamin/mineral	

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supplement.
- Nineteen of 20 calculated the total daily intake of calcium in the diet and supplements as applicable
- Seventeen of 19 calculated the total daily intake of Vitamin D in the diet and supplements as applicable.

From the sample of six medical records reviewed, six had a diagnosis of osteopenia or osteoporosis.
- Six of six (100%) had completed a DEXA scan.
- Six of six (100%) of these DEXA scans were completed in the prior three years.
- Of these, six of six (100%) had a DEXA scan/T score recorded.
- Of these, six of six (100%) had a T score consistent with the diagnosis of osteoporosis or osteopenia.
- Of these, three of six had been prescribed supplemental calcium.
- Of these, five of six had been prescribed supplemental vitamin D.
- Of these, two of six had a bisphosphonate ordered.
- Of these, zero of six were currently prescribed Miacalcin.
- Of these, two of six were prescribed Prolia.

Down Syndrome and Hypothyroidism
Four individuals were identified with a diagnosis of Down syndrome. As of 6/2/14, four of four (100%) had a thyroid test completed within the prior 12 months.

Acute and Emergency Care
Documentation was provided for Emergency Room visits from December 2013 through May 2014. The following table lists the analysis of 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	Number of ER Visits	GI	Musculo-skeletal	Neuro-logical	Respira-tory	GU	Dehydra-tion	Lacera-tions	Infec-tion	ENT	Car-diac	Other
December 2013	5	1	1	1	0	0	0	2	0	0	0	0
January 2014	9	5	1	0	0	2	0	0	0	0	0	1
February 2014	3	2	0	1	0	0	0	0	0	0	0	0
March 2014	16	7	2	2	0	1	0	1	0	0	0	3
April	8	1	1	0	1	1	0	2	0	0	1	1

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2014													
May 2014	14	8	0	0	1	1	0	4	0	0	0	0
June 2014	8	2	2	1	1	0	0	1	0	0	1	0

The Medical Department routinely tracked reasons for ER visits.

The active record was reviewed for 10 Emergency Room visits for individuals that returned to LBSSLC. One individual went to the ER twice, seven days apart. The individuals are listed in the documents reviewed section. The following summarizes the results of this review for these 10 ER visits by nine individuals:

- For two of 10 ER visits, the individual arrived from a community setting and not from LBSSLC directly. These two were removed, as a transfer note from LBSSLC to the ER was not applicable. For one of these transfers, the PCP wrote an IPN. For the other, no IPN was submitted.
- Information was submitted indicating that the ER was notified prior to the arrival of the individual from LBSSLC with appropriate medical background information provided for two of eight (25%) records.
- For zero of eight transfers from LBSSLC to the ER, there was a PCP pre-transfer IPN. It appeared that for three of the 10 ER visits, the transfer occurred during regular business hours, but no information was submitted. The ER visit occurred after hours in five ER transfers. The PCP might not have been involved in the direct communication with the ER for two visits transferred from a community setting until after the transfer
- Reason for the transfer was documented in the record as: gastrointestinal concern (five), genito-urinary concern (one), neurological condition (one), trauma (two), and circulatory system concern (one).
- A copy of the ER report was available in 10 of 10 (100%).
- When the individual returned to the Facility after evaluation at the ER, seven of the 10 (70%) active records had a PCP IPN.
    - One of seven had an incomplete copy of the IPN.
    - For three of 10 records, this requested information was not submitted.
    - Seven of seven (100%) post-ER visit PCP IPN included date and time.
    - Five of seven (71%) post-ER visit PCP IPN included recording of vital signs or referenced vital signs.
    - Seven of seven (100%) post-ER visit PCP IPN utilized a SOAP format.
    - A summary of ER information and findings was included in seven of seven (100%) PCP IPNs.

Documentation was provided for hospital admissions from Dec 2013 through May 2014. The following table lists information the Medical Department provided and includes the analysis of this raw data by month, the number of hospitalizations for the month, and the most frequent/common categories of diagnosis for the admissions:

Month	Number of Admissions	GI	Musculo-skeletal	Neuro-logical	Resp-iratory	GU	Dehydra-tion	Lacera-tion	Infec-tion	ENT	Card-iac	Oth-er

#	Provision	Assessment of Status	Compliance

December 2013	9	0	0	0	4	0	0	0	2	0	1	1
January 2014	7	2	0	0	1	0	2	0	1	0	0	1
February 2014	5	2	0	0	1	0	1	0	1	0	0	0
March 2014	5	1	1	0	1	2	0	0	0	0	0	0
April 2014	4	1	0	0	1	2	0	0	0	0	0	0
May 2014	7	1	0	2	1	2	0	0	1	0	0	0
June 2014	10	6	0	1	2	0	1	0	0	0	0	0
Total	**47**	**13**	**0**	**3**	**11**	**6**	**4**	**0**	**5**	**0**	**1**	**2**

Additionally, 10 active records were reviewed for those individuals admitted to the hospital. The following provide the results of this review:

- Ten individuals returned to the Facility and zero of 10 individuals died while in the hospital.
- Seven of 10 (70%) had PCP IPNs post-hospitalization. For three, no information was submitted post-hospitalization and this information could not be determined.
- Of the seven post-hospital PCP IPNs submitted, seven (100%) included vital signs.
- Seven of seven (100%) post-hospital PCP IPNs included date and time.
- Seven of seven (100%) post-hospital PCP IPNs had an adequate summary of hospital events and findings.
- Seven of seven (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.
- Seven of 10 (70%) active records included a copy of the hospital discharge summary. There was one short stay hospital admission, which might not have generated a formal discharge summary, but no further information was available.
- Ten of 10 (100%) included Hospital Liaison Nurse notes for the individuals. A separate request included Hospital Liaison Nurse notes for 10 of 10 (100%) hospital admissions. When reviewing the weekdays, which would have generated a Hospital Liaison Nurse note, there were one or more days for which notes were not submitted for four of 10 admissions.
- For the 10 hospitalizations, major organ system categories included the following: Respiratory (four), gastrointestinal system (three), orthopedics (one), infection of skin (one), and sepsis with change in mental status (one).

#	Provision	Assessment of Status	Compliance
		LBSSLC did not have an Infirmary. An area of concern in reviewing the submitted documents for the ER visits and hospitalizations was legibility of physician orders as well as IPNs. Although IPNs are dictated, these dictated notes are not immediately available in the record. A covering PCP, or other Facility staff would have difficulty understanding the content of the hand written IPNs. There was also considerable risk of misinterpretation of orders due to the illegibility. The Medical Department should identify potential causes of this issue and determine ways to improve this challenging concern. *Pneumonia* Data was submitted for documented cases of pneumonia from December 2013 to June 2014. The Facility did not use the Avatar pneumonia-tracking database. According to a Facility database, there were 14 pneumonias during this time period. ▪ Of these 14, seven were categorized as aspiration pneumonia. Five of the seven occurred while hospitalized as complications of the hospitalization. ▪ Information concerning where the pneumonia was diagnosed (i.e., hospital, LBSSLC, etc.) was not consistently provided. It was noted that six diagnoses occurred while hospitalized, and one was diagnosed at LBSSLC. No information was provided for seven of 14 cases of pneumonia. ▪ Whether a chest x-ray confirmed the diagnosis was submitted for four of the 14. For one of 14, no chest x-ray was done. No information was submitted for nine of 14 regarding whether a chest x-ray was completed or the results of the reading. ▪ Nine of 14 individuals had long-term feeding tubes. One individual had a feeding tube temporarily, but later was demonstrated to be safe in taking a diet of therapeutic texture and thickening of fluids. Two of 14 had a diet with modified texture and/or thickened fluids. No information was submitted for two of 14 concerning route of nutrition. o For those with feeding tubes, whether the formula was ordered by bolus, intermittent, or continuous feedings was not submitted. ▪ Information was not submitted whether blood cultures were done or if completed, the results of the blood cultures. The incidence per month from the Facility database was as follows:	

Month	Number of Pneumonia Cases	Number of Aspiration Pneumonias	Number of Bacterial Pneumonias	Other Pneumonia
December 2013	4	0	3	1*
January 2014	1	1***	0	0
February 2014	2	0	2	0
March 2014	3	2***	1	0
April 2014	1	0	0	1 (mixed)**
May 2014	1	1	0	0
June 2014	2	1	0	1 (mixed)**
Total	14	5	6	3

#	Provision	Assessment of Status	Compliance
		*Bronchopneumonia **Both bacterial pneumonia and aspiration pneumonia occurring while hospitalized ***Occurred while hospitalized It was noted that the data submitted by the Infection Control Nurse was consistent with the data submitted by the Medical Department. Four individuals had tracheostomies. The Facility submitted evaluations for dysphagia and GERD for five individuals that had acute respiratory distress requiring an ER visit or hospitalization. For a dysphagia evaluation, four had a bedside swallow and/or a Modified Barium Swallow Study (MBSS) on the record. For one with long-term enteral nutrition, this was not applicable. For a GERD work-up as a potential cause or contributing comorbid condition, four of five had an esophagoduodenoscopy, two of five had a gastric emptying study, and zero of five had evaluation with a pH probe in the esophagus. For treatment, zero of five had a fundoplication, zero of five had a jejunostomy tube (J-tube), and zero of five had a gastrostomy tube (G-tube) for stomach drainage, for feeding, or had a gastrostomy tube in the past that was replaced with a jejunostomy tube. Two of five had G-tubes. Five of five were prescribed medication for GERD/gastritis. Five of five had consultation (i.e., gastroenterology, pulmonary). Three of five were complicated by family/guardians not allowing G-tube placement when severe dysphagia was proven. Based on submitted information, there appeared to be no system to ensure complete evaluation of acute respiratory distress in ruling out severe GERD with potential acute aspiration of gastric contents, with optimal treatment based on findings. Evaluation and treatment of dysphagia appeared to be standardized, complete, and effective within limitations of consent by family/guardian. Although it was positive that dysphagia was being assessed and treated, GERD also has significant implications for individuals at risk for respiratory issues, including life threatening aspiration pneumonia. The risk/benefit of additional evaluation and therapeutic options (frequent monitoring of positioning, additional medical options, surgical options, etc.) needed to be reviewed, offered in a timely manner, when appropriate, and documented, to ensure for each individual that all appropriate options were considered in order to limit severe respiratory distress caused in part or entirely by GERD. *Sepsis* From data submitted by Infection Control, three individuals were diagnosed with sepsis in the time period from October 2013 through April 2014. The following table provides the breakdown per month: Separately, the Medical Department submitted a document entitled "Individuals' Names, dates of diagnosis, specific	

Month	Number of Sepsis Cases	Month	Number of Sepsis Cases
October 2013	0	February 2014	1
November 2013	0	March 2014	0
December 2013	0	April 2014	1
January 2014	1		
Total all months = 3			

#	Provision	Assessment of Status	Compliance

diagnoses for past year for individuals who have been newly diagnosed with sepsis." The following information reflects the contents of this document:

Month	Number of Sepsis Cases	Month	Number of Sepsis Cases
October 2013	1	February 2014	1
November 2013	1	March 2014	0
December 2013	3	April 2014	1
January 2014	1	May 2014	1
Total all months = 8 for October 2013 through April 2014			

The reason for the discrepancy in data was not determined.

Trauma

Month	Number of Injuries Requiring ER Visit or Hospitalization	Month	Number of Injuries Requiring ER Visit or Hospitalization
November 2013	4	March 2014	6
December 2013	4	April 2014	2
January 2014	2	May 2014	0
February 2014	0	June 2014	1

Month	Number of Injuries	Laceration	Fracture
November 2013	4	Not submitted	2
December 2013	4	2	2
January 2014	1	0	1
February 2014	0	0	0
March 2014	6	2	2
April 2014	2	0	0
May 2014	0	0	1
June 2014	1	0	1

During the time period from November 2013 through 6/5/14, there were nine fractures. Six involved the hand or fingers/toes. Two involved the femur and one involved a nasal fracture.

Chronic Conditions and Specific Diagnostic Categories

GERD

#	Provision	Assessment of Status	Compliance
		As part of the review of six records, GERD was reviewed. Of the six, two were diagnosed with GERD. Additionally, two others had GERD listed in documents other than the annual medical assessment, but not in the annual medical assessment. For the following, not each case would have had the listed test or procedure, but provides evidence of the spectrum of treatment at the Facility: ▪ Of these six, six results of an Esophagogastroduodenoscopy (EGD) or Upper Gastrointestinal (UGI) report were available or discussed in the IPN/ISP. ▪ Of these six, zero had a fundoplication. ▪ Of these six, six had a feeding tube. ▪ Of these six, six had medication indicated for GERD. ▪ Of these six, five had a history of gastroparesis or gastric emptying study completed. ▪ Of these six, it was noted that zero of six had a history of surgical procedures to assist in treatment of severe GERD. For one of six, there was documentation of discussion concerning surgical treatment to reduce GERD. *Newly Diagnosed Chronic Conditions* Information was submitted concerning new diagnoses of chronic conditions that occurred over the past year. One individual was newly diagnosed with diabetes mellitus type II. No individuals were newly diagnosed with cardiovascular disease. One case of a newly diagnosed cancer was reported in the past year. *Pica* The Facility submitted a document entitled: "Individuals that ingest inedible items," which included all incidents of pica on campus from 2000 (or earlier) to 2014. Three pica incidents were recorded from November 2013 through May 2014 (scan date 6/2/14). The most recent pica event was recorded and did not indicate prior pica events for the individual. Documentation was submitted from an additional source through the Medical Department. This second set of data had discrepancies with the data from the first document reviewed. When there was a difference in information, the second data set is represented by parentheses.	

Month	Number of Individuals	Number of Pica Events	ER Visit	Hospitalization	Procedure/Surgery
November 2013	1 (2)	1 (2)	0 (1)	0	0
December 2013	0 (1)	0 (1)	0	0	0
January 2014	1 (2)	1 (2)	0 (1)	0	0
February 2014	0 (1)	0 (1)	0	0	0
March 2014	1	1	0	0	0
April 2014	0 (1)	0 (1)	0	0	0
May 2014	0 (2)	0 (2)	0	0	0
Total	3 (10)	3 (10)	0 (2)	0	0

The two databases did not record similar information. This caused the discrepancy in submitted numbers. The second

#	Provision	Assessment of Status	Compliance
		set of data reflected the number of events that occurred at LBSSLC. *Chronic Constipation* Seventy-seven individuals had a diagnosis of constipation or received treatment for constipation at least weekly. A document entitled: "Individuals' Names, dates of diagnosis, specific diagnoses for past year for individuals who have been newly diagnosed with bowel obstruction," with scan date 6/2/14, listed the number of bowel obstructions per month:	

Month	Number of Bowel Obstructions	Month	Number of Bowel Obstructions
June 2013	1	December 2013	0
July 2013	1	January 2014	0
August 2013	0	February 2014	1
September 2013	3	March 2014	0
October 2013	1	April 2014	0
November 2013	0	May 2014	1
Total	6		2

It is noted that the most recent six months had a reduction in the number of small bowel obstructions/ileus/ constipation/ impaction. From a separate submitted document entitled: "Absolute number of new cases for the following: bowel obstruction," there was agreement in data for the above months except the month of September. This separate document listed two cases of bowel obstruction (the above table listed three cases).

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 or used with caution through these specific tubes were ordered through these enteral tubes (i.e., Quinolones, Sucralfate, Anatacids, Bismuth, Beta blockers, Nitrates, Opioids, and Tricyclic anti-depressants). The review indicated that for two of five individuals with gastro-jejunostomy tubes or jejunostomy tubes, these medications were not prescribed. There were two individuals prescribed one or more of these medications, but the route of administration was through a G-tube (two individuals had both G-tubes and J-tubes). For one individual with a J-tube, one of these medications was prescribed long term. Further information was not submitted, but there were a number of monitoring processes in place for this medication, which was a psychotropic medication.

Skin Integrity
On 1/24/14, the Nursing Department completed training regarding decubitus care. Seventeen nurses completed the training. On 5/28/14, there was a Skin Integrity Committee meeting, which was an educational meeting with the topic "Nutrition: Critical Component of Wound Management." Twelve nursing and dietary staff attended this training.

The Skin Integrity Committee did not have minutes indicating committee review of data tracking for decubiti,

#	Provision	Assessment of Status	Compliance

determining whether they originated in the hospital, at LBSSLC or elsewhere, the body location, the staging, and progress toward healing. Data was provided to the Monitoring Team (which follows), but there was no information indicating whether there was any analysis of the information by the committee and implementation of corrective actions based on findings of the committee.

A chart was submitted entitled: "Persons experiencing pressure ulcers from December 2013 – June 2014." This listed two decubiti in December 2013, one in January 2014, and one in April 2014. All were resolved. One was hospital acquired. All were considered stage two and all were located in the coccyx, back, or spine area.

Separately, from a submitted document entitled: "Absolute number of new cases for the following: decubitus ulcers" the following new cases of decubitus ulcers occurred per month:

Month	Number of New Decubiti	Month	Number of New Decubiti
July 2013	2	January 2014	2
August 2013	1	February 2014	0
September 2013	2	March 2014	0
October 2013	3	April 2014	1
November 2013	2	May 2014	0
December 2013	1	June 2014	2
Total for six months	**11**	**Total for six months**	**5**

The six-month time intervals indicated a downward trend in the incidence of decubitus ulcers. The two sources of decubitus ulcer information indicated similar information for April 2014, but not for December 2013 and January 2014.

Seizure Management
A list was submitted indicating that 120 individuals had a diagnosis of a seizure disorder as of 6/2/14.

The Facility submitted information concerning antiepileptic medication usage. As of 5/13/14, 93 individuals were prescribed antiepileptic medication.

- Of these, 33 of 93 (35%) were prescribed one antiepileptic medication, 28 of 93 (30%) were prescribed two antiepileptic medications, 23 of 93 (25%) were prescribed three antiepileptic medications, five of 93 (5%) were prescribed four antiepileptic medications, and four of 93 (4%) were prescribed five antiepileptic medications.
- Additionally, 27 individuals with a diagnosis of seizures were on no antiepileptic medications.
- Seven individuals were considered to have a refractory seizure disorder. Five of these seven had a VNS implant. There were no individuals with a refractory seizure disorder who were currently being evaluated for a VNS.
- In the prior six months, four individuals were sent to the ER for an uncontrolled/prolonged/new onset seizure. One individual was hospitalized three times for uncontrolled/prolonged seizures.
- One individual was diagnosed with status epilepticus. One additional individual had an EEG that indicated "no

#	Provision	Assessment of Status	Compliance
		clear evidence of status epilepticus," but the conclusion was "uncertain at this time if these findings are due to …status epilepticus." A list was submitted indicating the percentage of individuals that were prescribed older antiepileptic medications. A total of 39 (42%) of individuals with seizures on anti-epileptic medications were prescribed Dilantin, four (4%) were prescribed Primidone, 10 (11%) were prescribed Phenobarbital, and none (0%) was prescribed Felbamate. Additionally, eight individuals had a VNS implant. For two of these eight individuals, the VNS was not currently activated. <u>Do Not Resuscitate Orders</u> A document was submitted entitled: "Do Not Resuscitate List," last updated 10/18/12, which listed 12 individuals, but did not appear to be up-to-date. Of these, four had died since the last update. It was determined from Ethics Committee meetings that two additional individuals were added to the DNR list, indicating the list was not kept current. For the remaining eight individuals, the following information was submitted: ▪ A DNR order was initiated for one individual in 2012, for one individual in 2011, for no individuals in 2010, for three individuals in 2009, and three individuals in years prior to 2009. ▪ For eight of eight (100%), adequate clinical justification was provided for the DNR. o Clinical justification included the following: three individuals had dementia, three had compromised respiratory function, one had cancer, and one had end stage renal disease. ▪ As the document was outdated, there was no information from this document whether a DNR had been ordered for an individual after 10/18/12. The Facility Ethics Committee met on the following dates to discuss specific individuals to review DNR status: 12/6/13 and 1/24/14. Minutes of the Facility Ethics Committee included the following components: ▪ Two of two (100%) meeting minutes documented date and time. (For one, the time was listed on the participant roster rather than the narrative section of the minutes). ▪ Two of two (100%) meeting minutes included the name(s) of individuals for discussion of DNR. ▪ Two of two (100%) meeting minutes listed names of attendees. ▪ Two of two (100%) meeting minutes included a signature sheet. ▪ Two of two (100%) meeting minutes included a synopsis of the proceedings and critical review of information. ▪ Two of two (100%) meeting minutes included a summary of critical discussion with family/guardian. ▪ One of two (50%) meeting minutes included discussion by the PCP. ▪ Two of two (100%) meeting minutes included a recap with recommended action steps outlined. ▪ One of two (50%) meeting minutes included documentation of any DNR documents signed based on the decision of the ethics committee. ▪ Meeting minutes indicated the need for follow-up in zero of two meetings. A document was subsequently submitted at the time of the Monitoring Team visit entitled: "Notes and orders for any DNRs and rescinding of DNRs." This listed nine individuals with current DNR orders. There had been no DNR orders	

#	Provision	Assessment of Status	Compliance
		rescinded. Nine of nine were Resuscitative Status 2. This form was to be reviewed by the team yearly and signed by the PCP and other IDT members. Eight of nine had a current signed document. For nine of nine, an ISPA was submitted indicating discussion and approval of the continued DNR status. For five of nine, the discussion documented the qualifying condition for the DNR. It is recommended that ISPAs that discuss DNR status, and require a decision of initial or ongoing DNR status include the qualifying condition to ensure IDT members are aware of this information prior to the decision-making process. The four qualifying conditions included the following: cancer (two) and restrictive lung disease (two). <u>Medical Chemical Restraints</u> Information was submitted concerning chemical restraint use (i.e., pre-treatment sedation) for three individuals undergoing tests/procedures/appointments. These included a CT scan, mammogram, DEXA (three attempts), and an appointment with a specialist. The following was noted from this information: ▪ Three individuals underwent six chemical restraints for pre-treatment sedation. Of the six chemical restraints for medical procedures, the Monitoring Team reviewed five. One individual underwent three of the five. These three were for the same procedure during this time period and was successful at the third attempt. ▪ Date range of chemical restraint use was 2/26/14 to 4/2/14. Medication used for these chemical restraints included: Zyprexa, Ativan [By mouth (PO) and Intramuscular (IM)]. ▪ Five of five (100%) had a completed restraint checklist. ▪ Four of five (80%) included recording of vital signs prior to the medication administration. ▪ Five of five (100%) included recording of vital signs during post-sedation monitoring. ▪ Five of five (100%) had current consent. ▪ Five of five (100%) had HRC approval. <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-	<u>Non-facility Physician Case Reviews</u> During the prior six months, the Facility completed one non-facility physician audit review (Round #8). The following represents a synopsis of the information: ▪ For this one external peer review dated February 27 to 28, 2014, PCP compliance in essential areas ranged from 86 to 100 percent. Two of four PCPs (50%) attained 100 percent compliance ▪ For areas considered non-essential, compliance ranged from 92 to 100 percent. Four of four (100%) attained compliance of 90 percent or greater. ▪ The external audit review process information did indicate the number of records chosen for review. A total of 20 charts were evaluated. Eleven charts were reviewed using the General Medical Audit. Nine charts were reviewed using the Medical Management Audit addressing the following clinical topics: aspiration pneumonia, osteoporosis, and diabetes mellitus. ▪ The external audit review process information did indicate how the sample was obtained. ▪ Areas that appeared to need improvement from the external peer review included answers to the following audit probe questions:	Noncompliance

#	Provision	Assessment of Status	Compliance
	Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	

Clinical Indicator Number in General Medical Audit Tool	Description of Clinical Indicator	Number of Records Noncompliant with Clinical Indicator	% Compliance with Clinical Indicator
#37	Is the provider's documentation legible?	5 (3)	55% (73%)
#4	Is the Annual Physical Exam complete, including past medical history, family history, and a plan of care?	2 (1)	82% (91%)
#9	Has the MMR been given?	2 (1)	82% (91%)
#26	Was the preventive care flow sheet updated at the time of the last annual assessment?	2 (2)	82%
#30	Do the Medication Orders for acute conditions include indication and duration for all the medications prescribed?	2 (1)	82% (91%)
#31	Do the Medication Orders for chronic conditions include indication and duration for all the medication prescribed?	2 (1)	82% (91%)

The data above was provided by the Medical Department. However, it was noted that there were only nine corrective action plans. The Monitoring Team member reviewed the raw data to determine accuracy, and this information is noted in parentheses.

- From the external peer General Medical Audit, there were nine corrective action plans generated.
- At 30 days following the general medical audit, there were two corrective action plans outstanding.
- At 60 days following the general medical audit, there were zero corrective action plans outstanding.

- An external medical management audit for Round # (labeled as # 8 or #9 on different documents) was also completed on February 27 to 28, 2014. The three areas of clinical focus were: diabetes mellitus, osteoporosis, and aspiration pneumonia.
    - Compliance per PCP for diabetes mellitus was 100 percent for three of three PCPs. Compliance for osteoporosis was 78 percent for one of one PCP. Compliance for aspiration pneumonia was 61 to 78

percent for two PCPs.

- Areas that appeared to need improvement (repeated noncompliance responses) from the external medical management peer review audit included answers to the following audit probe questions:

Diagnostic Category	Clinical Indicator Number for the Diagnosis	Description of Clinical Indicator on Monitoring Tool	Number of Records with Noncompliance in This Area	Percent Records with Compliance in This Area
Osteoporosis	#3	Is there a diagnosis of a pathological fracture?	2 (2)	33%
Osteoporosis	#4	Did the provider order or document findings of a Dental exam before initiating a bisphosphonate?	2 (2)	33%
Aspiration pneumonia	#11	Did the provider review the medications to see if any changes or addition was needed to reduce the risk of aspiration pneumonia?	3 (3)	0%
Aspiration pneumonia	#10	Did the provider review the risks and interventions for the individual for aspiration pneumonia and recommendations made?	2 (2)	33%
Diabetes mellitus	No noncompliant areas	Not applicable	0	100%

The Monitoring Team member checked the data and the findings are in parentheses. This data agreed with the Monitoring Team members review.

- From the external medical management audit for Round (labeled as # 8 or #9 on different documents), there were 13 corrective action plans generated.

#	Provision	Assessment of Status	Compliance
		▪ At 30 days following the external medical management audit, there were eight corrective action plans outstanding. ▪ At 60 days following the external medical management audit, there were zero corrective action plans outstanding. ▪ The external reviewer had provided the Facility with a summary of the review, including aggregate data representing their findings. ▪ A Medical Provider Exit Interview was conducted on 2/28/14. o Areas needing improvement were listed/identified as: ▪ There was need for improved documentation of risk factors, precipitating factors, preventive steps, and medication review for those admitted to the ER/hospital with the diagnosis of aspiration. ▪ There was a recommendation for aggressive work-ups and treatments for those with GERD and frequent respiratory concerns. ▪ There was no system for dental evaluation prior to initiating bisphosphonate therapy. o Areas considered strengths were listed/identified as: ▪ Annual medical assessments were current and informative. ▪ The 90-day medication orders included dosage, frequency, route, duration, and diagnosis for prescribing the medication. ▪ Preventive care and immunizations were current. ▪ The QDRRs were reviewed and signed in a timely manner (it was not clear whether this was a reference to the PCPs, psychiatrists, or both). ▪ Preventive Care Flow Sheets were completed and signed. ▪ Consultation referrals were signed, dated, and clearly noted PCP agreement or disagreement with the consultant recommendations. ▪ Compliance rates were calculated per PCP for the general medical audit and the medical management audit. ▪ The above external audit review process for Round #8 reviewed 20 records, which was 10 percent (20 of 204) of the records at the Facility. Since 1/1/14, this was a total of 10 percent, with a goal of 20 percent compliance annually. ▪ A follow-up system was implemented to ensure compliance/completion of corrective action plans for each PCP's area(s) of noncompliance with the general medical audit and medical management audit. ▪ The QA Nurse/QI Department did compile compliance data with corrective action plans. These indicated: o The QA Department tracked corrective action plan resolution every 30 days until resolution. o During this 90-day time period, the QA Department determined that four of four (100%) providers corrected all deficiencies. o The Medical Department staff meeting minutes documented a discussion of the results of the external peer review results. The Medical and QA Departments met on 3/26/14, 4/30/14, and 5/5/14 to discuss the deficiencies noted in the external and internal medical peer review audits, as well as progress in completing the corrective action plans. There were additional medical staff meetings to discuss audit results on 5/9/14.	

#	Provision	Assessment of Status	Compliance
		Mortality Reviews At the time of the review, the Facility had no outstanding clinical death reviews for deaths that occurred more than 30 days from the Monitoring Team's visit. Since the Monitoring Team's last review of mortality reviews, three deaths had occurred for which the Facility had conducted mortality reviews. ▪ The average age was 62. ▪ One individual was over the age of 65. Two were under the age of 65. ▪ One individual was a female. Two were males. ▪ The cause of death was respiratory failure due to septic shock, sepsis due to colitis, and complications of end stage renal failure. ▪ An autopsy was performed in one of three. ▪ The death certificate was received in three of three. ▪ DNR status was not ordered while residing at LBSSLC, but ordered during the final hospitalization for two of three. One had a DNR status at LBSSLC. ▪ Three of three individuals died in a hospital setting. ▪ Two of three individuals had a G-tube. ▪ There was documentation indicating the individual was aggressively treated or aggressively treated until a decision of DNR was made or care was considered futile in three of three individuals. ▪ Zero of three individuals were enrolled in hospice. ▪ Zero of three individuals were considered ambulatory (either independently or with assistance). ▪ One of three individuals was prescribed routine oxygen administration. Since the Monitoring Team's last visit, three clinical death review investigations and three administrative death reviews were completed. Clinical death review recommendations and nursing QI death review recommendations were discussed at the administrative death reviews. The administrative death reviews recorded the final list of recommendations for the death review process of the individual. For the three administrative death reviews, there were a total of 33 recommendations. ▪ Thirty-two of 33 had responses, but the information did not address the recommendation in several cases. For one, a meeting to respond to the recommendation was postponed, and no further follow-up was submitted to indicate it had occurred. ▪ Of these death reviews, 23 (70%) administrative death recommendations had evidence of closure/follow-up. ▪ Administrative death reviews included from 10 to 13 recommendations per review. ▪ Systemic issues related to potential improvements in medical care were zero of the 33 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in nursing care were 28 of the 33 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in pharmacy services were zero of the 33 recommendations from the administrative death reviews. ▪ Systemic issued related to potential improvements in dental services were zero of the 33 recommendations from the administrative death reviews.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>

Systemic issues related to potential improvements in habilitation therapies were zero of the 33 recommendations from the administrative death reviews.
Systemic issues related to potential improvements in residential services care were five of the 33 recommendations.
Systemic issues related to potential improvements in other departments (i.e., maintenance, housekeeping, furlough, etc.) were zero of the 33 recommendations from the administrative death reviews.

Increasing the breadth of the diagnoses assessed through the medical management audits is necessary to attempt to encompass the scope of medical services. It was learned that two topics had been chosen. It is recommended that these be diagnoses or clinical concerns common to the Intellectual/Developmental Disability (IDD) population at the SSLCs and that the clinical indicators be easily measured. In addition, with regard to mortality review recommendation, it is recommended that the Facility review submitted documentation to ensure it includes evidence for closure of the recommendation.
</td><td></td></tr>
<tr><td>L3</td><td>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</td><td>
<u>Medical Department Internal QA System</u>
Internal Medical Provider Quality Assurance Audit of February 18 to 21, 2014
The data from Round #9 of the internal medical peer review was provided. This peer review occurred from February 18 to 21, 2014. The audit questions were identical to those used in the external medical peer review audit. Compliance for PCPs in essential areas ranged from 95 to 100 percent. Three of four PCPs (75%) attained 100 percent compliance. Compliance for PCPs in non-essential areas ranged from 91 to 100 percent. One PCP attained 100 percent compliance. Four of four (100%) PCPs attained compliance with non-essential areas for this internal peer review audit. The QA Department had tracked action plans each month.

Areas that appeared to need improvement included answers to the following audit probe questions:
<table>
<tr><th>Clinical Indicator Number in General Medical Audit Tool</th><th>Description of Clinical Indicator</th><th>Number of Records Noncompliant with Clinical Indicator</th><th>Percent Compliance with Clinical Indicator</th></tr>
<tr><td>#2</td><td>Is there evidence that the Active Problem List was updated with each new problem?</td><td>2</td><td>82%</td></tr>
<tr><td>#3</td><td>Is there evidence that the Active Problem List was updated as problems were resolved?</td><td>2</td><td>82%</td></tr>
<tr><td>#9</td><td>Has the MMR immunization been given?</td><td>6</td><td>45%</td></tr>
<tr><td>#13</td><td>Has the PPD been given?</td><td>3</td><td>73%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>corrective action; and monitors to ensure that remedies are achieved.</td><td>
For the internal medical peer review audit, there were 16 corrective action plans identified. There was information submitted concerning tracking these corrective action plans to closure.

At 30 days following the internal general medical audit, 15 of 16 corrective action plans remained outstanding.
At 60 days following the internal general medical audit, zero corrective action plans remained outstanding.

An internal medical management audit was completed from February 18 to 21, 2014, utilizing the same audit questions from the external medical management peer review. Compliance among PCPs ranged from 93 to 100 percent. Areas that appeared to need improvement included answers to the following audit probe questions:
<table>
<tr><th>Diagnostic category</th><th>Clinical Indicator Number for the Diagnosis</th><th>Description of Clinical Indicator on Monitor Tool</th><th>Number of Records with Noncompliance in This Area</th><th>Percent Records with Compliance in This Area</th></tr>
<tr><td>Osteoporosis</td><td>#1</td><td>Is osteoporosis listed on the Active Problem List?</td><td>1</td><td>91%</td></tr>
<tr><td>Aspiration pneumonia</td><td>#5</td><td>Did the provider order a GI consult or a pulmonary consult if indicated?</td><td>1</td><td>91%</td></tr>
<tr><td>Diabetes mellitus</td><td>No non-compliant areas</td><td>NA</td><td>0</td><td>100%</td></tr>
</table>
For the internal medical management peer review audit, there were two corrective action plans identified.
At 30 days following the internal medical management audit, two of two corrective action plans remained outstanding.
At 60 days following the internal medical management audit, zero corrective action plans remained outstanding.
There was information submitted concerning tracking these corrective action plans to closure.

Inter-Rater Reliability
The QA Department provided inter-rater reliability information for the past six months. The QA representative tracked test scores of one external peer reviewer, one member of the QA Department and four PCPs. Results indicated the following:

Inter-rater reliability for the external/internal review ranged from 78 to 100 percent per PCP.
Inter-rater reliability for the February 2014 external/internal general audit was 77 percent.
Inter-rater reliability for the February 2014 external/internal medical management audit was 72 percent.
Actions taken to improve inter-rater reliability were not provided.

Internal Medical Provider Quality Assurance Audit of May 20 to 23, 2014
The data from Round #9 of the internal medical peer review was provided. The audit questions were identical to those used in the external and internal medical peer review audits of February 2014. Twelve records were reviewed and compliance for PCPs ranged from 87 to 96 percent. The QA Department tracked action plans each month and areas that
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance

appeared to need improvement included answers to the following audit probe questions:

Clinical Indicator Number in General Medical Audit Tool	Description of Clinical Indicator	Number of Records Noncompliant with Clinical Indicator	Percent Compliance with Clinical Indicator
#2	Is there evidence that the Active Problem List was updated with each new problem?	2	83%
#3	Is there evidence that the Active Problem List was updated as problems were resolved?	2	83%
#4	Is the annual physical exam complete, including past medical history, family history and a plan of care?	1	92%
#9	Has the MMR immunization been given?	3	75%
#10	Has the Tdap/TD immunization been given?	1	92%
#11	Has the influenza immunization been given?	1	92%
#12	Has the pneumovax been given?	2	83%
#13	Has the PPD been given?	1	92%
#15	Has the Zostavax (over 60) been given?	1	Denominator of sample size not determined
#17	Have the appropriate Preventive screenings for mammograms been provided?	1	Denominator of sample size not determined
#19	Have the appropriate preventive screenings for colonoscopies been provided?	2	Denominator of sample size not determined
#26	Was the Preventive Care Flow sheet updated at the time of the last annual	1	92%

#	Provision	Assessment of Status	Compliance

	assessment?		
#28	Is there evidence that the provider responded to the pharmacist quarterly drug regimen review recommendations on the quarterly rug regimen review form within 15 business days?	1	92%
#37	Is the provider's documentation legible?	4	67%
#38	Is the provider's documentation organized in appropriate SOAP format, when appropriate?	1	92%
#39	Do notes regarding acute medical problems contain pertinent positive and negative findings?	1	92%
#40	If a medical treatment was ordered during an acute illness or injury was it documented in the progress note?	1	92%
#42	Did the provider indicate resolution and closure of acute problems in the IPN?	1	92%

For the internal medical peer review audit, there were 29 corrective action plans identified. There was information submitted concerning tracking these corrective action plans to closure.

- At 30 days following the internal general medical audit, one of 29 corrective action plans remained outstanding.
- At 60 days following the internal general medical audit, zero corrective action plans remained outstanding.

An internal medical management audit was completed in May 2014, utilizing the same audit questions from the external medical management peer review for the following clinical concerns: diabetes mellitus, aspiration pneumonia, and osteoporosis. Three individuals with diabetes were reviewed. Six individuals with aspiration pneumonia/pneumonia were reviewed. Three individuals with osteoporosis were reviewed. Compliance among PCPs was 100 percent. Compliance from review of raw data by the Monitoring Team member also indicated 100 percent compliance with each of these three clinical areas.

#	Provision	Assessment of Status	Compliance

Diagnostic Category	Clinical Indicator Number for the Diagnosis	Description of Clinical Indicator on Monitoring Tool	Number of Records with Noncompliance in This Area	Percent Records with Compliance in This Area
Osteoporosis	No noncompliant area	Not applicable	0	100%
Aspiration pneumonia	No noncompliant areas	Not applicable	0	100%
Diabetes mellitus	No noncompliant areas	Not applicable	O	100%

Medical Department Internal Reviews/ Initiatives and Improvement Projects

The Medical Department has implemented the following additional processes for internal peer reviews:

- Quality indicators were identified for several clinical areas, independent of the audit tools utilized in the external and internal medical peer review and medical management peer review process. These are listed in Section L.4, as they were included in the Medical Department Policy and Procedure Manual.
- Copies of the actual audit results were forwarded for the same three clinical areas as in the medical management audits for the internal and external peer review process. The clinical monitoring tools of the Medical Department were not identical to the peer review audits.
- Completed audits were submitted for two individuals for each of the following diagnoses: osteoporosis, diabetes mellitus and aspiration pneumonia. There were six clinical indicators for osteoporosis, with two additional non-scored questions. There were seven clinical indicators for diabetes mellitus, with five additional non-scored questions. There were five clinical indicators for aspiration pneumonia. All six audits scored 100 percent compliance. The date of the audit was only documented in two of six audits.
- A number of meetings occurred that provided a forum for discussion and communication with the PCPs concerning the audit tool results, as well as results of tracking completion of required documents. There were Medical Quality Improvement meetings with both the medical staff and QI staff held on 1/16/14, 3/26/14, 4/1/14, and 4/24/14.
- There were additional medical staff meetings to further discuss audit results and completion of required documents on 1/30/14, 2/21/14, 4/7/14, 4/17/14, 5/9/14, 5/16/14, 5/20/14, and 6/3/14.
- There were other interdepartmental meetings to discuss implementation of revised systems and processes for areas identified needing corrective action through quality improvement initiatives on 1/16/14.
- There was a medical/pharmacy meeting on 5/19/14 to review the adverse drug reaction policy (refresher in-service). There was a Medical/Program Compliance Nurse meeting held on 6/5/14.
- An inter-disciplinary meeting on 5/8/14 provided in-service for "blood borne pathogen protocol."

The above meetings included detailed documentation of agenda items and discussion. There were several areas identified for QI review, with handouts, if applicable, for such areas as records of mammogram completion, quarterly medical review completion, etc. The minutes included action steps to be taken by the PCPs as appropriate, as well as information in the context of the QA/QI process. These minutes demonstrated good communication among the medical

#	Provision	Assessment of Status	Compliance
		staff, and ongoing communication and cooperation with other departments: QA, Pharmacy, and the QIDP Educator. There appeared to be a rigorous process for quality improvement in the Medical Department. However, the breadth of tools (as noted with regard Section H) indicated the need for a rigorous QI approach to abnormal findings, with sufficient data over months to determine trends and identification of areas that would benefit from improvement. The QI review based on diagnoses and national standards for preventive and maintenance care appeared to indicate 100 percent compliance in several areas. This suggested the ability to reduce the amount of time auditing with these tools, with more focused efforts on the review of abnormal test results to determine timely and appropriate response of the medical team. Tracking clinical indicators in the medical peer review audits that had indicated noncompliance is indicated to ensure there is a trend toward improvement for those specific questions. Demonstration of approaches to improve inter-rater reliability also is indicated. No information was submitted to determine if this had been a focus.	
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	The Monitoring Team requested a copy of the complete medical policy and procedure manual including all Facility policies that were related to medical care and all clinical guidelines developed and implemented. Since the Monitoring Team's last visit, the following policies/procedures/protocols were approved and/or implemented: ▪ "LbSSLC – Health Services – Choking," dated 3/25/14, revised 4/17/14; ▪ "LbSSLC – Health Services – Coding Requirements," dated 3/25/14; ▪ "LbSSLC – Health Services - Administration of IV fluids and IV antibiotics," dated 3/25/14; ▪ "LbSSLC – Health Services – Seizure Management," dated 3/25/14; ▪ "LbSSLC- Health Services - Seizure Management," revised 4/17/14; ▪ "LbSSLC – Health Services - Tracking System for Consultations," dated 3/25/14; ▪ "LbSSLC – Health Services – Tracking System for Lab/Radiology Department," dated 3/25/14; ▪ "LbSSLC – Health Services - Tracking System for Health Care Professional Licensure," dated 3/25/14; ▪ "LbSSLC – Health Services – Transportation of LbSSLC residents in Nonemergency conditions," dated 3/25/14, revised 4/17/14; and ▪ "LbSSLC – Health Services – Weight Monitoring," revised 5/8/14. A policy and procedure was in place for the following aspects of medical care: ▪ "Organizational chart of Medical Services," dated July 2014; ▪ "Physician Home Assignments," revised 5/27/14; ▪ "Clinical Death Review Template," undated document; ▪ "Clinical Death Review Recommendations," dated 3/09; ▪ "Death/Discharge Summary," revised 3/09; ▪ "Report of Death," revised 8/2011; ▪ "Ethics Committee Template," undated; and ▪ "Medical Open Chart Review Template," revised 6/24/14. Policies and Procedures also included:	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	▪ "Administration of IV fluids and IV antibiotics," dated 3/25/14; ▪ "Choking," dated 3/25/14; ▪ "Coding Requirements," dated 3/25/14; ▪ "Life Sustaining Treatment," revised 12/20/13; ▪ "Medical Care Policy," dated 8/22/13 (included expectations of medical services, documentation requirements, active problem list, documentation of acute medical problems, addressing chronic health problems, PCP orders, consultations, hospitalizations/transfers/readmissions and discharges, annual medical assessments/annual medical summary/plans of care, pharmacist concerns, patient communication, meeting attendance for PCPs, management of acute illness and injury, seizure management, aspiration pneumonia, management of chronic conditions, prevention (i.e., infection control, preventative care flow sheet, immunizations and screenings, smoking cessation), and quality of medical care (i.e., external audits, internal audits, and data); ▪ "Medical Peer Review," dated 8/29/12; ▪ "Morning Provider Meeting- Integrated Clinical Services," dated 9/25/13; ▪ "Planning End of Life Care and Death of an Individual," revised 12/20/13; ▪ "Preventive Medicine," dated 3/1/12; ▪ "Process for on-campus and off-campus consultations," dated 4/1/13; ▪ "Seizure Management," dated 3/25/14; ▪ "Transportation of LbSSLC residents in Non-emergency conditions," dated 3/25/14; ▪ "Blood Borne Pathogen Protocol," revised 4/7/14; ▪ "Protocol for Blood Draws in Lab," dated 6/13/12; ▪ "Tracking System for Consultations," dated 3/25/14; ▪ "Tracking System for Health Care Professional Licensure," dated 3/25/14; and ▪ "Tracking System for Lab/Radiology Department," dated 3/25/14. Clinical Guidelines included the following: ▪ "Anticoagulation Therapy," dated 4/3/12; ▪ "Aspiration Pneumonia," dated 1/13/12; ▪ "Constipation," dated 1/13/12; ▪ "Diabetes," dated 1/13/12; ▪ "Down Syndrome," dated 10/25/12; ▪ "Enteral Feedings," dated 1/13/12; ▪ "Metabolic Syndrome," dated 10/25/12; ▪ "Osteoporosis," dated 1/13/12; ▪ "Prader-Willi Syndrome," dated 10/25/12; ▪ "Seizures," dated 1/13/12; ▪ "Tuberous Sclerosis," dated 10/25/12; and ▪ "UTI," dated 2/3/12. Quality Clinical Indicators included: ▪ "Aspiration pneumonia," reviewed/revised 3/26/14;	

#	Provision	Assessment of Status	Compliance
		▪ "Constipation," reviewed/revised 3/26/14; ▪ "Diabetes," reviewed/revised 3/26/14; ▪ "Down Syndrome," reviewed/revised 3/26/14; ▪ "ER/Hospital visits," reviewed/revised 3/26/14; ▪ "GERD," reviewed/revised 3/26/14; ▪ "Hypertension," reviewed/revised 3/26/14; ▪ "Metabolic Syndrome," reviewed/revised 3/26/14; ▪ "Ogilvie Syndrome," reviewed/revised 3/26/14; ▪ "Osteoporosis," reviewed/revised 3/26/14; ▪ "Prader-Willi," reviewed/revised 3/26/14; ▪ "Seizures," reviewed/revised 3/26/14; ▪ "Tuberous sclerosis," reviewed/revised 3/26/14; ▪ "UTI," reviewed/revised 3/26/14; and ▪ "Quarterly Progress Notes," undated. In reviewing the contents, it appeared all significant areas were addressed. Some areas, such as missed appointments, were discussed in the policies involving consultation appointments. Most of the documents included revision or review dates indicating documents were current. For documents last reviewed or created more than three years ago, documentation of review is recommended. As is discussed with regard to Section V.2, the QA Department now played a role in identifying policies that required review, and prompting the Departments to conduct necessary reviews. However, this was the case for the minority of the documents. Additionally, some documents were not dated. All documents should include a date of implementation. Future revisions should also have dates to identify the version being completed or referenced during discussions/minutes. Although specific training rosters for each policy, procedure, audit tool or clinical guideline was not requested, record reviews, audit results, morning provider minutes, medical staff meeting minutes, P&T Committee minutes, and QI/medical staff meeting minutes provided evidence that medical staff had been trained on Clinical Guidelines, Quality Clinical Indicators, and clinically focused policies. Areas of revision to policies/procedures/audits were specifically reviewed and documented at medical staff meetings to ensure the medical staff had input into potential changes, were in agreement with changes, and were informed of the changes. Medical staff meetings included attendance. Dates of medical staff meetings were discussed with regard to Section L.3. There appeared to be an efficient communication system in place to ensure the medical staff were updated/trained on new information concerning policies/procedures/audits, etc. As is discussed in greater detail with regard to Section V.2, the Facility was implementing an effectively working system to identify staff that needed training on policies, and providing and documenting the training. Evidence was presented to show that the Medical Department staff were completing training on policies and procedures, as necessary. Given that the Facility had a comprehensive set of medical policies, a system for regular review of such policies, as well as a system to ensure staff completed necessary training, the Facility was found to be in substantial compliance with Section L.4.	

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents** o LBSSLC's Self-Assessment; o LBSSLC At-Risk Individuals list; o LBSSLC's Nursing Department Presentation Book; o LBSSLC's nursing staffing data; o LBSSLC's Nursing Monitoring Tools and data; o LBSSLC's Action Plans for Nursing; o LBSSLC's lists of individuals who were seen in the emergency room, and hospital; o Medical records for the following individuals: Individual #165, Individual #299, Individual #192, Individual #168, Individual #55, Individual #139, Individual #115, Individual #128, Individual #99, Individual #91, Individual #288, Individual #143, Individual #310, Individual #34, Individual #20, Individual #74, Individual #173, Individual #98, Individual #304, Individual #68, Individual #269, Individual #322, Individual #288, Individual #131, Individual #181, Individual #225, Individual #242, Individual #223, Individual #161, Individual #30, Individual #293, Individual #317, Individual #323, Individual #276, Individual #76, Individual #136, Individual #175, Individual #179, Individual #111, Individual #259, Individual #106, Individual #245, Individual #103; o Facility list of individuals with Methicillin-resistant Staphylococcus aureus (MRSA); Hepatitis A, B, and C; human immunodeficiency virus (HIV); positive Purified Protein Derivative (PPD); converters; Clostridium difficile (C-Diff); H1N1; and sexually transmitted diseases (STDs); o Real Time audit data for Infection Control; o Hand washing 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 Medication Safety and Systems Committee meetings minutes, dated 1/7/14, 3/19/14, and 7/8/14; o LBSSLC Executive Safety Committee meeting minutes for August 2013 through January 2014, and September 2013 through February 2014; o Infection Control Data Reliability Processes, dated May 2014; o Infection Control Committee meeting minutes for 12/23/13, 3/27/14, 4/24/14, and 5/29/14; o LBSSLC's list of individuals affected by outbreaks; o LBSSLC's Outbreak information; o Quarterly Emergency Response Drill data; o Standard Precautions Monitoring Tool data; o Medication Observation raw data;

	○ Medication Variance data by month; ○ Unexplained Returned Medication data; ○ Returned Medication data by home; ○ Medication Observation Tracking data; ○ Medication Variance data and graphs; ○ Raw data from the Nursing Chart Review audits; ○ Medication Variance Corrective Action Plan; ○ Environmental audits and raw data; and ○ Entrance Presentation information. ▪ **Interviews with**: ○ Brandi Villarreal, RN, BSN, Chief Nurse Executive; ○ Lilly Burton, RN, Program Compliance Nurse (PCN); ○ Norma Gutierrez, Safety Officer; ○ Ken Ferguson, Director of Risk and Support Services; ○ Eric Benson, RN, Infection Control Nurse (IC); ○ John Todd, R.Ph., Clinical Pharmacist; ○ Mary Ortiz, Competency Training Department (CTD); ○ Jim Forbes, Assistant Director of Programs; and ○ Ruth Clark, RN, Quality Assurance Nurse. ▪ **Observations of**: ○ Medication Administration in the Sparrow; and ○ Use of emergency equipment at Sparrow and Zinnia.
	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, the Facility had been in the process of establishing inter-rater reliability for some of its monitoring tools since turnover in staffing had resulted in some gaps in the auditing process. In addition, the Facility continued to complete a weekly Nursing Chart Review audit. However the Monitoring Team's previous review of the tool and process 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) Although more data was included in the Self-Assessment for Section M, at times, the data presented was uninterpretable mainly due to the lack of compliance scores by item by month. As noted in past reports, an overall compliance score for a tool that contained several items for six months of data is meaningless in reflecting strengths, weaknesses, and progress for a given area being monitored. Consequently, there continued to be significant problematic issues regarding the format, the organization, the presentation, the interpretation, and analysis of the Facility's data. ○ It was unclear why some of the specific data included in the Self-Assessment were

	presented since it appeared that it was not related to the specific provision, did not identify the specific standards used to determine compliance for the different areas audited, and did not reflect the quality of the nursing services and documentation. o In most of the subsections for Section M, many of the items presented did not reflect review of the quality (as opposed to just the presence) of the services provided as well documentation. In addition, monitoring results were not included for each area upon which the Monitoring Team's findings focused and the Settlement Agreement required. As the Facility reviews its monitoring tools, the Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ▪ The Facility did not have a plan for consistently presenting the data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not consistently present findings based on specific, measurable indicators, and in alignment with the specific provision. For example, at times, without citing a standard, such as a nursing protocol, it was unclear what criteria had been used to determine compliance with quality. o Did not adequately address the quality as well as the completion of documentation. The Facility should consider adopting a standardized format for presenting data in a meaningful way that facilitates its interpretation and analysis, and provide training to the disciplines regarding how to analyze their data to identify problematic trends. ▪ The Facility rated itself as being in compliance with none of the subsections of Section M. This was consistent with the Monitoring Team's findings. ▪ The Facility's data identified some of the areas that were in need of improvement, but did not consistently provide information regarding initial attempts to analyze the information, identifying some potential causes for the issues, and possible barriers to improvement. Significant work was needed to present compliance by month by item, rather than only presenting one overall compliance score for the entire review period, analyzing the data, and providing a description of actions planned to correct issues identified.
	Summary of Monitor's Assessment: Since the last review, nursing staffing continued to be a significant challenge for the Facility. As of May 2014, 82 out of 102 (80%) nursing positions were filled, and 67 of the 102 (66%) positions were direct care nursing positions. At the time of the Monitoring Team's onsite review, of the 67 direct care nursing positions, 49 (73%) were filled. As a result of these staffing challenges, the Facility indicated that since the last review, a total of 251 shifts fell below minimum staffing requirements due to the vacant nursing positions, extended sick leave, regular sick leave, and workman's compensation cases. Agency nurses and overtime hours were utilized to fill all the shifts that fell below the minimums staffing requirements. Some of the changes regarding the Nursing Department and nursing positions since the last review included the following: ▪ Since the last review, the Nurse Operations Officer (NOO) position was vacated and in June 2014, the position was again filled;

	▪ In June 2014, the RN Case Manager Supervisor position was filled; and ▪ As of May 2014, all 16 RN Case Manager positions were filled. Since the last review, five out of the 16 RN Case Managers (31%) were new to their positions. However, some of the Facility's positive steps forward included: ▪ In April 2014, the Facility revised the Infection Control data reliability process to include a review of the Pharmacy's monthly antibiotic usage and a daily review of physicians' orders for antibiotics, antivirals, antifungals, and/or anti-parasitics to increase the reliability of the Facility's Infection Control data in order to accurately identify the Facility's trends related to infectious and communicable issues. ▪ Since the last review, the Facility focused much effort in reviewing the Facility's immunization database to verify if all immunizations, boosters, and titers were current and available in the records. The results of the review were being shared with the RN Case Managers for further follow-up and collaboration with physicians regarding immunization data that were not current. ▪ The Competency Training Department (CTD) staff continued to present a weekly report of the Emergency drills to the Incident Management Committee. The data indicated that of the 124 total drills conducted 118 (95%) were deemed as passing, which was a very positive finding. ▪ The Facility established a workgroup that developed a very specific and comprehensive Corrective Action Plan (CAP) addressing the Facility's medication systems with the goal of ultimately reducing the number of medication variances. At the time of the Monitoring Team's onsite review, the Facility had already held a number of Medication Systems CAP meetings, and was in the process of extensively examining all the Facility's medication systems, as well as implementing a number of steps contained in the CAP. Although the Facility had made some positive steps forward in the areas noted above, an overall lack of progress continued regarding 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 Reviews. Unfortunately, since the last review, the challenges in stabilizing the nursing coverage due to staff turnover continued to be a problem, and slowed the Facility's momentum in making measurable 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	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	Noncompliance

#	Provision	Assessment of Status	Compliance
	appropriate records of the individuals' health care status sufficient to readily identify changes in status.	Agreement. Information and recommendations 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 data was generated since the last review regarding this requirement of the Settlement Agreement: ▪ Based on a 15% random sample of individuals requiring hospitalization or ER visits (two individuals a month who had either gone to the hospital or the ER) from November 2013 through April 2014, using the Urgent Care/ER/Hospitalizations Tool, nurses were not following the Hospital Transfer protocol regarding completion of the transfer form correctly and completely, and nurses had not always completed an assessment and/or acute care plan. The Facility's Self-Assessment indicated the acute care plans that were completed were often not of an acceptable quality. The information contained in the Self-Assessment indicated that in May 2014, training addressing the problematic issues found was conducted for the RNs. Although these valuable findings were reported in the Self-Assessment, the data presented only included an overall compliance score for each month and a total percentage for the review period, which did not reflect the specific items contained in the monitoring tools. Consequently, the Monitoring Team could not determine the specific strengths, weaknesses, and progress made across the specific items each month. ▪ Although item-specific data was not included in the Facility's Self-Assessment, information regarding the Facility's review of the infection control monitoring data and Environmental Surveillance Surveys found the following: Acute Care Plans needed to be implemented within the time frame allowed by policy (within 24 hours); Acute Care Plans needed to be clinically sound; Acute Care Plans needed to be personalized to the specific individual; and documentation in the integrated progress notes (IPNs) of timely reporting to the Primary Care Physician (PCP) and Infection Control Nurse needed to be done consistently. This showed an effort to analyze and trend the information to identify systemic and/or staff-related problems with the potential to impact rates of infection. In response to these findings, the Facility indicated that in March and April 2014, the RN Case Manager Supervisor, Infection Control Nurse, and QA nurse provided training that focused on individualizing care plans, developing measurable goals, and including interventions to stop the spread of infectious illness. <u>Self-Rating</u> The Facility's Self-Assessment indicated that: "based on this self-assessment, this provision is not in substantial compliance due to lack of monitoring, and inadequate	

#	Provision	Assessment of Status	Compliance
		response to all health care issue and change of status. Protocol monitoring between QA and department is being revised to reflect real time client health issues addressed in action steps M1.5.a." <u>Staffing</u> Regarding nursing staffing, discussions with the Chief Nurse Executive indicated that since the last review, the Facility continued to experience staffing challenges. As of May 2014, 82 out of 102 (80%) nursing positions were filled and 67 of the 102 (66%) positions were direct care nursing positions. Of the 67 direct care nursing positions, 49 (73%) were filled at the time of the review. As a result of these staffing challenges, the Facility indicated that since the last review, a total of 251 shifts fell below minimum staffing requirements due to the vacant nursing positions, extended sick leave, regular sick leave, and workman's compensation cases. Regarding the number of shifts that fell below minimum staffing requirements, 6 a.m. to 2 p.m. shift had 94 shifts, 2 p.m. to 10 p.m. shift had 116 shifts, and the 10 p.m. to 6 a.m. had 41 shifts below minimum requirements. Agency nurses and overtime hours were utilized to fill all the shifts that fell below the minimums staffing requirements. At the time of the review, LBSSLC had a census of 204 individuals. Since the last review, changes LBSSLC experienced regarding the Nursing Department and nursing positions included: ▪ Since the last review, the Nurse Operations Officer position was vacated and in June 2014, the position was again filled; ▪ In June 2014, the RN Case Manager Supervisor position was filled; and ▪ As of May 2014, all 16 RN Case Manager positions were filled. Since the last review, five out of the 16 RN Case Managers (31%) were new to their positions. In addition, at the time of the review, the Nursing Department had a total of 102 allotted positions. The current nursing vacancies included 11 RN positions and nine LVN positions. From a review of the Facility's nursing staffing data in the Facility's Self-Assessment and discussions with the CNE, due to the staffing challenges within the Nursing Department, the Facility had to continue to use agency nurses for staff coverage. The CNE reported that since the last review, the 10 to 6 shift had lost five nurses due to retirement. Although the Facility participated in a number of recruitment activities since the last review, filling the needed nursing positions remained challenging. As previously recommended, the Facility should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement. <u>Quality Enhancement Efforts</u> Since the last review, an auditing process was established for the Quality Assurance	

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		Nurse and the Program Compliance Nurse. Every month the QA Department selected a random sample from the high-risk database for the PCN and the QA Nurse to audit. However, the Facility indicated essentially no data were generated from the sample regarding the implementation of the nursing protocols, because no acute episodes of the acute health issue had occurred during the month of monitoring. In response, the Facility determined real time audits were needed to address the implementation of nursing protocols in response to acute events. Thus, beginning in June 2014, the Facility indicated real time audits would be completed for the following protocols: constipation, UTIs, falls, and seizures. However, the Facility was not monitoring the use of nursing protocols for individuals with existing health conditions or diagnoses, because it was monitoring only the reactive implementation of nursing protocols in response to an acute issue. Consequently, the current format for monitoring the implementation of nursing protocols did not generate data based on an adequate and accurate review of the quality of the clinical care and treatment that individuals at LBSSLC received. In addition, the Monitoring Team's review of the process and data from the Unit Managers' weekly case reviews for individuals that had been hospitalized using the nursing protocol cards found that the monitoring tools and data only included a review of the reactive use of nursing protocols addressing nursing assessments, and not the use of the protocols regarding existing health issues that warranted regular nursing assessments proactively. As noted in the previous report, the current format of these reviews was concerning in that it also did not lend to generating an adequate and accurate review of the quality of the clinical care and treatment that individuals received. However, if the Facility modified the process addressing the monitoring regarding nursing protocols and the weekly case reviews to include a proactive review of the use of nursing protocols, the data generated would reflect a more accurate picture of the current nursing practices and clinical care provided to the individuals. In addition, the monitoring tools used for these areas would need to include 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. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> Although the Monitoring Team found an increase in the use of the Nursing Protocols in the Integrated Health Care Plans for individuals with high and/or medium risk levels, the IHCPs indicated that the nursing assessments contained in the nursing protocols were only to be implemented after the individual demonstrated a change in status. According to the IHCPs reviews, nurses were only to complete nursing assessments in response to an acute issue. This meant that an individual with existing health conditions or diagnoses had to become acutely ill in order for nursing staff to implement assessments. Consequently, the addition of the nursing protocols to IHCPs did not increase the clinical	

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		care the individuals' warranted. A review of eight individuals' IPNs (i.e., Individual #165, Individual #299, Individual #192, Individual #168, Individual #55, Individual #139, Individual #115, and Individual #128) who had been transferred to a community hospital, or emergency room found: ▪ Nurses promptly and consistently performed a physical assessment on any individual displaying signs/symptoms of potential or actual acute illness in none (0%) of the cases 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, and only then were nursing protocols implemented for individuals with a number of existing medical conditions, such as constipation and/or respiratory issues. ▪ The documentation indicated that appropriate information was communicated to the PCP in none (0%) of the cases. ▪ The nurse consistently performed appropriate ongoing assessments in alignment with nursing protocols as dictated by the symptoms in none (0%) of the cases. ▪ 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 nursing protocols addressing the specific health issue. ▪ The documentation indicated that all acute illness/injuries were adequately followed through to resolution in none (0%) of the cases. As noted in past reports, the Monitoring Team noted more IPNs containing an adequate nursing assessment initiated after acute symptoms were identified than found during previous reviews. However, the lack of consistent regular nursing assessments for existing health conditions rendered the overall care of the individuals insufficient to address their specific needs. Although the IPNs indicated that some nursing protocols had been implemented after the individuals demonstrated symptoms of an acute illness, no nursing protocols were implemented regarding the existing high and medium health risks these individuals already had experienced and continued to experience. Consequently, there was no indication that nursing protocols were being used consistently to guide nursing assessments and documentation. As noted in several previous reports, due to the number of individuals with complex medical needs at LBSSLC, this area should be considered an urgent priority. As noted in previous reports	

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		and during onsite reviews, the Facility should continue to implement and expand the use of nursing protocols to guide nursing practices for existing health conditions in addition to in response to an acute event, such as a seizure or fall. The Facility's Self-Assessment indicated 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 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 when making decisions regarding treatments and health care services. <u>Infection Control</u> Since the last review, no turnover had occurred in the Infection Control Nurse position. However, due to the past chronic turnover noted from February through May 2013, then again from August 2013 through September 2013, the Facility continued to focus its efforts on establishing and implementing systems that had not been maintained throughout the periods of time the position was vacant. Although some positive gains had been made since the last review, the Monitoring Team continued to find some problematic areas as noted below. ▪ In a positive step forward, in April 2014, the Facility revised the Infection Control data reliability process to include a review of the Pharmacy's monthly antibiotic usage and a daily review of physicians' orders for antibiotics, antivirals, antifungals, and/or anti-parasitics to increase the reliability of the Facility's Infection Control data in order to accurately identify the Facility's trends related to infectious and communicable issues. However, from discussions with the Infection Control Nurse and CNE, the Facility had not yet been using the Drug Utilization Discrepancy Reports to identify and track any differences actually found each month regarding the infection control data. Implementing this step would assist the Facility in identifying data sources that might have consistent discrepancies in need of corrective actions to ensure the data from these sources are complete and reliable. ▪ On a positive note, since the last review, the Facility focused much effort in reviewing the Facility's immunization database to verify if all immunizations, boosters, and titers were current and available in the records. The results of the review were being shared with the RN Case Managers for further follow-up and collaboration with physicians regarding immunization data that were not current. The documentation presented to the Monitoring Team clearly indicated what immunization information was present or absent. The Facility's data indicated that as of June 2014, 181 out of 206 (88%) individuals had missing or	

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		incomplete immunization information. Thus, the formal system for tracking this process is important because it indicates which individuals' immunization status and immunizations have been researched, confirmed, or updated to assist Facility staff in ensuring all individuals have received all the required immunizations as outlined in the Health Care Guidelines. ▪ Although the Facility had conducted hand-washing audits as a corrective action related to a survey deficiency, no analysis of the raw data had occurred to identify problematic trends, even though infectious outbreaks were reported during the review period. ▪ While the Facility had been conducting regular Infection Control Committee meetings since the previous review, additional information regarding infection control issues using aggregated and analyzed IC data, actual infection rates by home, along with other monitoring data addressing IC issues needed to be included in the meetings and reflected in the minutes of the committee meetings. Such information was needed 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 and had established 100% inter-rater reliability between the Infection Control Nurse and the QA Nurse, the analyses of these audits were not reviewed in conjunction with other IC data, such as the hand-washing audits, 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 also be included in the Infection Control Committee meeting minutes. ▪ In April 2014, the Facility re-initiated conducting Environmental Surveillance Surveys. Although these had not been consistently completed, the IC Nurse indicated his goal was to complete one survey daily in order to survey each building on campus at least once per quarter. However, at the time of the review, the Facility had been surveying buildings using a random selection process rather than focusing on buildings that had experienced outbreaks or other high infection rates, which would have been a more clinically-oriented choice in light of the infections and outbreaks that had occurred at the Facility in the past year. In addition, no trending or analysis of these data was found in the Infection Control Committee meeting minutes. ▪ While the Facility identified problematic issues regarding the lack of systems and processes addressing the communication and tracking of staff illnesses based on a review of an Influenza outbreak, the Facility's corrective action of implementing a weekly IC report to notify the IC Nurse regarding staff sick calls was not adequate to timely alert the Facility Administration to a possible pending outbreak. Only reporting this information on a weekly basis could continue to result in a delay in identifying similar symptoms among the staff	

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		calling in sick and symptoms the individuals at the Facility experienced. ▪ Regarding nursing care plans addressing infectious illnesses, the documentation the Facility provided to the Monitoring Team indicated 11 individuals had incidents of Influenza (i.e., Individual #165, Individual #99, and Individual #91, Individual #288, Individual #143, Individual #310, Individual #34, Individual #20, Individual #74, Individual #173, and Individual #98). Of the 11 incidents, 11 (100%) were found to have had Care Plans addressing the infectious issue. Of the 11 Nursing Care Plans reviewed, only three (27%) were found to be clinically adequate (i.e., Individual #310, Individual #34, and Individual #20). Although the care plan template addressing Influenza included clinically sound information, the care plans reviewed were not individualized, did not consistently include stopping the spread of the infection as a goal, and did not indicate how often assessments should be conducted. Many of the care plans consisted of the template without any additional individual-specific added. (The discussion related to Section M.3 includes specific details of these findings). At the time of this review, LBSSLC was in the process of rebuilding the infrastructure of its IC program. The Facility continued to have 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 interventions to prevent the spread of infections. <u>Mock Code Drills and Emergency Response Systems</u> Since the last review, LBSSLC indicated the following steps were initiated regarding this area: ▪ The Facility continued to conduct the required number of Emergency drills. ▪ The CTD staff continued to present a weekly report of the Emergency drills to the Incident Management Committee. The data indicated that of the 124 total drills conducted 118 (95%) 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. ▪ At the time of the review, the QA Nurse and CTD had established inter-rater reliability for the Emergency Drill tool. ▪ Also at the time of the review, the Facility had a total of 24 Automated External Defibrillators (AEDs). ▪ The QA Nurse was conducting regular Emergency Equipment Competency Checklists for nursing. ▪ 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.	

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		Consequently, the status of the Facility's emergency systems was not being reviewed, discussed, or tracked by any clinical staff. Although data regarding the Mock Code Drills were discussed in the Incident Management meetings, there was no indication that emergency systems were being discussed and evaluated using data from the Mock Codes and actual medical emergencies (i.e., 3733 calls). ▪ The Monitoring Team's observations of nurses demonstrating the emergency equipment at Sparrow and Zinnia found that the staff observed were familiar with the emergency equipment. However, problematic issues found included not all nurses observed were being regularly asked to actually turn on the oxygen tanks during the observations as well as to assess how much oxygen was in the tank; a number of pieces of back-up equipment, such as oxygen tanks and suction machines, were not being checked and documented that they were in good operational condition; the alarm on the AED in Sparrow did not work; and Nurse Case Managers were not being included in the observations of the use of emergency equipment. 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.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. LBSSLC indicated its Self-Assessment that since the last review, the following steps had been taken regarding this requirement of the Settlement Agreement: ▪ The Facility indicated that as of May 2014, 15 out 16 (94%) Registered Nurse Case Managers attended training. However, the specific nature of the training was not indicated in the Facility's Self-Assessment. In addition, the Facility indicated that in February 2014, Nursing Assessment training was conducted and that a Nursing Assessment/IRRF/IHCP workgroup was established at that time to focus efforts on the improvement of the quality of the Nursing Assessments/IRRF/IHCPs. ▪ The Facility's Self- Assessment indicated that a review of a sample of Comprehensive Nursing Reviews from November 2013 through April 2014 addressing the timeliness of annual nursing assessments (submitted 10 days prior to an ISP meeting) found the percent compliance 79%, 92%, 74%, 57%, 45%, and 64%, respectively. In response to these findings, in December 2013, a Corrective Action Plan was implemented that included changing the process where the RN Case Manager Supervisor was now designated to move the completed Nursing Annual Assessments into the shared drive in order to track which Nursing Assessments were completed. Along with this change, a new database was created to assist in tracking the Nursing Annual Assessments. In	Noncompliance

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		addition, the Annual Nursing Assessments were now to be completed within 21 days of the ISP meeting, which should increase compliance regarding timely submission of the Annual Nursing Assessments. Also, in March 2014, the Facility developed a promising template addressing Nursing Annual Assessments in an attempt to increase the quality of the assessments. ▪ In addition, the Facility's compliance data addressing the Nursing Quarterly Assessments regarding timely completion indicated that from November 2013 through April 2014, the compliance percentages were 100%, 89%, 92%, 90%, 94%, and 90%, respectively. ▪ Although the Facility's Self-Assessment contained compliance data regarding the quality of the Annual and Quarterly Nursing Assessments indicating that the RN Case Managers needed to elaborate in multiple sections of the assessment, the Facility only provided one compliance score (37.8%), which the Monitoring Team could not interpret. ▪ In addition, the Facility's Self-Assessment indicated that a review of five nursing discharge assessments from November 2013 through April 2014 found that three of the five assessments were specific and detailed enough to maintain continuity of care in the community. However, there was no indication as to what criteria were used to determine compliance, and these findings did not comport with the findings of the Monitoring Team as noted below. <u>Self-rating</u> The Facility's Self-Assessment indicated that: "based on this self-assessment, this provision is not in substantial compliance as assessment quality, timeliness, and additional monitoring is warranted to obtain compliance." The Facility's finding of noncompliance was consistent with the Monitoring Team's findings. However, the Monitoring Team's finding of noncompliance as noted below was based on specific findings related to problems regarding the quality of the content of the Annual and Quarterly Nursing Assessments Reviews. Such a review of the quality of the information included in the documentation was demonstrated in only a few items in the Facility's Self-Assessment for this section. In addition, the Facility did not identify the specific criteria used in determining compliance. The Quarterly/Annual Nursing Reviews for 21 individuals who the Facility identified as being at risk for specific health indicators were reviewed, including those for: Individual #304, Individual #68, and Individual #269 for aspiration; Individual #322, Individual #288, and Individual #131 for behavioral issues; Individual #181, Individual #225, and Individual #242 for fluid imbalance issues; Individual #223, Individual #161, and Individual #30 for gastrointestinal issues; Individual #293, Individual #317, and Individual #323 for infections; Individual #276, Individual #76, and Individual #136 for	

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		weight issues; and Individual #175, Individual #179, and Individual #111 for constipation. ▪ Of the 21 individuals' quarterly nursing assessments reviewed, 21 (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 Reviews 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 Quarterly/Annual Nursing reviews. ▪ Nursing assessments were updated as indicated by the individual's health status in none (0%) of the Annual/Quarterly Nursing Reviews reviewed. Although not consistent, the Monitoring Team found that since the last review, more progress had been made regarding the use of data from the current quarter as compared to the previous quarter in the analysis of the high and medium health/mental health indicators in a number of the nursing summaries. However, overall, none of the Annual/Quarterly Nursing Review summaries reviewed actually included an adequate analysis of the individuals' health/mental health issues between quarters, indicating if the health issues were improving, maintaining, or getting worse. In addition, due to the ongoing lack of implementation of the nursing protocols for existing conditions/diagnoses, appropriate clinical nursing assessments were not consistently being conducted for the individuals, and this resulted in an absence of objective clinical data generated to even allow a complete and thorough analysis of the health/mental health issues to occur. Although based on interviews with Nursing Department staff and review of nursing documentation, the Monitoring Team noted an increase in understanding regarding the use of the nursing protocols in guiding nursing assessments and the associated nursing documentation, most of the nursing assessments that were conducted in alignment with the nursing protocols were only initiated after changes in status occurred, and then discontinued, rather than continuing them on a regular basis for existing health issues such as aspiration and constipation. Consequently, the data generated from the nursing assessments reflected only indicators of illness, not indicators of periods of stability. Thus, only using these data for analysis offered little in determining the individuals' healthy baselines compared to data during their changes in status. In addition, much of the existing nursing assessment data did little to identify changes in status early, so that they could be addressed and/or reported to medical staff to potentially avoid acute periods of illness. At this juncture of the review process, the lack of consistent progress found regarding the quality of the Comprehensive Nursing Reviews continued to be very concerning due to the potential impact it had on the health and wellbeing of individuals	

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		residing at the Facility. As articulated during the onsite reviews as well as in past reports, it is absolutely essential that the nurses responsible for completing the quarterly/annual Nursing Reviews and Physical Assessments have the ability and understanding to document, analyze, and summarize health/mental health issues to determine whether the individuals under their care are actually making progress regarding their health/mental health status. As previously recommended, clinically appropriate competency-based training and mentoring should be provided from a competent source to ensure that the nursing assessments include an adequate clinical analysis of the individuals' progress. Regarding the nursing documentation for four discharges/individuals transitioning to the community, a review of the nursing notes and CLDP-Comprehensive Nursing Review for four individuals including: Individual #259, Individual #106, Individual #245, and Individual #103 found the following: ▪ None (0%) of the CLDP-Comprehensive Nursing Review adequately addressed the health/mental issues of the individuals. ▪ There was adequate information contained in none (0%) of the CLDP-Comprehensive Nursing Review 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 three (75%) of the individuals. Individual #259's documentation did not include a nursing assessment at the time of the discharge. ▪ There was adequate documentation identifying specific nursing interventions needed for all health/mental health issues in none (0%) of the cases reviewed. On a positive note, as noted above, the Facility had made progress regarding conducting a nursing assessment prior to the individuals' discharge from the Facility as found in the IPNs. However, the poor quality of the overall nursing documentation did not sufficiently reflect the nursing care and services that would be needed from a community provider. The problems found regarding the nursing documentation in Sections M.3, M.4, and M.5, addressing the Annual/Quarterly Nursing Reviews, the IHCPs, the IRRFs, and Acute Care Plans demonstrated that the nursing documentation was not specific and detailed enough to ensure appropriate clinical care upon transition. The Monitoring Team's findings were not in alignment with the Facility's findings noted above in the Self-Assessment. 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	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	Noncompliance

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	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.	that since the last review, the following steps were taken regarding this requirement of the Settlement Agreement: ▪ The Facility's Self-Assessment indicated that 15 out 16 (94%) RN Case Managers received training regarding IHCPs, and 14 out of 16 (88%) RN Case Managers received training regarding Acute Care Plans. In April 2014, the RN Case Manager Supervisor, Infection Control Nurse, and QA Nurse provided additional training regarding care plans to 15 out 16 (94%) RN Case Managers. This training focused on individualizing care plans, writing measurable goals, and developing interventions to stop the spread of infectious illness. ▪ The Facility indicated in March 2014, the Nursing Department and QA Nurse reinstated the monitoring of IHCPs utilizing the monitoring tool entitled "Nursing Care: Annual Nursing Care Plans." At the time of the review, the RN Case Manager Supervisor and the QA Nurse had been establishing inter-rater reliability and clarifying instructions on the tool. ▪ The Facility's Self-Assessment indicated that a review of the timely completion of IHCPs (within 14 days following the ISP) found the following compliance percentages from November 2013 through April 2014: 100%, 83%, 77%, 81%, 61%, and 77%, respectively. Based on these findings, the Facility indicated that the fluctuation found regarding the compliance addressing timely IHCPs was due to the turnover in the RN Case Manager positions. In addition, in April 2014, a new database was created to assist in tracking IHCPs, and training addressing the quality of the IHCPs was recently initiated. <u>Self-rating</u> The Facility's Self-Assessment indicated that: based on their self-assessment, this provision was not in compliance due to lack of quality of the Acute Plans and Integrated Health Care Plans addressing individuals' health needs. The records of 21 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #304, Individual #68, and Individual #269 for aspiration; Individual #322, Individual #288, and Individual #131 for behavioral issues; Individual #181, Individual #225, and Individual #242 for fluid imbalance issues; Individual #223, Individual #161, and Individual #30 for gastrointestinal issues; Individual #293, Individual #317, and Individual #323 for infections; Individual #276, Individual #76, and Individual #136 for weight issues; and Individual #175, Individual #179, and Individual #111 for constipation. Of the 21 individuals' Integrated Health Care Plans reviewed: ▪ All 21 (100%) were found to have a care plan addressing the high or medium risk health/mental indicators. ▪ One (5%) of the care plans for Individual #225 contained nursing interventions	

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		that were to be regularly conducted addressing the specific existing health issue in alignment with the nursing protocols. Nursing Protocols that were found in the other 20 IHCPs were only to be conducted in response to an acute event. ▪ One (5%) of the 21 care plans (i.e., for Individual #225) was found to be clinically adequate. There was no indication for the other 20 that any type of nursing assessments were to be proactively conducted addressing the specific health issue in alignment with the nursing protocols. The overall quality of the nursing interventions in the other 20 was poor in that they were generic, and non-specific to the individual's health care needs. ▪ One (5%) of the 21 care plans contained adequate proactive interventions addressing the health indicator (i.e., Individual #225). ▪ One (5%) of the 21 care plans was adequately individualized (i.e., Individual #225). ▪ Due to the nonspecific interventions contained in 20 of the 21 care plans reviewed, validating the implementation of the interventions was not possible, rendering them inadequate guides for the provision of care. Although the Facility recently had provided training regarding Acute Care Plans, the results of these trainings had not yet impacted the quality of the documentation found in the IHCPs the Monitoring Team reviewed with the exception of one noteworthy IHCP. Although increased use of nursing protocols was found in most of the IHCPs, the nursing assessments contained in the nursing protocols were to be implemented only after the individual demonstrated a change in status. As training and reviews of IHCPs continue, the Facility should ensure that any improvements discussed during the reviews are made to the IHCPs using the appropriate Facility methods (i.e., ISPAs to integrate new interventions into existing ISPs). Overall, some of the problematic issues identified in the Facility's previous care plans were found in the current IHCPs including: ▪ Most of the goals listed in the IHCPs reviewed 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, most of the nursing action steps found in the IHCPs reviewed were not in alignment with the clinical assessments the nursing protocols required for the specific existing health issues. ▪ The action steps contained in the IHCPs 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; consistent notation of where they were to be documented;	

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		how often they would be reviewed; and/or when they should be considered for modification. Unfortunately, many of the nursing action steps were generic, not measurable, and non-specific to the individual's health care needs. ▪ At the time of the review, all but one of the IHCPs 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 contained in the IHCPs prohibited validation that the steps were actually being implemented. One of the IHCPs reviewed was found to be exceptional and was reviewed and discussed with the Facility Director, ADOP, CNE, and Program Compliance Nurse. However, it was very troubling that nursing was still not implementing regular, proactive and individualized nursing assessments for individuals who had clear histories of repeated hospitalizations, Infirmary admissions, multiple orders for treatments addressing their chronic health issues, and whose teams had assigned high and medium health risk ratings indicating the need for interventions to attempt to prevent or minimize the occurrence of acute changes in status regarding existing health conditions. There is no clinical justification for nurses or IDTs to wait for an individual to experience a change in his/her status to implement proactive and individualized nursing assessments in alignment with nursing protocols, especially when the individual has known health conditions. Consequently, the increased inclusion of the reactive use of nursing protocols in the IHCPs yielded no increase in the clinical care provided to individuals with high and medium health risks. In fact, it only reinforced the inadequate reactive care that already existed at LBSSLC. Given the significant nursing resources currently available, discussions between Facility Administration and State Office should include consideration of the realignment of responsibilities within the Nursing Department and/or for individuals with higher acuities, as identified through the at-risk system. Regarding nursing care plans addressing infectious illness, the documentation the Facility provided to the Monitoring Team indicated 11 individuals had incidents of Influenza (i.e., Individual #165, Individual #99, and Individual #91, Individual #288, Individual #143, Individual #310, Individual #34, Individual #20, Individual #74, Individual #173, and Individual #98). ▪ Of the 11 incidents, 11 (100%) were found to have had Care Plans addressing the infectious issue. ▪ Of the 11 Nursing Care Plans reviewed, three (27%) were found to be clinically adequate (i.e., Individual #310, Individual #34, and Individual #20). Although the care plan template addressing Influenza included clinically sound information, the care plans reviewed were generally not individualized, did not consistently include stopping the spread of the infection as a goal, and did not indicate how often assessments should be conducted.	

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		Considerably more work was needed to ensure that individuals with infectious diseases were being tracked, monitored, and provided care plans that included the appropriate infection control measures, and clinically appropriate interventions to prevent the spread of infections. Consistent with findings from previous reviews, Nursing Administration, in conjunction with the Infection Control Nurses should develop and implement a system to ensure that the care plans addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently. The Facility indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the findings of the Monitoring Team.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. With regard to this provision, LBSSLC's Self-Assessment indicated the following: ▪ The Facility's Self-Assessment indicated that at the time of the review, 100% of the nursing staff had been trained using nursing protocol cards. In addition, the Facility indicated that ongoing training was being provided through random protocol audits along with nursing chart reviews. The nursing chart reviews had been reinitiated since the last review to include an increased emphasis on proactive nursing care. At the time of the review, the Nursing Department was revising and implementing the protocol follow-up process to assist with protocol monitoring, and to ensure that nursing protocols were consistently implemented. <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." Although the nursing protocol training and tracking system was a promising step in generating data regarding acute health events that had taken place, at the time of the review, the Facility continued to essentially only implement nursing protocols reactively rather than in alignment with individuals' current and existing health needs. In addition, although there continued to be more nursing entries found in the IPNs than during previous reviews, ongoing adequate clinical nursing assessments in alignment with the nursing protocols for the particular health issues the individuals were experiencing were not found in the documentation. Unfortunately, the additional	Noncompliance

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		documentation that was found in the IPNs did not actually result in an improvement in clinical care. Regarding the IHCPs, the Monitoring Team found an increase in the use of nursing protocols in the IHCPs reviewed. However, the nursing assessments listed in the nursing protocols in the IHCPs were interventions that were to be implemented only after an acute health event had occurred rather than on a regular basis for individuals who had known high and medium health risks to attempt to prevent the occurrence of an acute health event. As noted with regard to Section M.3, 20 out of 21 IHCPs were not in alignment with the nursing assessments contained in the nursing protocols. Using nursing protocols only reactively meant 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 persisted. Waiting for an individual to experience a change is their status in order to implement nursing assessments in alignment with nursing protocols, especially when the individual has repeated Infirmary admissions and hospitalizations related to existing health conditions and diagnoses defies sound clinical logic and practice. Consequently, the increased use of reactive nursing protocols found in the IHCPs did not result in an improvement in clinical care. These major concerns, especially those related to individuals with high/medium risk health indicators and their changes in status warranting hospital admissions, were exemplified in a review of eight individuals who had been hospitalized since the last review: Individual #165, Individual #299, Individual #192, Individual #168, Individual #55, Individual #139, Individual #115, and Individual #128. Specific details are provided with regard to Section M.1. In summary, a review of these individuals' records indicated the following: ▪ There was no indication that nursing staff were actually using nursing protocols as part of a structured system to guide nursing practice and the associated documentation; ▪ Clinically appropriate nursing assessments were not conducted for significant existing health issues and documented at the appropriate clinical frequency; ▪ Clinical baseline data had not been established to quickly recognize changes in health status; ▪ Timely communication had not occurred with practitioners/physicians or other disciplines regarding changes in status; and ▪ Appropriate and clinically adequate care plans had not been developed and implemented that outlined specific nursing interventions for specific health issues. Given the numbers of nursing positions at LBSSLC, staffing barriers should not be the reason why nurses are not implementing nursing protocols for existing health	

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		conditions. However, the root of the problem might be the allocation of those positions, job duties assigned, and/or accountability issues. In addition, these issues might also be relevant within other SSLC Nursing Departments and should be openly discussed with Facility Administration and the appropriate State Office staff for prompt remediation to ensure individuals are provided the clinical services that they require. When evaluating where clinical resources and staff should be deployed to meet the individuals' clinical needs, the Facility is encouraged to utilize its At-Risk List and data in determining acuity levels for individuals in order to determine the clinical intensity regarding the types and frequency of nursing assessments each individual warrants. The consistent problematic findings found in the nursing documentation reviewed for Section M.1 regarding nursing care for individuals admitted to a community hospital, Section M.2 regarding the nursing assessments, Section M.3 regarding Integrated Health Care Plans, and Section M.5 related to individuals with high-risk health indicators demonstrated that the Facility clearly was not implementing nursing protocols sufficiently to address the health status of the individuals served as required by this provision of the Settlement Agreement. 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 in May 2014, compliance regarding the Facility's At-Risk procedure was 99%, using training records from Competency Training and Development (CTD) Department and the current filled positions reports. The remaining staff that were in need of the required training included new professionals serving on IDTs (three QIDPs), one Psychiatrist, one Residential Coordinator, one RN Case Manager), one Primary Care Provider (PCP) out on extended leave during the initial training, and three Direct Support Professionals out on extended leave during the initial training. These data indicated that the Facility's overall compliance regarding the required training had increased from 86% during the last review to 99% in the last six months. ▪ In addition, the Facility's Self-Assessment indicated that as of 5/15/14, 15 out 16 (94%) RNCM's had attended training regarding the ISP process. The RNCM that had not yet received the training was currently in New Employee Orientation	Noncompliance

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		(NEO) and would be trained once released. ▪ Also, in February 2014, Nursing Assessment training was conducted and a Nursing Assessment/IRRF/IHCP workgroup was established to improve the quality of documents. ▪ The ISP attendance tracking data completed by the ISP Technician for nursing attendance indicated the following compliance percentages for November 2013 through April 2014: 100%, 100%, 95%, 100%, 96%, and 100%, respectively. <u>Self-rating</u> The Facility's Self-Assessment indicated that: "based on this self-assessment, this provision is not in substantial compliance due to processes to ensure quality of risk assessments and integrated interventions are [sic] implemented." Consistent with past reviews, the findings from the Monitoring Team detailed below indicated that although some improvements were noted in some of the documentation reviewed, the supports and related documentation did not adequately address individuals' health/mental clinical health risks in alignment with the requirements of this provision. A review of records for 21 individuals determined to be at risk (i.e., Individual #304, Individual #68, and Individual #269 for aspiration; Individual #322, Individual #288, and Individual #131 for behavioral issues; Individual #181, Individual #225, and Individual #242 for fluid imbalance issues; Individual #223, Individual #161, and Individual #30 for gastrointestinal issues; Individual #293, Individual #317, and Individual #323 for infections; Individual #276, Individual #76, and Individual #136 for weight issues; and Individual #175, Individual #179, and Individual #111 for constipation) found that none (0%) included adequate nursing risk assessments including individual-specific information to clearly justify the risk ratings assigned. However, from a review of these nursing assessments, it was clear the Facility was in the process of improving the documentation contained in the Comprehensive and Quarterly Nursing Reviews. Although not consistently found, improvements included using some of the past quarterly or annual information and providing an update regarding the current status of the health risk indicators. However, considerable more work was needed regarding the analysis of the information. In addition, regarding the Integrated Risk Rating forms, a review of these 21 individuals' records was conducted to assess nursing staff's role in the assessment of the health categories that nursing was responsible for in the Integrated Risk Rating forms. Although the Monitoring Team found that there continued to be 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	

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		constipation, weight issues, cardiac, falls, injuries, and/or fractures, there continued to be a lack of individual-specific information from the previous year that made it difficult to determine the accuracy of the risk rating that was assigned. In addition, a review of the 21 records for these individuals determined to be at risk found there was documentation that the Facility: ▪ Established an appropriate plan within fourteen days of the plan's finalization, for each individual, as appropriate, in one of the cases reviewed (5%) (i.e., Individual #225). Although all 21 individuals (100%) were found to have a care plan addressing their high or medium health/mental risk indicator, only one sufficiently addressed the health risk in accordance with applicable nursing protocols. ▪ Implemented a plan within fourteen days for each individual, as appropriate in one (5%) of the cases reviewed (i.e., Individual #225). The 21 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 for 20 of the 21 reviewed. In addition, a number of the action steps in the 20 IHCPs were nonspecific and thus, could not be verified. ▪ Implemented a plan that met the needs identified by the IDT assessment in one of these cases (5%) (i.e., Individual #225). ▪ Included preventative interventions in the plan to minimize the condition of risk in one of the cases (5%) (i.e., Individual #225). Although some generic interventions were found in some other IHCPs addressing, for example, the need to encourage adequate fluids or 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 one of the cases (5%) (i.e., Individual #225). ▪ Integrated the IHCP into the ISPs in 21 of the 21 cases (100%). ▪ None (0%) of the plans reviewed showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ One of the plans (5%) (i.e., Individual #225) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan. ▪ One of the plans (5 %) consistently included the specific clinical indicators to be monitored (i.e., Individual #225). ▪ The frequency of monitoring was included in the plans for one of the individuals (5%) (i.e., Individual #225). Although the other 20 plans contained a heading addressing "Monitoring Frequency," the frequency was either noted generally as ongoing, daily or weekly without the specific shift or day included to ensure	

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		accountability, or it was not addressed. LBSSLC should continue to focus its efforts on the process of developing specific and clinically appropriate IHCPs. The one IHCP that was found to be in compliance should be used as an example to illustrate for nursing staff how the Nursing Protocols should be used to direct clinical care. The nursing protocols that were found in the other 20 IHCPs were noted to be implemented only in the event of an acute issue related to the high/medium health risk indictor. It was very troubling at this juncture of the Settlement Agreement review process that only one IHCP included clinically appropriate nursing protocols that required nursing staff to conduct regular nursing assessments for high and medium health risks, particularly because the other 20 IHCPs were also for individuals that had already experienced health issues related to their elevated health/mental health risk ratings. 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.	
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 from November 2013 through April 2014, 23 new staff members received medication administration class. Overall, 82 of 82 (100%) nursing staff had completed the medication administration class. Training continued to be provided during Nursing New Employee Orientation. ▪ In addition, the Facility reported that since the last review, RN Unit Mangers conducted 97 medication administration observations, and 96 of 97 (99%) passed. Regarding the one failed medication administration observation, immediate corrective action was taken. ▪ Also, a review of 97 medication ID card audits from November 2013 through April found that all 97 (100%) indicated that medication ID cards were used to identify the individual receiving medications. Re-training of this process was included as an action step in the Facility's Medication Variance Correction Action Plan, including both residential and nursing staff. ▪ Regarding the Medication Safety and Systems Committee Meeting minutes, the Facility indicated that from a review of the minutes of the six meetings that were held since the last review, six out of six (100%) meetings reflected attendance by and collaboration between nursing and pharmacy including the CNE, NOO, RN	Noncompliance

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		Unit Managers, and pharmacists; six out six (100%) meetings reflected that the committee reviewed data and discussed patterns and trends; and six out of six (100%) meetings reflected discussion of documentation. ▪ Beginning in March 2013, any unexplained returned medications were counted as an omission and a variance report completed for each individual involved. The Facility reported that these variances were reviewed monthly and analyzed and tracked on a spreadsheet. In addition, beginning in August 2014, any returned medications were now counted in doses instead of individual units (number of pills) in alignment with the State policy. From November 2013 through April 2014, the Facility reported that 3368 doses of medication had been returned to the pharmacy as unexplained. ▪ In March 2014, an interdisciplinary work group representing Nursing, Quality Assurance, Physicians, Pharmacy, and the Settlement Agreement Coordinator was initiated to review the Facility's medication systems and identify opportunities for improvement. In May 2014, a comprehensive Corrective Action Plan (CAP) was developed, approved, and initiated as a result of several meetings that had been conducted to review key elements of the medication system in need of correction. <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 as systems to provide and ensure all nurses implement assessments and protocols is not yet fully established." From a presentation and from discussions with the Facility staff while the Monitoring Team was on site, the Facility had established a workgroup that developed a very specific and comprehensive CAP addressing the Facility's medication systems with the goal of ultimately reducing the number of medication variances. At the time of the review, the Facility already had held a number of Medication Systems CAP meetings and was in the process of continuing to extensively examine all the medication systems as well as to implement a number of steps contained in the CAP. The Monitoring Team's review of the CAP found it to be a very promising tool. It should provide direction as the Facility works to assess and evaluate the current medication systems to determine strategies and processes necessary to make improvements. Although the development and implementation of the Facility's comprehensive Medication Variance CAP discussed above included positive forward movement, at the time of the review, the Monitoring Team found LBSSLC continued to have significant problematic issues regarding its overall medication administration system as noted below:	

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		▪ Although the Facility was in the process of implementing the Medication Variance CAP, the CNE indicated that previous actions to address medication variances had not been consistently implemented, and thus, had little positive impact regarding the number of unexplained excesses and/or shortages of medications. At the time of the review, the Facility Pharmacist and CNE indicated that it was too soon to determine the impact of the CAP steps that had been implemented. ▪ At the time of the review, the Facility had not begun to consistently identify or any address emerging clinical issues that might have occurred as a result of the unexplained medications being returned to the Pharmacy, such as medications for constipation or seizures, or to determine if there had been any association with physical or chemical restraint use. ▪ As noted in previous reports, although the Facility was spending much time and effort 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. ▪ As noted above, 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 still showed a significant number of unreconciled excess/shortages of medications, the high passing rate regarding the Medication Administration Observations was highly suspect. In addition, the Monitoring Team's observations of medication administration in Sparrow found that until prompted by the Facility observer, one nurse was going to proceed with administering medications without having the Medication Administration Record (MAR) available in order to verify she was administering the right medication and dosage at the right time, to the right Individual, by the right route. This was a substantial deviation from nursing standards of practice. A review of the medication variances (Category A-E) the Facility reported indicated the following (variance data included MAR blanks): ▪ November 2013 - 810 variances (513 returned medications and 243 MAR blanks); ▪ December 2013 - 545 variances (155 returned medications and 355 MAR blanks); ▪ January 2014 – 521 variances (143 returned medications and 350 MAR blanks); ▪ February 2014 – 754 variances (327 returned medications and 404 MAR blanks); ▪ March 2014 - 747 variances (543 returned medications and 203 MAR blanks); and	

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		▪ April 2014 – 672 variances (397 returned medications and 272 MAR blanks). Based on observations of medication administration at Sparrow, the following problematic issues were found. Specifically, the nurse did not: ▪ Until prompted by the Facility observer, initially have the MAR present when preparing to administer medications; ▪ Check the correct position of Individual #258 in a wheelchair, as required by the individual's PNMP; ▪ Assess lung sounds prior to or after administering medications for Individual #258 who had a G-Tube. The nurse reported she had done an assessment on the individual hours earlier and felt that another assessment was not warranted; ▪ Consistently tell the individuals what medication they were receiving; and ▪ Consistently provide instructions for positioning after medication administration to the direct support professionals. However, on a positive note, ID cards were used to identify all the individuals the Monitoring Team observed during medication administration. Since the last review, the Facility clearly had taken additional steps by establishing a workgroup and a Medication Variance CAP in order to extensively review all systems regarding medication administration. It is the hope of the Monitoring Team that the Facility's thorough review and implementation of strategies will result in positive forward movement in addressing some of the problematic elements of LBSSLC's medication administration system. 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, continued collaboration should occur between the Pharmacy, Nursing, and the Medical Departments in constructing a format and structure to critically review the overall medication system. The Monitoring Team found the Facility was not in compliance with this provision. The Facility's finding in its Self-Assessment was consistent with the Monitoring Team's finding.	

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Any policies, procedures and/or other documents addressing the provision of pharmacy services, including for updated policies, highlights of the approved changes; o Any pharmacy surveys completed since the last Monitoring Team visit: plans of correction and/or internal auditing procedures and reports related to pharmacy services; o List of staff who work in the Pharmacy Department, including names, titles, and degrees; o All Drug Utilization Evaluations (DUE) reports completed since last monitoring 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 QDDR, 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 QDDR, 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 #304, Individual #191, Individual #309, Individual #124, Individual #120, Individual #67, Individual #290, Individual #65, Individual #4, Individual #7, Individual #70, Individual #288, Individual #222, Individual #172, and Individual #76; o For five most recent QDRR in which recommendations were made and accepted, copies of physician orders. For 10 most recent QDRR in which recommendations were made and not accepted, copy of IPN or other entry indicating reason for non-agreement, including those for: Individual #22, Individual #75, Individual #320, Individual #73, Individual #239, Individual #251, Individual #108, Individual #10, Individual #267, Individual #255, Individual #83, Individual #320, Individual #264, Individual #25, and Individual #276;

	○ All "single patient intervention reports" in WORx system for the 60 days prior to the Monitoring Team visit; ○ Since the last review, copy of any internal Pharmacy Department audits/monitoring data to review Section N of the Settlement Agreement (i.e., pharmacist review and placement of new orders in WORx system); ○ Copy of "notes extracts" associated with "single patient intervention reports" for the 60 days prior to the Monitoring Team visit; ○ For the past six months, any ADR completed; ○ Any policies and/or procedures regarding medication error/variance, including prescription, dispensing, administration, documentation and potential errors; ○ 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 (i.e., per month, per quarter), and analysis reports, as well as corrective action plans, root cause analysis summaries, etc.; ○ Copies of the last 10 medication error forms completed and any plans of correction arising from review of the medication errors; ○ 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; ○ For the past two months, reports and/or summaries of any medication administration observations conducted; ○ Any policies, procedures and/or other documents addressing medication administration; ○ List of antibiograms per month for last six months by building; ○ Medication history for individuals with J or G/J tubes (not G tubes); ○ A schedule of when QDDR are conducted by residence; ○ All documentation for each emergency chemical restraint, including restraint checklist. Information for the following individuals was submitted: Individual #85 (2/1/14), Individual #288 (3/31/14), Individual #134 (3/29/14 and 4/7/14), and Individual #4 (4/7/14); ○ Any trend analysis of chemical restraint use (i.e., 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 five orders involving drug-drug interactions, copies of serial computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by Pharmacy, or copy of pharmacy label indicating Pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following five individuals: Individual #73, Individual #136, Individual #102, Individual #187, and Individual #45; ○ For five orders involving potential allergic reactions for new orders, copies of serial

	computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by Pharmacy, or copy of pharmacy label indicating Pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following individuals: Individual #197, Individual #114, and Individual #174; o For five orders involving drug dosages below or exceeding normally prescribed dosage regimens, copies of computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by Pharmacy, or copy of pharmacy label indicating Pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following individuals: Individual #33, Individual #227(two new orders), Individual #134, and Individual #116; o For five new orders in which labs were reviewed/monitored, copies of serial computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by Pharmacy, or copy of pharmacy label indicating Pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following individuals: Individual #76, Individual #90, Individual #167, Individual #88, and Individual #3; o For five new orders for in which there was potential for significant side effects, copies of serial computer screen shots for each step, including any written documentation/information provided to the PCP and response of the PCP. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by Pharmacy, or copy of pharmacy label indicating Pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following individuals: Individual #51, Individual #152, Individual #134, Individual #115, and Individual #313; o For the self-assessment process: list of monitoring/audit tools used and for each tool, identification of the total number of the eligible population to be sampled, the sample size, clarification how the sample was chosen, the frequency of data collection, the staff that completed the audit/monitor survey/review, and whether any inter-rater reliability data was obtained/analyzed for the audit/monitoring review; o For the self-assessment process: list of databases utilized (other than audit information), including title of each database/chart/table with date range of each database. When the data was collected periodically rather than continuously, the frequency of data collection

	was requested; and o Presentation Book for Section N. ▪ **Interviews with**: o John Todd, RPh, Clinical Pharmacist.
	Facility Self-Assessment: For Section N, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: new order processing audit, QDRR reviews, and chemical restraint review. o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. o The monitoring tools included adequate methodologies, such as record reviews, QDRR reviews, and chemical restraint form review. o The Self-Assessment identified the sample 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: pharmacy staff. o Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools. ▪ The Facility used other relevant data sources and/or key indicators/outcome measures to show whether or not the intended outcomes of the Settlement Agreement were being reached, such as tracking timely completion of QDRRs. The quality of the data maintained in the databases was noted to be complete and accurate. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Consistently measured the quality as well as presence of items. o Distinguished data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with Section 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 an analysis of the information, identifying for example the need to define the reason for unexplained return of medication. The following provides some specific information about self-assessment activities: <u>Section N.1</u> The Pharmacy Department completed an internal QA review of the new order process. Instructions for

	Monitoring Section N.1 provided guidance for interpretation of the audit tool. Each month a 100% review was completed using a new order monitoring tool which included the following areas: drug interaction interventions, allergy/disease state contraindications, laboratory interventions, therapeutic consultations (dose range alerts), side effect notifications, and other interventions. From November 2013 through April 2014, there was 100 percent compliance in each of these areas. One hundred seventeen interventions were reviewed during this time period. The Pharmacy Department and QA Nurse met on 1/22/14, 2/20/14, 3/18/14, 4/17/14, 5/12/14, and 6/20/14. For Section N.1, the QA nurse completed a 20 percent sample of potential drug interaction alerts from the prior month for each meeting. Results indicated 100 percent compliance for November 2013, January 2014, February 2014, and March 2014. Results of the December 2013 and April 2014 review were not listed in the Pharmacy/QA meeting minutes. For May 2014, compliance was less than 100 percent (actual percentage not recorded) due to lack of filing of documentation in the active record. Inter-rater reliability was 100 percent for November 2013, December 2013, January 2014, February 2014, March 2014, and April 2014. Inter-rater reliability was not reported for May 2014 in the Pharmacy/QA meeting minutes. <u>Sections N.2, N.3, and N4</u> For Sections N.2 and N.3, the QA nurse reviewed the QDRRs from a randomly selected residence that had a QDRR completed the same month as the review (i.e., "real time" audit). The QA Nurse reviewed ten QDRRs each month from one residence. The residence was then removed from the list until each residence was reviewed. Written monitoring instructions for the audit tools for Sections N.2 and N.3 had been developed. A list of required components to be addressed by the Clinical Pharmacist was reviewed for each QDRR in the sample. Clinical indicators reviewed the following areas: indication for psychotropic drug use, whether the individual was prescribed an atypical/new generation antipsychotic medication, laboratory monitoring for any atypical/new generation antipsychotic medication prescribed, serum drug levels monitored for applicable medications, clinical justification and side effects of benzodiazepines if applicable, presence and justification of polypharmacy, anticholinergic side effects and clinical justification documentation, and whether abnormal lab results were noted. For chemical restraints, a document entitled "Behavioral chemical restraint monitoring instructions" provided guidance in completing the audit tool for this clinical area, with guidance for determining the completeness of the Pharmacist review. A separate monitoring tool reviewed the timeliness of completion of the Pharmacist and Psychiatrists' reviews. These two audit tools were completed monthly when an emergency chemical restraint occurred. For emergency chemical restraints from November 2013 through April 2014, there was 100 percent compliance for all clinical indicators from both monitoring tools. For Section N.4, all QDRRs were reviewed to determine timeliness of pharmacy review, PCP and psychiatry signature on each QDRR, as well as timeliness of PCP and psychiatry completion if applicable. A document

	entitled: "Provision N.4 Monitoring Instructions" provided a standardized approach in reviewing this information from each QDRR, as well as providing instructions on routing the QDRRs for completion by the PCP and psychiatrist, as well as steps in documenting return of the signed QDRR back to the pharmacy with follow-up of recommendations if indicated. For Section N.4, the QA nurse reviewed a 20 percent sample of QDRRs from five residences monthly. The QDRRs reviewed were completed two months prior to the QA nurse audit. The Pharmacy Department and QA nurse met on 1/22/14, 2/20/14, 3/18/14, 4/17/14, 5/12/14, and 6/20/14. According to the Facility's data, results indicated 100 percent compliance for November 2013, January 2014, February 2014, and March 2014, and May 2014. Results of the December 2013 and April 2014 review were not listed in the Pharmacy/QA meeting minutes.
	Summary of Monitor's Assessment: The Pharmacy continued to demonstrate an effective system of processing new orders. QDDRs were timely and appeared thorough. Adverse drug reaction training was up-to-date. There was a thorough internal QI system to review the results of the new order process, the components of the quarterly drug regimen reviews, the timely response by the PCPs and psychiatrists to the recommendations, as well as the pharmacy review of chemical restraints. Medication variances remained a challenge. It was recently discovered that the data reports generated actual individual medications involved in variances rather than tracking them as events. However, information could be gained from both these approaches to database management. The Pharmacy indicated that for most returned medications, they were able to determine the individual for whom the medication was dispensed, so that there were few "unknown" excess medications returned (i.e., unknown referring to the inability to determine which individual missed the medication). However, the reason for most returned medications remained unexplained and the challenge continued of determining why the individual did not receive the medication (e.g., individual on furlough, refused medication, omitted medication, etc.). The reason remained a challenge. Since the Monitoring Team's previous visit, an extensive corrective action plan had been implemented. The Facility was in substantial compliance in Sections N.1, N.2, N.3, N.4, N.5, N.6, and N.7. 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	The Pharmacy Department staffing included the following: Five registered pharmacists (i.e., Pharmacy Director, Clinical Pharmacist, a Pharm D, and two staff Pharmacists) and one RPhT (Registered Pharmacy Technician). The Pharmacy Department indicated there were no medication administration or medication variance guidelines, policies, or procedures that had been newly implemented or updated since the Monitoring Team's previous visit.	Substantial Compliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>"Patient intervention" entries for new orders entered into the WORx software program were submitted for review. Interventions were broken down into several different categories. The Pharmacy Department provided guidance on the appropriate categorization in a document entitled: "WORx Intervention Category Guide: Guide to Proper Categorization of Interventions." The following categories and numbers of patient interventions for each category follows, per month:

<table>
<tr><th>Category of intervention</th><th>April 2013</th><th>May 2013</th><th>June 2013</th><th>Total</th></tr>
<tr><td>Medication monitoring</td><td>10</td><td>5</td><td>0</td><td>15</td></tr>
<tr><td>Drug interaction identified</td><td>6</td><td>11</td><td>6</td><td>23</td></tr>
<tr><td>Allergy/adverse drug effect ID or prevented</td><td>0</td><td>3</td><td>1</td><td>4</td></tr>
<tr><td>Not recorded</td><td>0</td><td>1</td><td>0</td><td>1</td></tr>
<tr><td>Total per month</td><td>16</td><td>20</td><td>7</td><td>43</td></tr>
</table>

A sample of 23 new prescriptions was reviewed. The following summarize the results:
▪ Five new orders were submitted in which the Pharmacy found concerns with drug-drug interactions with the current drug regimen. A copy of the order was submitted in five of five (100%). A computer screen shot of the order process, label, or MAR was submitted for five of five (100%). For five of five (100%), a copy of the patient intervention form was submitted. A PCP communication form was submitted in five of five. A handout was provided to the PCP in three of five. A change in the order occurred in two of five orders, and no change in three of five orders. Evidence indicated compliance in five of five (100%) orders.
▪ Three new orders were submitted in which allergies were reviewed and determined by Pharmacy as a concern (from November 2013 through April 2014). A copy of the order was submitted in three of three (100%). A computer screen shot of the order process, label, or MAR was submitted for three of three (100%). For three of three (100%), a copy of the patient intervention form was submitted. A change in the order occurred in two orders, and no change in one order. A copy of the PCP communication form was submitted in three of three. Evidence indicated compliance in three of three (100%) orders.
▪ Five new orders were submitted in which significant side effects were reviewed by Pharmacy and determined to be a concern. A copy of the order was submitted in five of five (100%). A computer screen shot of the order process, label, or MAR was submitted for five of five (100%). For five of five (100%), a copy of the patient intervention form was submitted. A handout was provided to the PCP in five of five. A change in the order occurred in zero orders. A PCP communication form was submitted in five of five. Evidence indicated compliance in five of five (100%)</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		orders. ▪ Five new orders were submitted in which **current laboratory results and potential need for further testing** were identified by pharmacy during initial review. A copy of the order was submitted in five of five (100%). A computer screen shot of the order process, label, or MAR was submitted for five of five (100%). For five of five (100%), a copy of the patient intervention form was submitted. Evidence of an order for a follow-up test was submitted in five of five. Evidence indicated compliance in five of five orders (100%). ▪ Five new orders were submitted in which Pharmacy had concerns about the potential need for **dosage adjustments**. A copy of the order was submitted in five of five (100%). A computer screen shot of the order process, label, or MAR was submitted for five of five (100%). For five of five (100%), a copy of the patient intervention form was submitted. A handout was provided to the PCP in one of five. A PCP communication form was submitted in five of five. A change in the order occurred in zero orders. Evidence indicated compliance in five of five (100%) orders. In summary, there was adequate documentation of the new order process in 23 of 23 (100%) submitted new orders. The Facility remained in substantial compliance with this provision.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. A schedule of QDRRs to be completed for each residence was submitted. This listed the month each residence was to have QDRRs completed for the year. Each residence was scheduled for QDRRs every three months. A schedule of completed QDRRs was submitted for the prior 12 months (i.e., June 2013 through May 2014). Each of the prior QDRRs was reviewed for date of completion and compared to the current QDRR date of completion. For the time period of March through May 2014, for the 218 QDRRs due during this time period, 218 were completed in a timely manner. For the prior quarter of December 2013 through February 2014 for the 218 QDRRs due during this time period, 217 were completed in a timely manner. There was one individual with a QDRR completed 11/20/13, and the following QDRR was 3/26/14 (126 days apart). This exceeded the agreed upon time period based upon a due date of 90 days after the prior QDRR, with additional parameters established as a time period of seven days prior to the due date through 13 days after the due date. Compliance was 99.8 percent (435/436).	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		A sample of 15 QDRRs was reviewed. These are listed above in the documents reviewed section. The following summarizes the results of this review: ▪ Laboratory information was submitted as part of 15 (100%) QDRRs. o The lab results did include exact values or indication of normal range for Vitamin D levels, complete blood counts (CBC), electrolytes, glucose, Hemoglobin (Hgb) A1C, lipid panel, hepatic function, ammonia level, thyroid function, as well as blood levels of specific medications (most commonly noted were antiepileptic drug levels with therapeutic ranges), as appropriate to the medication regimen of the individual. ▪ 15 of 15 (100%) QDRRs included the date the lab was drawn. ▪ Abnormal values were listed under the notes/comments section line for that particular lab. ▪ The lab testing that was completed, and the frequency with which laboratory testing was completed indicated the PCPs generally were providing appropriate lab monitoring of medication side effects, adverse effects, and therapeutic drug levels.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	This provision of the Settlement Agreement encompasses a number of requirements. Each of them is discussed below, including the Pharmacy and Medical Departments' roles in addressing the use of "Stat" medications and chemical restraints, as well as benzodiazepines, anticholinergics, polypharmacy, and monitoring the metabolic and endocrine risks associated with second generation antipsychotics. <u>"Stat" Emergency Medications/Chemical Restraint Use</u> The Facility submitted completed Restraint Checklist and Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint forms for five chemical restraints used from January to April 2014 were reviewed. These are listed above in the documents reviewed section. The chemical restraint documentation indicated that four individuals had five chemical restraints from December 2013 through April 2014. For the five chemical restraints, the pharmacy sections were reviewed for adequacy of completion and compliance. The following summarizes the review of these documents: ▪ Of the five chemical restraint forms, five (100%) included information concerning the justification of use due to the behavior. ▪ Effectiveness of the chemical restraint was documented in five of five (100%) chemical restraint forms completed. ▪ Side effects/ adverse effects/drug interactions were noted in five of five (100%) completed chemical restraint forms. ▪ There were no statements that were considered recommendations. ▪ The range of time from the administration of the emergency chemical restraint to completion of the pharmacy section of the forms varied from three to four days. <u>The following information provided a review of the data to determine timeliness of review</u>	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		(i.e., within 14 days) by the Pharmacy Department:	

Month	Number of Chemical Restraints	Number of Chemical Restraints Reviewed	Number of Reviews Completed in Seven Days	Number of Reviews Completed > Seven Days	Percent Compliance
December 2013	0	NA	NA	NA	NA
January 2014	0	NA	NA	NA	NA
February 2014	1	1	1	0	100%
March 2014	2	2	2	0	100%
April 2014	2	2	2	0	100%
Total	5	5	5	0	100%

As noted with regard to Section J.3, the Chemical Restraint Clinical Review Form was completed for all five (100%) individuals in a timely manner (i.e., within 10 days). Each of the five Clinical Review Forms contained comments from the Pharmacist and Psychiatrist related to 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 10 pages of specific, detailed information related to the incident, as described above. Both the Pharmacy and Psychiatric Reviews contained significantly more detailed information than those found in prior reviews.

<u>Polypharmacy</u>
Of the 15 QDRRs reviewed, polypharmacy was noted in 14 reviews.

- Justification by diagnosis of each of the medications listed in the polypharmacy regimen was documented in 14 of 14 (100%).
- Clinical justification for the use of polypharmacy was addressed in 14 of 14 (100%).
- Potential interactions with other drugs or side effect risk were reviewed in 14 of 14 (100%).
- For 14 of 14 (100%), the QDRRs reviewed whether monitoring/evaluation had occurred of effectiveness and appropriateness of the drug regimen.

<u>Benzodiazepine Use</u>
Benzodiazepine use was noted in seven of the 15 QDRRs.

- Of these, seven of seven (100%) documented justification with appropriate diagnoses.
- Seven of seven (100%) indicated whether side effects or other adverse risks were

#	Provision	Assessment of Status	Compliance
		present. Anticholinergic Monitoring Of the 15 QDRRs, 15 (100%) were screened for medications associated with potential significant anticholinergic side effects. Three QDRRs identified anticholinergic medications. The results of the review of the QDRRs are as follows: ▪ The anticholinergic section of the QDRR was completed in three of three (100%) of cases with this medication prescribed; ▪ Three of three (100%) documented clinical justification of the use of each of the medications contributing to anticholinergic load/effect, (i.e., the clinical burden of the side effects was less than the benefit). ▪ Three of three (100%) QDRRs listed/addressed side effects/significant risks. New Generation Antipsychotic Endocrine and Metabolic Side Effects Out of the 15 QDRRs reviewed, eight had atypical antipsychotic medication listed. Eight of eight (100%) included lab values that reviewed endocrine and metabolic risks (i.e., BMP, glucose level, Hgb A1C, and/or lipid panel as appropriate). The Facility remained in substantial compliance with this subsection.	
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 conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. Review of 15 QDRRs showed the following: ▪ Of the 15, 15 (100%) had the PCP signature. ▪ Of the 15, 15 (100%) had the date the PCP reviewed the document. ▪ Of the 15, 15 (100%) were reviewed by the PCP within 14 days of completion. ▪ Recommendations were clear and helpful in 15 of 15 QDRRs. ▪ Evidence of PCP review of recommendations and agreement or disagreement with justification and plan was documented in 15 of 15 (100%). ▪ Psychiatry reviewed the QDRR when psychotropic medication was prescribed. A Psychiatrist reviewed 10 of 15 QDRRs. ▪ The Psychiatrist responded within 14 days of the QDRR being completed by Pharmacy in 10 of 10 QDRRs (100%). To determine if the recommendations that were agreed upon were actually acted upon, the Facility submitted five active records in which recommendations were made on the QDRR. These are listed above in the documents reviewed section. In the sample of five, five (100%) demonstrated that the PCP/Psychiatrist acted upon the recommendation with follow-up orders.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The Facility submitted 10 active records in which recommendations from the QDRR were not followed, which are listed in the documents reviewed section. In 10 of 10 cases (100%), the response, rationale, and plan were written on the QDRR. It was noted that three of the 10 were from March 2014, and seven of the 10 were from November 2013 (i.e., prior to the Monitoring Team's previous review).	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	This provision of the Settlement Agreement requires systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication, with the DISCUS and the monitoring of more general systemic side effects related to psychotropic medication with the MOSES every six months (per the Healthcare Guidelines). Another component of this review was also the latency between the time that the Nurse completed the evaluation and the prescribing practitioner reviewed and signed the documentation. The nursing staff performed the MOSES evaluations. The staff Psychiatrists performed the DISCUS evaluations on the individuals they followed in conjunction with the Quarterly Psychiatric Reviews. The review of the sample of the records of 19 individuals prescribed psychotropic medication indicated the MOSES evaluations were current (i.e., completed within the last six months), and had been performed every six months for all 19 (100%) individuals. The review of these documents during the current review indicated the Facility performed the MOSES on all individuals for whom they were required in the months of January and July. This schedule 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 reviewed the MOSES evaluation in a timely manner (i.e., within 14 calendar days) for 12 (63%) of these individuals. The data related to the seven individuals for whom there had been a delay, is as follows: MOSES EVALUATION Intervals Between Evaluation and Review by Prescriber	Substantial Compliance

#	Provision	Assessment of Status	Compliance

INDIVIDUAL #	EVALUATION DATE	DATE REVIEWED BY PRESCRIBER	INTERVAL BETWEEN EVALUATION AND PRESCRIBER SIGNATURE (# DAYS GREATER THAN THE 14 ALLOTTED)
Individual #82	1/14/14	2/4/14	21 (7)
Individual #114	1/23/14	2/22/14	30 (16)
Individual #68	1/17/14	2/4/14	18 (4)
Individual #266	2/12/14	Prescriber signed, but not dated	
Individual #202	2/12/14	Prescriber signed, but not dated	
Individual #33	1/22/14	2/12/14	21 (7)
Individual #137	1/23/14	2/21/14	29 (14)

The average number of days that exceeded the 14 days allotted was 9.6, with a range of four to 16.

The purpose of the DISCUS is to detect the emergence of motor side effects related to the use of antipsychotic medication. The review of the records of the sample of 19 individuals indicated the DISCUS was current, and had been performed quarterly for the past year for all (100%) of the individuals. The review of the DISCUS evaluations with regard to the interval between the evaluation and the review by the prescriber had been completed in less than 14 days for 18 of the 19 (95%) individuals. The exception was Individual #68, for whom there was an interval of 20 days between the 11/26/13 evaluation and the 12/16/13 review by the prescriber. The requirement that the DISCUS be reviewed and signed by the prescriber is now moot, because the prescribing Psychiatrists began performing the DISCUS evaluation themselves within the last three months. These evaluations were performed in conjunction with the individual's Quarterly Psychiatric Review, as the Psychiatrist evaluates each individual as part of the Quarterly Review process.

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 similar to those of antipsychotic agents. The Psychiatrist currently performed the DISCUS for those individuals prescribed Reglan, and the Nurse Case Manager performed the MOSES evaluations. Historically, the Psychiatric Nurse had performed the DISCUS evaluations for these individuals. A list was obtained from the

#	Provision	Assessment of Status	Compliance
		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 #199, Individual #135, Individual #176, and Individual #312. Review of the records of these individuals indicated that the MOSES evaluations had been performed as required for four of the five (80%) individuals. The exception was Individual #323, where there was a gap between the 7/8/13 and 5/8/14 evaluations. All of the evaluations had been reviewed in a timely manner for four of the five (80%) individuals. The exception was the 1/22/14 evaluation for Individual #312, for whom there was a gap of greater than 14 days until the review on 2/25/14. The Psychiatrist also performed the DISCUS for individuals prescribed Reglan. These evaluations were performed in conjunction with the Quarterly Psychiatric Reviews, even though they were not actually followed by the Psychiatrist. These evaluations were performed in the individual's residence when the Psychiatrist was performing the Quarterly Reviews for the individuals prescribed psychotropic medications. 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 all (100%) five individuals in the sample. In summary, the current review found that for the sample of 19 individuals: ▪ The MOSES evaluations were completed every six months, as required by the Settlement Agreement for 100 percent of the individuals in the sample; ▪ There was a delay in the prescriber review of the MOSES evaluation of greater than 14 days for five individuals, with an average of an additional 9.6 days beyond the allotted 14 days (range = four to 16 days). In addition, the second signature page was signed, but not dated, for an additional two individuals. A timely review was noted for 12 of the 19 individuals in the sample (63%) ▪ The DISCUS evaluations were completed every three months, as specified in the Settlement Agreement for 100 percent of the individuals in the sample; ▪ There was a delay in the review of the DISCUS for one individual that occurred in November 2013, which would indicate a completion range of 95 percent (18 of 19) for the last 12 months. As noted above, the Psychiatrists had begun to perform the DISCUS evaluations themselves, which will eliminate any delay between the performance of the evaluation and the review by the prescriber; ▪ The MOSES evaluations had been performed as required by the Settlement Agreement for four of the five (80%) individuals in the sample of individuals	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>receiving Reglan;
▪ The MOSES evaluation had been reviewed in a timely manner for four of the five (80%) individuals in the sample of individuals prescribed Reglan;
▪ The DISCUS evaluation had been performed quarterly for all five (100%) of the individuals in the sample;
▪ The DISCUS evaluations had been reviewed in a timely manner for all five (100%) of the individuals in the Reglan sample. The Psychiatrists also had begun to perform the DISCUS evaluations for those individuals prescribed Reglan.

The finding of substantial compliance was carried forward from the prior review, due to the 100 percent completion rate of both the MOSES and the DISCUS for those individuals in the sample of 19 individuals prescribed psychotropic medications. However, deficits were noted in the timely review of the January 2014 MOSES evaluations. The next six-month assessment of the MOSES for these individuals would be scheduled to occur in July 2014, and, thus, were not available at the time of the Monitoring Team's review. To maintain the substantial compliance rating in the next review, the Facility will need to implement mechanisms to ensure the timely review of the MOSES evaluations in the future.</td><td></td></tr>
<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 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.

According to the "Course Participation Report" from 11/1/13 to 4/23/14 for the in-service "Observing and Reporting Clinical Indicators of Health Status," 88 new employees completed ADR training since the Monitoring Team's last visit. As of 6/2/14, a total of 571 employees currently on the payroll had received mandatory training, according to the "Active Employee Course Participation Report." This training for new employees started in August 2011.

The nurse educator provided additional training to new nurses in a course entitled: "Adverse Drug Reaction Recognition and Reporting." The course materials included the "LbSSLC – Health Services policy: Adverse Drug Reaction Reporting," the "Adverse Drug Reaction Reporting Form," and a third document entitled: "Adverse Drug Reaction Reporting." The following indicates the number of newly employed nurses (including agency nurses) provided training each month:

<table>
<tr><th>Month</th><th>Number of Nurses Completing Training</th><th>Month</th><th>Number of Nurses Completing Training</th></tr>
<tr><td>January 2014</td><td>2</td><td>April 2014</td><td>1</td></tr>
<tr><td>February 2014</td><td>6</td><td>May 2014</td><td>3</td></tr>
<tr><td>March 2014</td><td>3</td><td>June 2014</td><td>5</td></tr>
</table>
</td><td>Substantial Compliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
The Pharmacy Department indicated refresher training had been completed in ADRs for the following:
<table>
<tr><th>Department</th><th>Number of Staff in Department</th><th>Number Completing Refresher Training</th><th>Percent Completing Refresher Training</th></tr>
<tr><td>Medical/Clinic staff</td><td>9</td><td>9</td><td>100%</td></tr>
<tr><td>Pharmacy</td><td>5</td><td>5</td><td>100%</td></tr>
<tr><td>Dental</td><td>1</td><td>1</td><td>100%</td></tr>
</table>
Training rosters were provided as evidence of in-service completion.

There were 77 nurses on the employee roster for June 2014. Ninety-six percent (74/77) had completed training either through the refresher course or new employee orientation. Training rosters were provided as evidence of in-service completion. The training rosters included Facility nursing, agency nursing, as well as duplicate names. The signatures for May 2014 totaled 77, and for June 2014 totaled 28, for a total of 105 signatures.

The Pharmacy Department indicated that there had been no adverse drug reactions reported/identified in the prior six months from the scan date of 6/4/14. The following table represents data extracted from the ADR reports submitted:
<table>
<tr><th>Date</th><th>Medication</th><th>Reaction</th><th>Date Notified Pharmacy</th><th>Naranjo ADR Probability Scale</th><th>ADR Reported to Med Watch</th><th>Added to Allergy Profile/Drug Alert</th></tr>
<tr><td>Not applicable</td><td>Not applicable</td><td>None reported</td><td>Not applicable</td><td>Not applicable</td><td>Not applicable</td><td>Not applicable</td></tr>
</table>
The Facility remained in substantial compliance with this provision.
</td><td></td></tr>
<tr><td>N7</td><td>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</td><td>A calendar was submitted for the fiscal years 2013 to 2015 indicating the medications to be included in drug utilization reviews. Since the Monitoring Team's last visit as well as for the remainder of 2014, these included the following:
▪ March 2014 – ACE inhibitors;
▪ June 2014 – Haloperidol;
▪ September 2014 – Phenobarbital; and
▪ December 2014 – Proton Pump Inhibitors.</td><td>Substantial Compliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>The P&T Committee meeting of 7/9/14 added additional studies to be done in 2015:
▪ March 2015 - Phenytoin; and
▪ June 2015 – Levetiracetam.

During the prior six months, two DUE studies were completed. Information concerning the DUE for ACE inhibitors was presented at the May 6, 2014 P&T Committee. Fifteen individuals (i.e., 58% sample of all those on this class of medication) were reviewed. Additionally, all five individuals with the demographic description of black race were reviewed for control and effectiveness of therapy. It was determined that two of the five were prescribed an ACE inhibitor for renal protection and not hypertension. For three of the five for which an ACE inhibitor was prescribed for hypertension, the hypertension was considered “well controlled.” For the DUE involving a review of 15 individuals on ACE inhibitors, for the three areas reviewed (i.e., indications for use – labeled and unlabeled, contraindications for use, and precautions/warnings warranting monitoring), compliance was 100 percent.

Information concerning the DUE for Haloperidol was presented at the July 9, 2014 P&T Committee. Fifteen individuals (100% sample) were reviewed. All 15 were on oral doses and not injection. Three areas were reviewed (i.e., indications for use - labeled and unlabeled, contraindications/relative contraindications for use, and precautions/warnings warranting monitoring). Compliance was 100 percent in these three areas.

No follow-up studies to prior Drug Utilization Reviews were indicated.

The Facility remained in substantial compliance with this provision.</td><td></td></tr>
<tr><td>N8</td><td>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.</td><td><u>Committee Monitoring of Medication Errors/Variances</u>
The development, progress, and tracking of a medication variance 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 2/19/14, 3/19/14, 4/16/14, and 5/21/14. This committee also met during the week of the Monitoring Team’s onsite visit. Since the last Monitoring Team’s last visit, the Pharmacy and Therapeutics Committee met on May 6, 2014. This Committee also met July 9, 2014, during the Monitoring Team’s onsite visit. The following describes some of the findings of these committees.

The number of medication variances per department were provided per month:
<table><tr><th>Month</th><th>Pharmacy Department</th><th>Nursing Department</th><th>Medical Department</th><th>Dental Department</th><th>Total</th></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

November 2013	49	761	0	Not submitted	810
December 2013	26	519	0	Not submitted	545
January 2014	28	493	0	Not submitted	521
February 2014	22	732	0	Not submitted	754
March 2014	0	747	0	Not submitted	747
April 2014	2	670	0	Not submitted	672
May 2014	3	277 (143)*	0	Not submitted	280

*The Pharmacy Department recently determined that the computation of medication variances previously reported was based on the number of medications rather than the number of events of medication variance. The Pharmacy Department interpreted the latter to be consistent with State Office guidelines. The number in parentheses represents the amended computation indicating the number of medication variance events. Although the number of events of medication variances would be essential in assisting the Nursing Department in reviewing root causes of such events, tracking the numbers of individual medications missed (for events in which several medications were missed) would provide information important to the clinical care of the individual. This could lead to further clinical questions, such as whether a seizure occurred when a seizure medication was missed, or whether the individual retained fluid or had worsening heart failure when a diuretic was missed. Tracking of both numbers of events and numbers of medications/types of medication would have potential to benefit to the Facility. In addition, some medication errors are most appropriately counted per medication as opposed to dose. More work was needed to determine which types of errors should be counted using which methodology to ensure appropriate clinical follow-up, as well as analysis of data.

The Pharmacy provided the Avatar monthly counts of medication variances in table format, comparing the number of non-pharmacy medication variances according to the prior system used in database management and the revised system. The following lists the most recent months of data for which this information was provided:

Month	Previous Number of Avatar Non-Pharmacy Medication Variances	Revised Number of Avatar Non-Pharmacy Medication Variances
November 2013	747	387
December 2013	738	313

#	Provision	Assessment of Status	Compliance

January 2014	495	229
February 2014	519	260
March 2014	751	363
April 2014	778	393
May 2014	278	144

The number of medication variances per month were categorized:

Month	Category A	Category B	Category C	Category D	Category E
November 2013	291	1	517	1	0
December 2013	380	2	160	3	0
January 2014	376	0	145	0	0
February 2014	424	0	329	1	0
March 2014	203	0	544	0	0
April 2014	274	0	398	0	0
May 2014	54*	1*	89*	2*	0

*These numbers reflect the revised information consistent with the Pharmacy Department's interpretation of State Office guidelines.

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

Month	Excess Unknown/Unexplained Returns (Doses)	MAR Not Initialed	Medication Not Given – Unexplained Returned Medication
November 2013	749	243	513
December 2013	186	355	155
January 2014	86	350	143
February 2014	624	404	327
March	912	203	543

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2014			
April 2014	811	272	397
May 2014	275	94	181

Documentation of reasons for returned medications remained a challenge. The Pharmacy Department indicated they were able to track the returned medication to the individual for which it was prescribed. However, there continued to be a large number of medications for which an explanation of the return was not explained. Based in part on the continued number of medication variances at LBSSLC, the Facility developed a "Medication Systems Corrective Action Plan." This required participation and cooperation from several clinical departments. This was a multi-page document with several issues/recommendations for reduction of unexplained medication return, reduction of MAR blanks, production of reliable medication variance data, improvement in consistency of nursing assignments in the homes, reduction of treatments administered during medication administration, increased nursing knowledge of location of items in the medication rooms, and an improved 90-day medication review process. A questionnaire was developed and was to be completed by the medication nurses, with anonymous return to assist in determining the root cause(s) of the medication variances. This was not successful (i.e., only six of 30 returned). The results of the six did reflect the committee's identified problem list (i.e., which identified problems, possible causes, and possible solutions). A total of 54 action steps were defined, along with responsible person, timeframe for completion and evidence used to determine completion of the step. Thirty-four of these steps were to be completed at the time of the Monitoring Team's visit. The submitted Corrective Action Plan chart indicated 31 had been completed (date of update was not indicated). The following action steps are provided as examples: evaluating the possibility of limiting access by locking the medication cart by shift to ensure nurses had access only to their shift of medication; an expanded 24-hour nurse-to-nurse report, which included missed medications/medication pass issues/missing forms/scheduled in town appointments/supply needs (updated 5/30/14, implemented 6/13/14); re-evaluating individual preferences for medication administration to reduce medication refusals; re-evaluating the need for each medication to reduce the number of medications prescribed and administered that were no longer justified (i.e., a 90-day medication review process by the nursing staff, including review of medication effectiveness, and refusal of medications); steps to improve data entry (i.e., identification of staff for this task and training of staff for this task); and evaluating standardization of the set-up of medication rooms to improve familiarity.

As the QA/QI Council recently approved the CAP on 5/15/14, the impact of this CAP remained undetermined. However, several steps were defined with potential for significant

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		impact in reducing medication variances. Additional Pharmacy Monitoring Processes The Pharmacy Department also developed and implemented an internal tracking system for medication variances occurring in the Pharmacy Department. Summary data was provided for November 2013 through May 2014 (except March 2014). The following table reflects selected contents of these monthly reviews:	

Month	Number of Category A Medication Variances	Number of Category B Medication Variances
November 2013	48	1
December 2013	25	1
January 2014	24	0
February 2014	20	0
March 2014	No report generated	No report generated
April 2014	2	0
May 2014	2	0

Medication Room and Cart Inspections by Nursing Department
Medication Rooms and cart inspections were conducted monthly. The number of medication rooms reviewed per month, and those found not in compliance, were noted as follows:

Month	Number of Residences	Number of Residence Inspections	Number and Percent Compliant
November 2013	15	14	8/14 (57%)
December 2013	15	14	7/14 (50%)
January 2014	15	14	8/14 (57%)
February 2014	15	15	5/15 (33%)
March 2014	15	14	7/14 (50%)*
April 2014	15	15	10/15 (67%)
May 2014	15	14	12/14 (86%)

*The April 2014 Medication Safety and Systems Committee minutes indicated 8/14, but the attached chart to the minutes indicated 7/14.

Pharmacy Spot Check Medication Accountability Audits
The Pharmacy Department completed a monthly audit for medication accountability in the residences. A "spot check" was completed on five residences per month. Data was submitted for January 2014 through May 2014. An average of three to four records were checked per residence, with a review to determine discrepancies in medication counts

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and/or in charting. Compliance rates per home per month varied from 0 to 100 percent.

Month	Number of Residences	Total Census of Residences	Number Reviewed	Percent Reviewed	Number Compliant	Percent Compliance
January 2014	5	66	15	23%	5	33%
February 2014	5	70	18	26%	9	50%
March 2014	5	73	18	25%	10	56%
April 2014	5	64	17	27%	10	59%
May 2014	5	70	15	21%	12	80%

Medication Error Reports

Copies of the 10 most recent medication error forms were submitted for review. The Monitoring Team member reviewed and classified the medication variances according to the State Office policy/guideline. There were eight Class A medication errors, zero Class B medication errors, two Class C medication errors, and zero Class D medication errors. Thirteen different medications were involved in these 10 medication variances. The Monitoring Team member disagreed with the Nursing Department's categorization for one medication error. Follow-up of the errors was documented in zero of 10 errors. Evidence of follow-up was lacking in all submitted forms.

Medication Observation Monitoring

Medication administration observations were completed monthly during medication passes. The submitted documentation indicated the number of observations per month, and the number/percent passing the observation.

Month	Total Number of Observations	Number Passed	Percent Passed
January 2014	18	18	100%
February 2014	19	19	100%
March 2014	8	8	100%
April 2014	13	13	100%
May 2014	12	12	100%

Given the ongoing number of medication variances, it was likely that these observations

#	Provision	Assessment of Status	Compliance
		were not effectively capturing issues with nursing practice. In summary, an ambitious CAP has been implemented to assist in decreasing medication variances. Continued trending of data will determine the impact of the CAP. Changing the parameters to be measured (medications versus events) might make it difficult to determine trends unless prior information is corrected retrospectively to provide consistency in data reporting. In addition, the methodology for counting variances by dose required further refinement. The number of Category D medication variances needed further review. The Facility needed to continue its efforts to determine the reason for unexplained returned medications, along with implementation of systems to prevent reasons that are identified.	

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 #252, Individual #71, Individual #134, Individual #116, Individual #183, Individual #167, Individual #171, Individual #68, Individual #181, Individual #321, Individual #283, Individual #196, Individual #62, Individual #223, and Individual #105): 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 four individuals in Sample O.2 (i.e., Individual #165, Individual #313, Individual #30, and Individual #53) on the PNMT caseload who were assessed or reviewed in the last six months and one individual who was discharged from the PNMT (i.e., Individual #284): 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 eight individuals in Sample O.3 (i.e., Individual #223, Individual #283, Individual #76, Individual #171, Individual #321, Individual #181, Individual #196, and Individual #62): 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 ISPAs 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 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;

	○ List of individuals for whom PNM monitoring tools were completed during last quarter; ○ Tools utilized for validation of competency of staff responsible for PNM monitoring; ○ Inter-Rater Reliability Scores; ○ Dining Plan (template) with changes; ○ PNM and PNMT-related database reports, and spreadsheets generated by Facility; ○ List of individuals on modified/thickened liquids; ○ List of individuals who require mealtime assistance; ○ List of individuals who receive nutrition through non-oral methods; ○ List of individuals whose diets have been downgraded or changed to a modified texture or consistency; ○ List of individuals with Body Mass Index (BMI) equal to or greater than 30; ○ List of individuals with BMI equal to or less than 20; ○ List of individuals who have had an unplanned weight loss of 10 percent or greater over a six-month period; ○ List of individuals who have had a choking incident during the past six months; ○ List of individuals who have had an aspiration and/or pneumonia incident during the past six months; ○ List of individuals who have had a fall during the past six months; ○ List of individuals who have had a decubitus/pressure ulcer during the past six months; ○ List of individuals who have experienced a fracture during the past six months; ○ List of individuals who have had a fecal impaction during the past six months; ○ List of individuals who are non-ambulatory or require assisted ambulation; ○ List of individuals with poor oral hygiene; ○ List of individuals who received a feeding tube since the last review; ○ List of individuals who are at risk of receiving a feeding tube; ○ List of individuals who have received a Modified Barium Swallow Study (MBSS) or other diagnostic swallowing evaluation during the past year; ○ Schedule of meals by residence; ○ Schedule of all PNM-related meetings occurring during the week of the Monitoring Team's onsite review; ○ Curricula on PNM used to train new staff responsible for directly assisting individuals; ○ 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; and ○ QA/QI Indicators for Sections O, P, and R. ▪ **Interviews with:** ○ Linda Thomas, Director of Habilitation Therapy; ○ Missy Olive, PNMT PTA (Physical Therapy Assistant); ○ Corey Verett, Chief Clinical Dietician, PNMT Dietician; ○ Megan Copeland, PNMT OT; ○ Jon Olive, PNMT PT; ○ Mitzi Umstot, PNMT SLP; ○ Christine Haggard, PNMT RN; ○ Jim Forbes, Assistant Director of Programs (ADOP); ○ Rodshadi Moore, Active Treatment Coordinator; and ○ Norma Guterrez, Safety Officer. ▪ **Observations of:** ○ Individuals in multiple residences, dining rooms, and day programs; and ○ PNMT meeting, on 7/10/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, updated 6/20/14. 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: ▪ 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 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).

	○ The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. ○ The following staff/positions were responsible for completing the audit tool: the Director of HT 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 reports 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: Sections O.1, O.2, O.3, O.4, O.5, and O.8. The Monitoring Team found the Facility was in substantial compliance with Sections O.1, O.5, and O.8. Significant progress had been made with Section O.2. However, PNMT recommendations and plans were not integrated into individuals' IHCPs. The Monitoring Team did not find compliance with Section O.3 as individuals' PNMPs were missing components, IDTs needed to review and document their decisions about PNMPs in individuals' ISPs, and the IDTs needed to discuss and approve PNMP changes through an ISPA. For Section O.4, observations showed reduced compliance with mealtime plans since the last review, and the Facility's system was not identifying concerns and addressing them quickly enough. The Facility found noncompliance with Sections O.6 and O.7. The Monitoring Team also found the Facility was in noncompliance with these sections. ▪ 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 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 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 continued to be in substantial

	compliance with Section O.1. The Facility continued to have 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. The PNMT assessments included the necessary components. Additional work needed to be done to integrate PNMT recommendations and plans into individuals' IHCPs. The Facility continued to implement significant revisions in the Mealtime Procedures training curriculum with an emphasis on dining plans and Home Procedures as well as other initiatives. However, during this review, the percentage of mealtime observations that showed correct implementation of dining plans fell to 53% from 81% compliance during the last review. Of additional concern was the fact that although two of the homes in which problems were noted during the Monitoring Team's onsite review had CAPs in place, the CAPs were developed only after they had not met mealtime monitoring thresholds for seven of eight months (i.e., Fir) and/or eight of eight months (i.e., Violet). It was positive that onsite discussions with the Active Treatment Coordinator and Safety Officer showed a commitment to ameliorate mealtime errors observed during the onsite review, and the observations completed with the PNMT OT, PTA, RN, and the Monitoring Team showed adherence to PNMPs for positioning, transfers, and alternate positioning plans. However, adherence to mealtime plans is an essential component in reducing individuals' risks to the extent possible. The Facility had implemented a comprehensive physical and nutritional management (PNM) foundational training program for new employees and veteran staff. Mandatory PNM foundational annual refresher training continued to be implemented. New employees and veteran staff had successfully completed PNM foundational performance check-offs. The Facility therapists had identified 29 individuals who required Physical and Nutritional Management Plan (PNMP) individual-specific training. There was a sustainable system developed and implemented for the provision of individual-specific training for staff. The Facility continued 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 for individuals on their caseloads. However, an essential piece was missing in that IHCPs did not include measurable goals based on clinical indicators. In addition, more work was needed to fully implement effectiveness monitoring (i.e., development of instructions/guidelines, effectiveness monitoring for all components of an individual's plan, etc.). The Facility continued to have a sustainable system for identifying individuals who received enteral nourishment. A protocol had been developed and implemented to define this process. The IDTs reviewed individuals in the sample who received enteral nutrition. Individuals' Consultation to Return to Oral Eating

	and/or Least Restrictive Intake, OT/PT Assessment of Current Status, and the IRRF addressed 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. At the time of the review, none of the individuals' IDTs had recommended a return to oral eating and/or that individuals receive enteral nutrition in a less restrictive manner.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and	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 loss and/or gain, 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 #252, Individual #71, Individual #134, Individual #116, Individual #183, Individual #167, Individual #171, Individual #68, Individual #181, Individual #321, Individual #283, Individual #196, Individual #62, Individual #223, and Individual #105. ▪ **Sample O.2** consisted of individuals who were assessed, reviewed, and/or tracked by the PNMT over the last six months. This sample included four individuals: Individual #165, Individual #313, Individual #30, and Individual #53. Six individuals had been discharged from the PNMT since the last review. One of these six individuals' discharge documentation was reviewed (i.e., Individual #284). ▪ **Sample O.3** was comprised of individuals who received enteral nutrition. These eight individuals were: Individual #223, Individual #283, Individual #76, Individual #171, Individual #321, Individual #181, Individual #196, and Individual #62. Some of these individuals were included in one of the other samples. ▪ **Sample O.4** consisted of 47 individuals (i.e., Individual #67, Individual #36, Individual #10, Individual #214, Individual #315, Individual #45, Individual #70, Individual #179, Individual #195, Individual #185, Individual #258, Individual #51, Individual #271, Individual #255, Individual #121, Individual #20, Individual #87, Individual #85, Individual #227, Individual #40, Individual #83, Individual #279, Individual #192, Individual #209, Individual #77,	Substantial Compliance

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	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.	Individual #308, Individual #12, Individual #100, Individual #282, Individual #90, Individual #127, Individual #137, Individual #272, Individual #223, Individual #182, Individual #111, Individual #270, Individual #28, Individual #172, Individual #47, Individual #233, Individual #178, Individual #58, Individual #183, Individual #30, Individual #23, and Individual #130) observed in the following 11 dining rooms: Fir, Violet, Aspen, Zinnia, Elm (i.e., two observations), Quail/Sparrow, Iris, Tulip, Birch, Oak, and Willow. An additional 19 individuals (i.e., Individual #165, Individual #21, Individual #280, Individual #6, Individual #171, Individual #312, Individual #161, Individual #192, Individual #128, Individual #74, Individual #179, Individual #175, Individual #313, Individual #250, Individual #55, Individual #199, Individual #80, Individual #308, and Individual #321) were observed in their seating systems; three individuals' were observed in alternate positions (i.e., Individual #90, Individual #205, and Individual #3); one individual's transfer (i.e., Individual #165) was observed; and three individuals were observed during a medication administration (i.e., Individual #167, Individual #258, and Individual #217). 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;	

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		▪ State Policy 006.3 At Risk Individuals, effective 12/7/12; ▪ LBSSLC – IDT Process – Program Development Individual Support Plan – At Risk Individuals, revised 12/5/13; ▪ State Policy 003.1 Quality Assurance, revised 5/22/13; ▪ LBSSLC – Review Processes - Quality Assurance Process/Plan, dated 6/24/14; ▪ LBSSLC – IDT Process – Program Development: Physical Nutritional Management, revised 5/16/14; ▪ LBSSLC PNMT Guideline, revised 5/16/14; ▪ Service Request for PNMT, dated 10/1/13; ▪ LBSSLC PNMT RN, dated 9/25/13; ▪ LBSSLC Protocol for Dental Department, effective date 11/6/13; ▪ LBSSLC – Health Services: Dental Services Overview, revision and implementation date of 12/13/13; ▪ Protocol for In-servicing Core Foundational Changes on Physical Nutritional Management Plans, Dining Plans and/or for Communication, not dated; ▪ LBSSLC Compliance/Efficacy Monitoring Guideline for Licensed Habilitation Therapists, dated 9/16/13; ▪ LBSSLC Protocol for Process of Maintaining Lists, dated 11/12/13; ▪ LBSSLC Protocol to Identify Individuals Who Are High Risk for Aspiration Pneumonia and/or Choking, dated 11/12/13; ▪ LBSSLC Color Code System, dated 11/13/13; ▪ LBSSLC Protocol for Persons Who Have Individual-Specific Training Techniques, dated 10/21/13; ▪ LBSSLC – IDT Process – Active Treatment: Pulled Staff/Transfer Staff Process, revision dated 12/11/13; ▪ LBSSLC – IDT – Program Development: Occupational Therapy and Physical Therapy Services, revised 5/16/14; ▪ 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 Consultation Report Pathway to Return to Oral Eating and/or Least Restrictive Intake, dated 4/28/14; ▪ LBSSLC Habilitation Therapy Protocol for Use of Consult for Pathway to Return to Oral Eating and/or Least Restrictive Intake, dated 6/4/14; ▪ LBSSLC Protocol for Checking/Monitoring of Assistive Devices Individual Equipment, dated 1/8/14; ▪ LBSSLC Protocol: Nutrition Services Weight Monitoring, revised 2/11/14; ▪ LBSSLC – Health Services: Weight Monitoring, revised 5/8/14; ▪ LBSSLC Guideline for Pharmacy for Texture and Fluids, dated 2/12/14; ▪ LBSSLC Occupational Therapy/Physical Therapy/Speech Therapy Use of Consult for LBSSLC Change of Status Protocol, dated 3/11/14;	

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		▪ LBSSLC Consultation Report Form Change of Status, dated 3/11/14; ▪ LBSSLC Occupational Therapy/Physical Therapy/Speech Therapy Direct Services Protocol, dated 4/23/14; ▪ LBSSLC Process to Validate that Staff Responsible for Training Other Staff are Competent to Assess Other Staff's Competency – Individual-Specific Competency Based Training PNM and Communication Skills, dated 11/11/13; and ▪ LBSSLC Monitoring of Habilitation Therapy Plans, dated 10/4/13. LBSSLC continued to have 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., 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);	

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		▪ 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 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 these policies, the Facility had policies and/or protocols that provided a comprehensive PNM policy, including the preceding elements. The Facility and HT Department continued to develop and/or revise policies/procedures to memorialize the provision of PNM services and supports for individuals.	

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		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 and documentation provided, 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 four individuals in Sample O.2 (i.e., Individual #165, Individual #313, Individual #30, and Individual #53) (100%), evidence was provided of medical providers' (i.e., primary care physician) participation in individuals' initial PNMT assessments. In addition, RN case managers 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 four of the four individuals (i.e., Individual #165, Individual #313, Individual #30, and Individual #53) (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.	

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		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: Habilitation Therapies Conference (10/31/13 – 11/1/13), Relearning Kinesia Treatment for Parkinson's Disease and Related Movement Disorders (11/6/13), Dementia Management: Advanced Skills for the Health Care Practitioner (4/1/14) for a total of 19.5 hours. ▪ SLP attended: Ethics (10/8/13), Dynavox (10/8/13), Habilitation Therapies Conference (10/31/13 – 11/1/13), Every Breath You Take… Maintaining Pulmonology Health (10/23/13), Disease Related Malnutrition: Characteristics and Consensus (3/12/14), and Absorption, Protein and the Gut – Where Are We? (3/12/14) for a total of 17.5 hours; ▪ OT attended: Absorption, Protein and the Gut – Where Are We? (3/12/14), Disease Related Malnutrition (3/13/14), Dementia Management: Advanced Skills for the Health Care Practitioner (4/1/14), Pain Free Posture: Correcting Postural Faults (5/7/14), and The Brainwork's Approach to Sensory Diets (6/1/13) for a total of 15 hours. ▪ RD attended: Role of the RD in Health Care Reform: Managing GI Function, Wound Healing, Glycemic Control and Aspiration with Enteral Nutrition (7/10/13), The Obesity Paradox: Is it all about Cardiovascular Fitness? (7/17/13), The Hunger Games: Applying the Science of Satiety to Fuel Health (7/18/13), With Every Breath You Take… Maintaining Pulmonology Health (10/24/13), Habilitation Therapies Conference (10/31/13 – 11/1/13), Nutrition and Oral Health: What Dieticians Need to Know (1/16/14), Disease Related Malnutrition: Characteristics and Consensus (3/12/14), Absorption, Protein and the Gut – Where Are We? (3/12/14), Mindless Eating to Eating Mindlessly (3/25/14), Intuitive Eating (3/13/14), Cancer and the ABCs of Lean Body Mass: Optimal Nutrition Interventions (4/9/14), The Protein Needs of Older Adults (4/10/14), Introduction to GI [Gastro Intestinal) Radiology (6/12/14), and Improving Patient Outcomes: Considerations in the New Health	

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		Care Landscape (6/25/14) for a total of 21.5 hours; ▪ RN attended: Medication Administration (10/4/13), C-Difficile (10/9/13), With Every Breath You Take… Maintaining Pulmonology Health (10/24/13), 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 22.5 hours; and ▪ PTA attended: Habilitation Therapies Conference (10/31/13 – 11/1/13), Parkinson and Movement Disorders (11/6/13), Neurology –Strokes and TIA [Transient Ischemic Attack] (11/20/13), Ethics and Jurisprudence (1/22/14), Absorption, Protein and the Gut – Where Are We? (3/12/14), Disease Related Malnutrition: Characteristics and Consensus (3/12/14), and Pain Free Posture: Correcting Postural Faults (5/7/14) for a total of 44 hours. **PNMT Meetings** PNMT meeting documentation was submitted for the time period from January 16 to May 1, 2014 for a total of 16 weeks. The PNMT met at least weekly on 16 of the 16 weeks (100%). Attendance by core PNMT and back-up members for 34 meetings conducted during the time frame from January 16, 2013 to May 1, 2014 was: ▪ RN: 83% attendance by core member, 12% for back-up member, 95% overall; ▪ RD: 97% attendance by core member, 3% for back-up member, 100% overall; ▪ PT: 82% attendance by core member, 18% for back-up member, 100% overall; ▪ OT: 88% attendance by core member, 3% for back-up member, 91% overall; and ▪ SLP: 100% 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-four of 34 (100%) PNMT meeting minutes (January to May 2014) 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, revised 5/16/14, provided information on the 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.	

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		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. At the time of the review, there were no CAPs related to resolution of systemic issues. In addition, on a daily basis, the PNMT RN continued to be 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. In summary, the Facility continued to achieve 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	**Identification of PNM Risk** The Facility continued to have a sustainable system to maintain lists (i.e., Process of Maintenance of Lists, revised 11/11/13) 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"). The Facility had 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 three additional lists: individuals who had	Noncompliance

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	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.	thickened liquids, individuals who had received a Modified Barium Swallow (MBS) study, and individuals who had enteral nourishment sites. 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 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. **Physical and Nutritional Management Team Referral Process** The Facility continued to utilize a 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, and 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. 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: ▪ Thirteen of the 15 individuals (i.e., Individual #252, Individual #71, Individual #134, Individual #183, Individual #167, Individual #68, Individual #181, Individual #321, Individual #283, Individual #196, Individual #62, Individual #223, and Individual #105) did not meet the PNMT referral criteria. ▪ Individual #171 had been referred to the PNMT. ▪ One of the 15 individuals (i.e., Individual #116) in Sample O.1 experienced a choking incident since the last review. This individual was not referred to the PNMT. However, the PNMT reviewed the choking incident, and an OT and SLP completed three consultations. In addition, a MBSS was completed. Changes	

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		were made to her diet texture (i.e., chopped/ground meats), which was reflected, in her current PNMP. The following was not applicable, because no individual had received a non-emergency tube placement since the last review: ▪ ____ of ____ individuals (%) who received a feeding tube (not on an emergency basis) since the last review had been referred to the PNMT prior to the placement of the tube. Four individuals had received an emergency feeding tube since the last review. ▪ Four of four (100%) (i.e., Individual #313, Individual #76, Individual #165, and Individual #55) individuals who received an emergency feeding tube placement since the Monitoring Team's last review had been referred to the PNMT after the emergency feeding tube placement. **PNMT Assessment** For the four individuals in Sample O.2, four of four PNMT assessments (100%) were initiated at a minimum within five working days of the referral (or sooner as specified in the PNMT policy). Four of four (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). Based on review of individuals' records, the comprehensiveness of the PNMT assessment components were as follows: ▪ Four of four (100%) contained date of referral by the IDT; ▪ Four of four (100%) contained the date the assessment was initiated; ▪ Four of four (100%) contained evidence of review and analysis of the individual's medical history; ▪ Four of four (100%) identified the individuals' current risk rating(s), including the current rationale; ▪ Four of four (100%) included updated risk ratings based on the PNMT's assessment and analysis of relevant data; ▪ Four of four (100%) contained evidence of discussion of the individual's behaviors related to the provision of PNM supports and services, including problem behaviors and skill acquisition; ▪ Four of four (100%) contained assessment of current physical status; ▪ Four of four (100%) contained assessment of musculoskeletal status; ▪ Four of four (100%) contained evaluation of motor skills;	

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		▪ Four of four (100%) contained evaluation of skin integrity; ▪ Four of four (100%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene; ▪ Four of four (100%) contained evaluation of current adaptive equipment; ▪ Four of four (100%) contained nutritional assessment, including, but not limited to history of weight and height, intake, nutritional needs, and mealtime/feeding schedule; ▪ Four of four (100%) contained evaluation of potential or actual drug/drug and drug nutrient interactions; ▪ Three of three (100%) identified residual thresholds, if enterally nourished. This was not applicable for one individual (i.e., Individual #30) as he ate orally; ▪ Four of four (100%) contained a tableside oral motor/swallowing assessment, including but not limited to mealtime observation. ▪ Four of four (100%) contained respiratory status; ▪ Four of four (100%) contained evidence of review/analysis of lab work; ▪ Four of four (100%) contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times, and side effects; ▪ Four of four (100%) contained discussion as to whether existing supports were effective or appropriate; ▪ Four of four (100%) contained oral hygiene status; ▪ Four of four (100%) contained evidence of observation of the individual's supports at their residence and day/work programs; ▪ Four of four (100%) contained evidence that the PNMT conducted hands-on assessment; ▪ Four of four (100%) identified the potential causes of the individual's physical and nutritional management problems; ▪ Four of four (100%) identified the physical and nutritional interventions and supports that were clearly linked to the individuals' identified problems, including an analysis and rational for the recommendations; ▪ Four of four (100%) contained recommendations for measurable skill acquisition programs, as appropriate; ▪ Four of four (100%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status; ▪ Four of four (100%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT; ▪ Four of four (100%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP); and	

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		▪ Four of four (100%) contained recommendations for monitoring, tracking or follow-up by the PNMT. The LBSSLC PNMT was to be commended for ensuring individuals' PNMT assessments contained all of the necessary components. **Integration of PNMT Recommendations into IHCPs and/or ISPs** For none of the four (0%) individuals, all recommendations by the PNMT were addressed and/or integrated in the ISPAs, 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 none of four (0%) individuals' plans reviewed (i.e., IHCPs), the plans addressed the individual's identified PNM needs as presented in the PNMT assessment. ▪ For three of the three (100%) individuals (i.e., Individual #165, Individual #313, and Individual #55) for whom HOBE assessments were conducted, the HOBE recommendations were integrated into individuals' plans. ▪ In none of four (0%) individuals' plans reviewed, there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. "Appropriate" is defined as objectives that are relevant to the PNM problem, and "functional" means, when appropriate, objectives that increase an individual's independence. ▪ In none of four (0%) individuals' plans reviewed, there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. ▪ In none of four (0%) individuals' plans reviewed, the plans included the specific clinical indicators of health status to be monitored. ▪ In none of four (0%) individuals' plans reviewed, the plans defined triggers. ▪ In none of four (0%) individuals' plans reviewed, the frequency of monitoring was included in the plans. **PNMT Follow-up and Problem Resolution** With regard to plan implementation: ▪ In none of four (0%) individuals' documentation reviewed, supporting documentation was present to confirm implementation of individuals' action plans within 14 days, or sooner as needed, of the plan's finalization. ▪ In none of four (0%) individuals' plans reviewed, documentation was provided to show action plan steps had been completed within established timeframes, or	

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		IPNs, consultations and/or follow-up reports provided an explanation for any delays, including a plan for completing the action steps. **<u>Individuals Discharged by the PNMT</u>** Six individuals had been discharged from the PNMT since the last review. Individual #284's PNMT discharge documentation was reviewed. ▪ One of the one (100%) individual had an ISPA meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT. ▪ One of the one (100%) individual's discharge summary/action plans provided objective clinical data to justify the discharge. ▪ One of the one (100%) individual's ISPA meeting documentation provided evidence that any new recommendations, as appropriate, were integrated into the IHCP. ▪ One of the one (100%) individual's 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, significant progress had been made within this section. The Facility continued to have a sustainable system to maintain and update lists to identify individuals having physical or nutritional management problems. The PNMT assessments included the necessary components. To move in the direction of achieving substantial compliance within this section, the Monitoring Team recommends the Facility consider the following area of focus: ensure PNMT assessment recommendations and plans are integrated into individual's IHCPs.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	**<u>Identification of Individuals Requiring a PNMP</u>** Two hundred and three (203) of the 204 individuals (99%) living at LBSSLC had a PNMP. The Facility continued to implement an ISP Preparation process that occurred three months prior to an individual's annual ISP meeting. 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 ISP Preparation meeting documentation for required attendance were reviewed. Three individuals did not have ISP Preparation meeting documentation available (i.e., Individual #134, who was newly admitted; Individual #171; and Individual #105, who was newly admitted). For these individuals, the IDT member attendance was not reviewed. For the remaining 12 individuals (i.e., Individual #252, Individual #71, Individual #116, Individual #183, Individual #167, Individual #68, Individual #181, Individual #321, Individual #283, Individual #196, Individual #62, and Individual #223), the ISP Preparation meeting documentation did not provide adequate justification to support non-attendance of therapists and/or a dietician. Some examples	Noncompliance

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		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, and/or SLP) 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 15 (0%) PNMPs in Sample O.1 were adequately reviewed by the individual's IDT during the annual ISP meeting. Each individual's ISP had a section for the review and 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** Fifteen PNMPs for individuals in Sample O.1 and four individuals in Sample O.2 were reviewed. The review of these 19 individuals' PNMPs found the following: ▪ PNMPs for 19 of 19 (100%) individuals were current within the last 12 months. ▪ PNMPs for 19 of 19 (100%) individuals included a list of risk levels and triggers; ▪ In 19 of 19 (100%) PNMPs, there were large and clear photographs with instructions. ▪ Nineteen of 19 (100%) individuals' PNMPs listed the adaptive equipment required by the individual with rationale. ▪ Eleven of the 19 individuals used a wheelchair as their primary mobility. In 11 of 11 (100%) PNMPs for individuals who used a wheelchair as their primary mobility (i.e., Individual #252, Individual #167, Individual #171, Individual #181, Individual #321, Individual #283, Individual #196, Individual #62, Individual #313, Individual #165, and Individual #55), positioning instructions	

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		for the wheelchair, including written and pictorial instructions were provided. ▪ In 19 of 19 PNMPs (100%), positioning was adequately described per the individuals' assessments. A review of OT/PT and/or PNMT assessments showed the PNMPs 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 19 of 19 (100%) PNMPs, the type of transfer was clearly described, or the individual was described as independent. ▪ In five of 19 (26%) PNMPs (i.e., Individual #134, Individual #223, Individual #105, Individual #165, and Individual #30), 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 19 (5%) PNMPs (i.e., Individual #165), 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 19 of 19 (100%) PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning. ▪ In 19 of 19 (100%) PNMPs/dining plans, instructions related to mealtime were outlined, including for those who received enteral nutrition. ▪ Nineteen of 19 (100%) dining plans were current within the last 12 months. ▪ Eleven individuals had feeding tubes with no oral intake (i.e., Individual #167, Individual #171, Individual #68, Individual #181, Individual #321, Individual #283, Individual #196, Individual #62, Individual #313, Individual #165, and Individual #55). One of 11 (9%) (i.e., Individual #62) PNMPs/dining plans indicated the individual was to receive nothing by mouth. ▪ In 19 of 19 (100%) PNMPs/dining plans, position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. ▪ Eight individuals ate orally within this sample (i.e., Individual #252, Individual #71, Individual #134, Individual #116, Individual #183, Individual #223, Individual #105, and Individual #30): o In eight of eight (100%) PNMPs/dining plans, for individuals who ate orally, diet orders for food texture were included; o In eight of eight (100%) PNMPs/dining plans for individuals who received liquids orally, the liquid consistency was clearly identified; and o In eight of eight (100%) 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;	

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		▪ In 19 of 19 (100%) PNMPs, medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency; ▪ In twelve of 19 (63%) (i.e., Individual #167, Individual #171, Individual #68, Individual #181, Individual #321, Individual #283, Individual #196, Individual #62, Individual #223, Individual #105, Individual #313, and Individual #165) PNMPs, oral hygiene instructions were included, including general positioning and brushing instructions. The remaining seven individuals' PNMPs did not include general positioning and/or brushing instructions; and ▪ Nineteen of 19 (100%) PNMPs included information related to communication (i.e., how the individual communicated, and how staff should communicate with the individual). **Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT** 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 input at the annual ISP meeting and as often as needed through an ISPA." ▪ For the four individuals (i.e., Individual #71, Individual #116, Individual #183, and Individual #105) in Sample O.1 with PNMPs for whom the IDT identified changes were needed to the PNMP after the annual ISP meeting, two of the four individuals' revised PNMPs (50%) (i.e., Individual #105, and Individual #116) had been reviewed and approved by the IDT in an ISPA meeting. ▪ For individuals for whom the PNMP was revised, there was supporting documentation (i.e., PNMP Change Log) that four of the four (100%) individuals' revised PNMPs had been implemented. In summary, individuals' PNMPs were missing some of the necessary components (i.e., bathing, toileting, and oral care). 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	**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. Forty-seven individuals (i.e., Individual #67, Individual #36, Individual #10, Individual #214, Individual #315, Individual #45, Individual #70,	Noncompliance

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	after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	Individual #179, Individual #195, Individual #185, Individual #258, Individual #51, Individual #271, Individual #255, Individual #121, Individual #20, Individual #87, Individual #85, Individual #227, Individual #40, Individual #83, Individual #279, Individual #192, Individual #209, Individual #77, Individual #308, Individual #12, Individual #100, Individual #282, Individual #90, Individual #127, Individual #137, Individual #272, Individual #223, Individual #182, Individual #111, Individual #270, Individual #28, Individual #172, Individual #47, Individual #233, Individual #178, Individual #58, Individual #183, Individual #30, Individual #23, and Individual #130) were observed in the following 11 dining rooms: Fir, Violet, Aspen, Zinnia, Elm (i.e., two observations), Quail/Sparrow, Iris, Tulip, Birch, Oak, and Willow. More specifically: ▪ No mealtime errors were observed in Fir, Violet, Aspen, Oak, Canna, Quail/Sparrow, Birch, and Rose. ▪ Twenty-five of 47 individuals' staff (53%) engaged in safe mealtime practices for individuals who ate orally (i.e., Individual #67, Individual #36, Individual #10, Individual #214, Individual #315, Individual #45, Individual #70, Individual #179, Individual #195, Individual #185, Individual #258, Individual #51, Individual #271, Individual #255, Individual #121, Individual #20, Individual #87, Individual #85, Individual #227, Individual #40, Individual #83, Individual #279, Individual #92, Individual #209, and Individual #77. 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. ▪ Twenty-two of 47 individuals' (47%) staff did not engage in safe mealtime practices for individuals who ate orally (i.e., Individual #308, Individual #12, Individual #100, Individual #282, Individual #90, Individual #127, Individual #137, Individual #272, Individual #223, Individual #182, Individual #111, Individual #270, Individual #28, Individual #172, Individual #47, Individual #233, Individual #23, Individual #130, Individual #178, Individual #58, Individual #183, and Individual #30). These individuals resided in Zinnia, Elm, Iris, and Tulip. ▪ Mealtime errors were noted in Zinnia (i.e., during the first of two observations), Elm (i.e., two mealtime observations completed), Iris, and Tulip. The Active Treatment Coordinator and Safety Officer agreed with the Monitoring Team that the observations completed in these dining rooms did not follow the established protocols for MTCs and table captains. Examples of mealtime errors observed included MTCs not providing coaching and mentoring to table captains to correct staff who were not following dining plan presentation techniques, staff not referring to the dining plan, staff not repositioning individuals in their	

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		wheelchairs or prompting individuals to reposition themselves in their dining chairs, staff not prompting individuals to slow their pace, staff not interspersing food and fluids as prescribed on dining plans, etc. The Active Treatment Coordinator, Safety Officer, and the Monitoring Team member made a second visit to Zinnia. No mealtime errors were noted during the second visit. However, the second visit to Elm indicated the MTC continued to not follow established protocol. The Safety Officer instructed the Residential Coordinator to replace the MTC with another MTC in the dining room. ▪ Corrective Action Plans had been developed for Fir (i.e., Residence 516) and Violet (i.e., Residence 523) as these residences failed to meet the 80% mealtime monitoring threshold for multiple months. Informal plans of correction had been implemented, but the plans of correction had not been effective in the residence achieving the monitoring threshold of 80%. The CAPs identified the issue/recommendation, action to be taken to remedy the issues and/or prevent the reoccurrence of problems, anticipated outcomes of each action step, responsible person, timeframe for completion of each action step, and evidence regarding completion. The Mealtime Committee workgroup should analyze the outcomes of these CAPs to determine if the implementation of the action steps elicited the desired result. For example, was the residence able to meet and sustain the mealtime monitoring threshold for consecutive months? If not, the CAP should be revised to ensure sustainability of mealtime monitoring thresholds. In addition, there should be clear criteria for when a CAP is developed. These CAPs were developed for residences only after they had not achieved mealtime monitoring thresholds for seven of eight months (i.e., Fir) and/or eight of eight months (i.e., Violet). Based on discussions with the Active Treatment Coordinator and the Safety Officer, the following initiatives were to be implemented to address the mealtime concerns that were identified during the onsite review: ▪ Meet with Residential Coordinators to discuss their concerns with mealtime errors that were observed during the onsite review and develop plans of correction; ▪ Initiate Residential Coordinator (RC) Buddy System to pair a strong RC (e.g., home that had achieved consecutive mealtime monitoring thresholds) with a RC whose residence dining room observations were not acceptable and/or had not reached the mealtime monitoring threshold of 80%; and ▪ Implement an onsite mealtime monitoring inter-rater agreement to assess RCs' mealtime competencies. Based on observations the Monitoring Team conducted with the PNMT PTA, PNMT OT,	

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		and PNMT RN: ▪ Nineteen of 19 individuals (100%) (i.e., Individual #165, Individual #21, Individual #280, Individual #6, Individual #171, Individual #312, Individual #161, Individual #192, Individual #128, Individual #74, Individual #179, Individual #175, Individual #313, Individual #250, Individual #55, Individual #199, Individual #80, Individual #308, and Individual #321) were positioned correctly in their seating systems; ▪ Three of three (100%) individuals' alternate positioning plans (i.e., Individual #90, Individual #205, and Individual #3) were implemented as written. ▪ One of one (100%) (i.e., Individual #165) individual's transfer plan was implemented as written. In three of three observations of medication administration (100%) (i.e., Individual #167, Individual #258, and Individual #217), direct support professionals repositioned individuals prior to their receiving their medication. The direct support professionals followed the positioning procedures in the PNMP. The Monitoring Team did not have the opportunity to observe the nurse repositioning individuals prior to receiving their medication. Staff implementation of 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: ▪ ___ of ___ (%) oral hygiene plans were implemented as written. ▪ ___ of ___ (%) bathing plans were implemented as written. Since the last review, the Facility continued to implement 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 fell to 53% from 81% compliance during the last review. Of additional concern was the fact that although two of the homes in which problems were noted during the Monitoring Team's onsite review had CAPs in place, the CAPs were developed only after they had not met mealtime monitoring thresholds for seven of eight months (i.e., Fir) and/or eight of eight months (i.e., Violet). It was positive that onsite discussions with the Active Treatment Coordinator and Safety Officer showed a commitment to ameliorate mealtime errors observed during the onsite review, and the observations completed with the PNMT OT, PTA, RN, and the Monitoring Team showed adherence to PNMPs for positioning, transfers, and alternate positioning plans. However, adherence to mealtime plans is an essential component in reducing individuals' risks to the extent possible. As a result of the findings from this onsite review coupled with indications that the Facility's system	

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		was not identifying and addressing problems quickly enough, the Facility was found to be in noncompliance with this provision.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	**New Employee Orientation (NEO)** The Facility continued to implement a PNM foundational competency-based training curriculum that contained the following components, and it was considered comprehensive: ▪ Lifting and transfers; ▪ Positioning (e.g., alternate, wheelchair, and bathing/showering); ▪ Adaptive equipment; ▪ PNMP orientation and implementation; ▪ Safe mealtime strategies; ▪ Basics of dysphagia; and ▪ Alternative/augmentative communication. LBSSLC New Employee Orientation was provided on a monthly basis. All new employees were required to successfully complete PNM foundational competency performance check-offs. Categories of staff and/or positions that required PNM-related NEO training included all direct support staff (i.e., residential, programs, vocational, recreational, and active treatment) and professional direct staff (i.e., behavioral health specialists, QIDPs, and nurses). The passing score for PNM competency testing was 80% or above. During the time period of 11/18/13 to 6/2/14, the Facility's New Hire tracking grid indicated 141 of 141 new employees (100%) had 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 included Competency Training and Development (CTD) participation reports that indicated 248 of 258 current staff (96%) required to complete PNM foundational training had successfully completed PNM performance check-offs. Twenty-three of 23 staff (100%) (i.e., four OTs, three PTs, one PTA, three RDs, four SLPs, one Habilitation Trainer, seven PNMP Coordinators) 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** The PNM annual refresher training had been scheduled during the months of January (i.e., one session), February (i.e., two sessions), March (i.e., two sessions), April (i.e., two sessions), May (i.e., two sessions), and June (i.e., two sessions). PNM annual refresher	Substantial Compliance

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		training included the following five annual refresher courses: ▪ Lifting People; ▪ PNM; ▪ Preventing Aspiration; ▪ Preventing Aspiration for Individuals Who Receive Oral and/or Enteral Nutrition; and ▪ Alternative/Augmentative Means of Communication. The Facility Self-Assessment and pre-review documentation included CTD participation reports that indicated that 418 of 420 (99%) veteran staff had completed the annual refresher training course for lifting. However, it was unclear why there was such a discrepancy between the number of current staff (i.e., 258) identified as requiring PNM foundational staff and the 418 staff that had completed annual refresher training. The Facility should provide an explanation in the future about the difference in the number of current/veteran staff who required and/or completed training. The CTD Participation report for Preventing Aspiration during the time period of 11/1/13 to 5/14/14 indicated 311 staff were required to complete this course. Three hundred eleven of 311 (100%) veteran staff completed the aspiration annual course. The CTC Participation report for Mealtime Procedures indicated 337 of 350 (99%) identified direct support professionals had received mealtime procedure training. **Individual-Specific 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. These individual-specific techniques required staff knowledge and expertise beyond what was presented to staff in PNM foundational 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. Facility therapists had identified 29 individuals who would require individual-specific training. Staff were required to have successfully completed individual-specific competency-based training prior to working with an individual. 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.	

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		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. Training documentation was reviewed for five individuals in Sample O.1 (i.e., Individual #71, Individual #167, Individual #171, Individual #68, and Individual #62) and two individuals in Sample O.2 (i.e., Individual #165 and Individual #30). These seven 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: For Sample O.1 ▪ Documentation showed that for 25 of 25 staff (100%) assigned to Individual #71, there was evidence of exchange of the information included in the PNMP prior to the provision of services; ▪ For 42 of 42 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 27 of 27 staff (100%) assigned to Individual #171, 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 #68, there was evidence of exchange of the information included in the PNMP prior to the provision of services; ▪ For 32 of 32 staff (100%) assigned to Individual #62, there was evidence of exchange of the information included in the PNMP prior to the provision of services; Sample O.2: ▪ For 37 of 37 staff (100%) assigned to Individual #165, there was evidence of exchange of information included in the PNMP prior to the provision of services; and ▪ For 29 of 29 staff (100%) assigned to Individual #30, there was evidence of exchange of information included in the PNMP prior to the provision of services.	

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		For staff assigned to seven 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: Sample O.1: ▪ The 25 of 25 staff (100%) assigned to Individual #71 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 42 of 42 staff (100%) assigned to Individual #167 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 27 of 27 staff (100%) assigned to Individual #171 had completed competency 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 #68 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; and ▪ The 32 of 32 staff (100%) assigned to Individual #62 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. Sample O.2 ▪ The 37 of 37 staff (100%) assigned to Individual #165 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; and ▪ The 29 of 29 staff (100%) assigned to Individual #30 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 (i.e., PNM non-foundational). This included four OTs, three PTs, one PTA, four SLPs, three RDs, 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	

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		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 receive 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. **Facility Mealtime Coordination Committee Initiatives** The Facility continued to revise and improve their Mealtime Coordination system. Since the last review, the Facility Mealtime Workgroup continued to initiate changes based on an analysis of mealtime monitoring data. These changes included: ▪ Mealtime Management training curriculum was again revised to place emphasis on correct diet textures and fluid consistency; ▪ There was an increased effort to ensure all RCs were competent MTCs; ▪ The number of certified MTCs increased to 99. The goal was to have four certified MTCs per shift; ▪ MTC schedules included only MTCs that were certified; ▪ Home Protocols were revised to better reflect the individuals' needs during mealtimes; and ▪ CAPs were developed and initiated for Fir and Violet as a result of monitoring scores falling below the established threshold. As is discussed with regard to Section O.4, the Facility should reconsider the criteria it uses to determine when corrective action is needed. 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: ▪ When all homes achieve 80% or higher for three consecutive months for each monitoring indicator, the committee with consider increasing the threshold to 85%; ▪ Mealtime monitoring data will be reviewed monthly. Action plans will be developed if monitoring data falls below the threshold; ▪ The committee was at the beginning stages of implementing Snack Time	

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		initiatives for safety. Snack Time Messages had been developed and were to be distributed to homes. A Snack Time Protocols was to be developed for the homes; and ▪ In the future, snack time will be monitored via video surveillance. The Facility had implemented a comprehensive PNM foundational training program for new employees and veteran staff. New employees and veteran had successfully completed PNM foundational training and performance check-offs. The Facility therapists had identified 29 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 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.	**Facility's System for Monitoring of Staff Competency with PNMPs** The LBSSLC Compliance/Efficacy Monitoring Guideline, dated 9/16/13, had been developed since the last review. It defined compliance monitoring for individuals with high or medium risks directly associated to PNM supports. Individuals identified with PNM high-risk indicators (i.e., aspiration, choking, falls, fractures, respiratory, and skin integrity) were to be monitored monthly and individuals at medium risk for PNM concerns 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 2/25/14; ▪ LBSSLC Communication Compliance Monitoring Completed by SLPs and PNMP Coordinators, revised 1/14; ▪ LBSSLC Compliance Monitoring, revised 1/14, for positioning, meal, bathing, and lifting/transfer, revised 1/14; and ▪ PNMT Compliance Monitoring, revised 4/15/13, for positioning, meal, snack, medication administration, oral care, bathing, lifting/transfer, and communication. These Compliance Monitoring forms had instructions, and additional indicators were 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, and bathing. There were no compliance monitoring forms for oral care. Without such discrete indicators, adequate information would not be available to identify individual and/or systemic issues requiring correction.	Noncompliance

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		The following positions were identified for compliance monitoring: three PTs, one PTA, four OTs, PNMT RN, and three dieticians. A spreadsheet with the following fields tracked Compliance Monitoring results: ▪ General information (i.e., monitor focus, date, time, and location); ▪ Individual (i.e., home, client name); ▪ Name of observer/monitor and title; ▪ Staff information (i.e., name, status, identification number, staff signature present, title, staff trained on missed items); ▪ 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 November 4, 2013 to April 30, 2014 in the following areas: meals, positioning, mobility, gait, lifting/transfers, communication, and medication administration. The Facility reported that 716 monitoring forms had been completed. The Facility presented the following data for the type of monitoring completed and the shift during which the monitoring occurred: ▪ 268 of the 716 monitoring forms (37%) focused on oral intake (meals and snacks); ▪ 239 of the 716 monitoring forms (33%) focused on positioning; ▪ 590 of the 716 monitoring (82%) occurred during first shift; ▪ 126 of the 716 monitoring (17%) occurred during second shift; and ▪ None (0%) occurred during third shift. The Facility did not provide data to complete the following: ▪ ____ of the ____ monitoring forms (%) focused on bathing; ▪ ____ of the ____ monitoring forms (%) focused on medication administration; and ▪ ____ of the ____ monitoring forms (%) focused on oral care. In order to address various types of risk, approximately 50 to 60 percent of monitoring should occur during meals, including individuals that are enterally nourished, with others activities 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., bathing). The Facility should produce a report that provides data to address all of the preceding indicators, as well as specify which PNMP monitoring occurred for individuals at high risk who require monthly monitoring, and individuals who require quarterly monitoring.	

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		Monitoring for Individuals in Samples Thirteen of the 15 individuals in Sample O.1 (i.e., Individual #171, Individual #116, Individual #183, Individual #167, Individual #171, Individual #68, Individual #181, Individual #321, Individual #283, Individual #196, Individual #62, Individual #223, and Individual #105) were rated as being at high risk in one or more of the areas Facility's monitoring policy identified as 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. PNM Compliance Monitoring forms were requested for April through June 2014. None of the 13 individuals (0%) were monitored on a monthly basis. Some of these individuals received monthly communication monitoring, which was not applicable in this section. The remaining two individuals (i.e., Individual #252, and Individual #134) were ranked at medium risk for one or more of the identified PNM risk indicators. One of the two individuals (50%) (i.e., Individual #252) were monitored at the frequency established in the Facility protocol. For two of four (50%) (i.e., Individual #165 and Individual #30) individuals in Sample O.2, the frequency of PNM compliance monitoring over the past three months did occur as per the individuals' PNMT assessments and/or the individuals' plans/IHCPs. 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 reports that identified 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. Because of the lack of aggregate information, the Monitoring Team did not attempt to calculate 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. "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.	

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		The Facility had 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, revised 10/28/13; ▪ LBSSLC – IDT Process – Program Development: Physical Nutritional Management, revised 3/20/13; ▪ LBSSLC PNMT Guideline, revised 5/16/14; ▪ 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; ▪ 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. The Facility had provided some data related to monitoring results, but additional data was needed. Additional work needed to be done, including an analysis of monitoring to identify the number of monitoring forms completed within a specified time period for bathing, medication administration, communication and positioning. 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	

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		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 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. Therapists used the PNM/Communication Effectiveness Monitoring Tool that included a review of PNM occurrences [i.e., hospitalizations, type of pneumonia, choking, emesis, skin breakdown, edema/DVT (deep vein thrombosis), falls with serious injury, fracture and/or other concerns]. No instructions and/or guidelines had been developed for the effectiveness monitoring tool. Fourteen of the 15 (93%) individuals' records in Sample O.1 contained a PNM/Communication Effectiveness Monitoring tool. Individual #134's effectiveness monitoring had not been completed but was scheduled to occur in July 2014. Three of three (100%) individuals' records in Sample O.2 had documentation of effectiveness monitoring. On a positive note, progress had been made as therapists had initiated effectiveness monitoring for individuals in the sample, but additional work needed to be done. More specifically: ▪ The effectiveness monitoring tool did not require evidence of indicators integrated as part of the IHCPs to assess the individuals' PNM status. ▪ Effectiveness monitoring had not been completed for activities that had the potential to place an individual at risk for aspiration. For example, Individual #252 was at high risk for aspiration, but the only program implementation monitoring completed by the therapist was for dining and wheelchair positioning. There was no effectiveness monitoring of bathing, oral care, alternate positioning, and medication administration, which had the potential to place her at risk of aspiration. ▪ Sections of the effectiveness monitoring tools were not completed. For example, Individual #252's PNM/Communication Effectiveness Monitoring Tool Review form for PNM Occurrences was not completed. In addition, her IHCP, dated 3/7/14, did not address the purpose and/or frequency of effectiveness monitoring and/or identify clinical indicators. ▪ Instructions/guidelines should be developed for the effectiveness monitoring tool. None of the 15 individuals' records (0%) contained evidence of indicators integrated as part of the IHCPs to assess the individuals' PNM issues.	Noncompliance

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		None of the 15 (0%) individuals' records in Sample O.1, and none of four (0%) individuals in Sample O.2 contained evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans were monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans. As stated in the previous report, 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 three (0%) individuals in Sample O.1 (i.e., Individual #252, Individual #71, and Individual #134) receiving direct therapy, the record contained evidence that documentation was reviewed of the plan's effectiveness based on objective clinical data included in the plan. Because plans did not include clinical indicators to alert teams to changes in status for the individuals in Sample O.1, the following could not be evaluated: ▪ _____ 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.	

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		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 completing the tool. However, additional work was needed. 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. To measure effectiveness of plans, IHCPs should include goals based on objective clinical data. The objective clinical data should be tracked by identified staff, and reviewed regularly to determine whether or not the plan is working (i.e., the efficacy/effectiveness of the plan), and if not, changes should be made to the plan. The Facility remained out of compliance with this provision.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	**Assessment of Individuals Who Receive Enteral Nourishment** The Facility HT Master List protocol, dated 11/11/13, identified the Chief Clinical Dietician as the person to maintain a list of individuals with enteral nourishment sties. 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 continued to have a sustainable system to maintain and update the list of individuals who received enteral nutrition. In addition, the HT Department utilized the following policies and/or procedures to guide the delivery of services and supports to individuals who received enteral nutrition: ▪ State Policy 012.3: Physical Nutritional Management, effective 3/4/13; ▪ State Policy 006.3 At Risk Individuals, effective 12/7/12; ▪ LBSSLC – IDT Process – Program Development Individual Support Plan – At Risk Individuals, revised 12/5/13; ▪ LBSSLC – IDT Process – Program Development: Physical Nutritional Management, revised 5/16/14; ▪ LBSSLC PNMT Guideline, revised 5/16/14; ▪ LBSSLC Protocol for Pathway for Return to Oral Eating and/or for Least	Substantial Compliance

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		Restrictive Intake, dated 1/8/14; ▪ LBSSLC Consultation Report Pathway to Return to Oral Eating and/or Least Restrictive Intake, dated 4/28/14; and ▪ LBSSLC Habilitation Therapy Protocol for Use of Consult for Pathway to Return to Oral Eating and/or Least Restrictive Intake, dated 6/4/14. A review was conducted of the eight individuals in Sample O.3 (i.e., Individual #223, Individual #283, Individual #76, Individual #171, Individual #321, Individual #181, Individual #196, and Individual #62). Eight of eight individuals (100%), who received enteral nutrition, were evaluated at a minimum annually. Eight of the eight (100%) individuals reviewed had an appropriate evaluation to determine the medical necessity of the tube. The information necessary for such an assessment was summarized on the IRRF, and the team discussion/deliberations regarding the necessity of the tube documented on the IRRF. In order to determine medical necessity of enteral nutrition, documentation included 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 eight individuals (i.e., Individual #102, Individual #105, Individual #134, Individual #152, Individual #142, Individual #187, Individual #227, and Individual #234) 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>** The Facility had implemented the following protocols to define the process for individuals who had the potential to return to oral intake and/or receive a less restrictive approach to enteral nutrition: ▪ LBSSLC Protocol for Pathway for Return to Oral Eating and/or for Least Restrictive Intake, dated 1/8/14; ▪ LBSSLC Consultation Report Pathway to Return to Oral Eating and/or Least Restrictive Intake, dated 4/28/14; and ▪ LBSSLC Habilitation Therapy Protocol for Use of Consult for Pathway to Return	

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		to Oral Eating and/or Least Restrictive Intake, dated 6/4/14. A review of these protocols revealed that they addressed the necessary components identified within this section. Eight of the eight (100%) 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 in the sample receiving enteral nutrition were assessed annually by the IDT to determine if improvements could be made to progress towards a less restrictive diet. This assessment/consultation meant each individual was: ▪ Assessed by the SLP and/or OT regarding oral motor status with a clear determination of whether the individual was 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 was included as part of assessment findings. ▪ Assessed by the Nutritionist/Dietitian regarding current formula and schedule of feedings to determine if there was a possibility for modification to the least restrictive schedule. Justification for/or against modification of formula/schedule was included as part of assessment findings. 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 and/or to receive a less restrictive method of enteral nutrition. As a result, the following metrics were not evaluated, but will be, as applicable, if an individual is recommended to return and returned to oral eating: ▪ ____ 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	

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		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 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 implemented to define this process. Individuals in the sample who received enteral nutrition were reviewed by their IDTs. Individuals' Consultation to Return to Oral Eating and/or Least Restrictive Intake, OT/PT Assessment of Current Status, and the IRRF did 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. However, no individuals had been recommended to return to oral eating and/or receive a less restrictive method of enteral nutrition. If individuals were recommended to return to oral eating, the Facility would have to ensure the plan to return an individual to oral eating included the necessary components. The Facility was in substantial 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 10 individuals in Sample P.1 (i.e., Individual #252, Individual #71, Individual #134, Individual #116, Individual #183, Individual #167, Individual #171, Individual #68, Individual #181, and Individual #321) 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)], 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, 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 OT/PT assessments for the following 12 individuals: Individual #251, Individual #181, Individual #137, Individual #210, Individual #1, Individual #265, Individual #276, Individual #239, Individual #267, Individual #108, Individual #227, and Individual #274; 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;

	○ OT/PT Assessments and Updates (templates) with changes made since the Monitoring Team's last review; ○ Tracking Log of completed individual assessments; ○ Wheelchair seating and PNM clinic assessment (templates); ○ Compliance Monitoring form template; ○ Competency-based performance check-off sheet templates for PNM core competencies and individual-specific PNMPs along with dining plans and other intervention plans; ○ Summary reports and monitoring results related to OT/PT; and ○ List of individuals receiving direct OT and/or PT services and focus of intervention. ▪ **Interview with**: ○ Linda Thomas, Director of Habilitation Therapy. ▪ **Observations of**: ○ Individuals in multiple residences, dining rooms, and day programs.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 6/20/14. 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: ▪ 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. ▪ 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. ▪ 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. ▪ 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. ▪ 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. ▪ 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's findings were the same. 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 eight individuals recently admitted to the Facility had OT/PT assessments completed within 30 days of admission. Individuals' OT/PT assessments included the necessary assessment elements. An individual who had experienced a change in status did have an assessment update and/or consultations completed. The Facility was in substantial compliance with Section O.1. Three individuals receiving direct OT and/or PT interventions had therapy plans. However, 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 been integrated into individuals' ISPs for three of four individuals. Competency-based training for the implementation of PNMPs was consistently being provided. 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. However, as Section P.4 explicitly states: "…the Facility shall develop and implement a system to monitor and address… 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." Although a policy existed for monitoring of treatment interventions, it was not fully implemented yet.

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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	**Definition of Samples** ▪ **Sample P.1** consisted of the following 12 individuals who received PNM supports and had recently received an OT/PT assessment: Individual #251, Individual #181, Individual #137, Individual #210, Individual #1, Individual #265, Individual #276, Individual #239, Individual #267, Individual #108, Individual #227, and Individual #274;	Substantial Compliance

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	Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	▪ **Sample P.2** consisted of 10 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 loss and/or gain, 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, and included: Individual #252, Individual #71, Individual #134, Individual #116, Individual #183, Individual #167, Individual #171, Individual #68, Individual #181, and Individual #321; and ▪ **Sample P.3** consisted of three individuals who received direct OT and/or PT services, including: Individual #252, Individual #71, and Individual #134. **Timeliness of Assessments** Eight of eight (100%) newly admitted individuals (i.e., Individual #102, Individual #105, Individual #134, Individual #152, Individual #142, Individual #187, Individual #227, and Individual #234) received an OT/PT assessment within 30 days of admission or readmission. Based on review of 12 assessments for individuals in Sample P.1: ▪ Twelve of twelve 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. ▪ Twelve of twelve (100%) individuals had received an assessment that was current within 12 months for individuals who were provided PNM supports and services. **OT/PT Assessment** Based on review of 12 assessments for individuals in Sample P.1 (i.e., Individual #251, Individual #181, Individual #137, Individual #210, Individual #1, Individual #265, Individual #276, Individual #239, Individual #267, Individual #108, Individual #227, and Individual #274) the comprehensiveness of the OT/PT assessments was as follows: ▪ Twelve of twelve (100%) individuals' OT/PT assessments were signed and dated by both the OT and PT clinicians upon completion of the written report. ▪ Twelve of twelve (100%) assessments included medical diagnoses. ▪ Twelve of twelve (100%) assessments included medical history. ▪ Twelve of twelve assessments (100%) documented analysis of the impact of diagnoses and relevance of medical history to functional status. ▪ Twelve of twelve (100%) assessments addressed health status over the last year.	

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		▪ Twelve of twelve assessments (100%) included a comparative analysis that clearly analyzed the individuals' level of health status with previous years or assessments. ▪ Twelve of twelve assessments (100%) included a section that reported health risk levels that were associated with PNM supports. ▪ Twelve of twelve (100%) assessments listed medications and potential side effects relevant to functional status. ▪ Twelve of twelve (100%) individuals' OT/PT assessments included individual preferences, strengths, and needs. ▪ Twelve of twelve (100%) assessments included evidence of observations by OTs and PTs in the individuals' natural environments (i.e., day program, home, work). ▪ Twelve of twelve (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. ▪ Three individuals required a wheelchair as a primary mobility device (i.e., Individual #181, Individual #210, and Individual #267). Three of three 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. ▪ Twelve of twelve assessments (100%) included discussion of the current supports and services provided throughout the last year and effectiveness, including monitoring findings. Although the assessments included information currently available, as discussed with regard to Section O.7, additional work was needed with regard to effectiveness monitoring. ▪ Twelve of twelve assessments (100%) included recommendations for services and supports. ▪ Twelve of twelve (100%) assessments included a comparative analysis of current functional motor and activities of daily living skills with previous assessments. ▪ Twelve of twelve 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. Although the assessments included information currently available, as discussed with regard to Section O.7, additional work was needed to improve effectiveness monitoring; ▪ Twelve of twelve (100%) assessments included discussion of the individual's potential to develop new functional skills. ▪ Twelve of twelve (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.	

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		▪ Twelve of twelve (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. ▪ Twelve of twelve (100%) assessments included a reassessment schedule. ▪ Twelve of twelve (100%) individuals' OT/PT assessments made a determination about the appropriateness of transition to a more integrated setting. ▪ Twelve of twelve (100%) assessments recommended ways in which strategies, interventions, and programs should be utilized throughout the day. The 12 OT/PT assessments reviewed had 22 of 22 assessment elements present. The following individual in Sample P.2 had experienced a change in status since the last review: Individual #116 (i.e., choking). For one of one (100%) individual an update/consultation provided the individuals' current status, a description of the interventions that were provided, and effectiveness of the interventions, including relevant clinical data (i.e., from the mealtime consultation that recommended a change in diet texture) with a comparison to the previous year, as well as monitoring data. In summary, the eight individuals recently admitted to the Facility had OT/PT assessments completed within 30 days of admission. Individuals' OT/PT assessments included the necessary assessment elements. An individual who had experienced a change in status did have assessment updates and/or consultations completed. The Facility was in substantial 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	**<u>Direct OT/PT Interventions</u>** Eleven individuals received or had received direct OT and/or PT services. Sample P.3 was comprised of three of these eleven individuals (i.e., Individual #252, Individual #71, and Individual #134). At the time of the Monitoring Team's review, all three individuals had been discharged from therapy. ▪ Three of three (100%) (i.e., Individual #252, Individual #71, and Individual #134) 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. ▪ For one of three (33%) (i.e., Individual #71) individuals' records reviewed, the current OT/PT assessment and/or consultation identified the need for direct intervention with rationale.	Noncompliance

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	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.	▪ Three of three (100%) (i.e., Individual #252, Individual #71, and Individual #134) individuals' records reviewed, there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. ▪ 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. There was a discharge summary completed by the therapist. However, there was no ISPA meeting to discuss the individual's discharge from direct therapy. 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 10 assessments and ISPs/ISPAs for individuals in Sample P.2 (i.e., Individual #252, Individual #71, Individual #134, Individual #116, Individual #183, Individual #167, Individual #171, Individual #68, Individual #181, and Individual #321) found the following: ▪ For eight of 10 individuals' ISPs (80%) (i.e., Individual #252, Individual #71, Individual #134, Individual #116, Individual #167, Individual #171, Individual #68, and Individual #321), 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 direct and/or indirect OT/PT supports and services, 10 of 10 plans (100%) 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 10 of 10 individuals, (100%), the ISP, or an ISPA following the assessment/update, addressed recommendations outlined in the current OT/PT assessment (i.e., PNMP). ▪ In three of three (100%)(i.e., Individual #183, Individual #171, and Individual #68) ISPs or ISPAs reviewed, skill acquisition programs that had been recommended in the OT/PT assessment were present. Six individuals' OT/PT assessments did not recommend skill acquisition programs (i.e., Individual #252, Individual #71, Individual #134, Individual #116, Individual #181, and Individual #321) ▪ For none of 10 individuals (0%), the ISP/ISPAs contained measurable objectives related to interventions.	

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		Generally accepted practice standards for comprehensive progress notes related to PT/OT interventions include that notes: ▪ 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 two (0%) individuals (i.e., Individual #252, and Individual #71) receiving direct OT/PT services for more than a month at the time of the review was provided with comprehensive progress notes at least monthly that contained each of the indicators listed above. For example, Individual #252'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 was present for none of the 10 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 individuals receiving direct OT and/or PT interventions had 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 been integrated into individuals' ISPs for three of four individuals. The Facility remained out of compliance with this subsection.	
P3	Commencing within six months of the Effective Date hereof and with	<u>Competency-Based Training</u> Competency-based training for direct support professionals related to implementation	Substantial Compliance

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	full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	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.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	<u>Monitoring System</u> 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 Occupational Therapy/Physical Therapy/Speech Therapy Direct Services Protocol, dated 4/23/14; ▪ LBSSLC Compliance/Efficacy Monitoring Guideline for Licensed Habilitation Therapists, dated 9/16/13; ▪ LBSSLC Monitoring in Habilitation Therapy Plans, dated 10/4/13; ▪ LBSSLC – IDT – Program Development Occupational Therapy and Physical Therapy Services, revision dated 5/16/14; ▪ LBSSLC PNMP/Revision/Finalization, revised 12/13/13; ▪ 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 11/12/13; 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 individuals' 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	Noncompliance

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		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 1/2/14 to 5/29/14. One hundred and six (106) 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. 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 10 of 10 (100%) individuals in Sample P.2, routine maintenance checks were conducted to ensure that positioning devices and other adaptive equipment identified in	

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		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. 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. As Section P.4 explicitly states: "…the Facility shall develop and implement a system to monitor and address… 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." The Facility was not in substantial compliance with Section P.4.	

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Any policies, procedures and/or other documents addressing the provision of dental care, including for updated policies/procedures/protocols, highlighted areas of approved change; o 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. Include copy from dental office's record of visit and copy from active record of same visit, including source of documentation (i.e., IPN or dental section of active record/dental office record) for: Individual #217, Individual #265, Individual #142, Individual #272, Individual #84, Individual #168, Individual #75, Individual #255, Individual #213, Individual #299, Individual #47, Individual #202, Individual #87, and Individual #90; o Five most recent off site oral surgery consults and progress notes past six months: Individual #68, Individual #168, Individual #172, and Individual #45; o List of abbreviations used in all dental records/reports; o For the past six months, any data summaries used by the Facility related to dental

	services, and/or quality assurance/enhancement reports, including subsequent corrective action plans; o Attendance tracking sheet for dental appointments for the past six months; o List of refusals for the past six months per date of refusal, including reason for appointment (i.e., prophylaxis, annual, etc.), name, dates of refusals and date of completion; o List of those who have not seen dentist in one year and reason; o List of those who have outstanding need for dental x-rays, according to current professional standards, and type of x-ray that is needed to fulfill requirement/ recommendations, including date of last full mouth x-rays; o List of those who were edentulous at time of the last on-site 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 ISPA 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 #27 (3/4/14), Individual #68 (2/25/14), Individual #211 (3/12/14), Individual #34 (3/31/14, 4/15/14, and 5/15/14), and Individual #121 (5/12/14); 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 #190, Individual #255, Individual #27, Individual #100, and Individual #91; 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 In response to request for individuals given dental pre-treatment sedation, communication from the Dental Department; o Current list of HRC approved dental medical restraints with sedation, including type of sedation, such as PO sedation, IV or general anesthesia;

	○ 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 (i.e., lower dosage, less mechanical restraint duration, etc.)); ○ In past six months, per month, percentage of individuals utilizing general anesthesia/IV sedation for dental exam and treatment; ○ In past six months, per month, percentage of individuals utilizing oral sedation for dental visits; ○ In past six months, per month, percentage of individuals utilizing mechanical restraints for dental visits; ○ Requested most recent five extractions in past six months, copy of initial evaluation for this, second opinion, and subsequent documentation. Submitted information for following 2 individuals: Individual #322 and Individual #273; ○ List of those who receive suction tooth brushing treatment; ○ 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.); ○ Copy of 10 annual dental assessments completed in last 30 days and for the prior year of these same individuals; ○ Dates of dental record annual examinations/assessments and treatment plan record completed in last six months, and the date of previous dental record annual examination/assessment and treatment plan record for all individuals, including copies of these annual exams (including odontogram); ○ Copy of 10 most recent annual dental summaries provided for the ISP submitted for the following individuals: Individual #8, Individual #213, Individual #321, Individual #173, Individual #217, Individual #181, Individual #1, Individual #300, Individual #227, and Individual #126; ○ 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; ○ 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; ○ List of those individuals that floss their own teeth; ○ List of individuals provided instructions on flossing with dates of training; ○ 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; ○ For those that are edentulous, list of those with dentures; ○ For those edentulous without dentures, list of reasons with documentation as indicated; ○ Summary information on desensitization plans since Monitoring Team's last visit, including any evidence of implementation of plan, progress logs, etc.; ○ For those undergoing TIVA, any incident of injury in 24-hour 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 Correspondence from "Anesthesia Services for Dentistry," dated 6/30/14; o For the self-assessment process: list of monitoring/audit tools used and for each tool, identification of the total number of the eligible population to be sampled, the 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; and o Presentation Book for Section Q. ▪ **Interview with**: o William Shipley, DDS.
	Facility Self-Assessment: For Section Q, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring /audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: "Dental Monitoring Tool" and "Suction Tooth brushing." 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 samples 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 RN. o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ The Facility used other relevant data sources and/or key indicators/outcome measures to show whether or not the intended outcomes of the Settlement Agreement were being reached. The quality of the data maintained in the databases was noted to be incomplete and inaccurate. Some of the Self-Assessment findings might have been based on incomplete and/or inaccurate data. Facility staff recognized this issue themselves, and reported the problems to the Monitoring Team. ▪ The Facility rated itself as being in noncompliance with Section Q. This was consistent with the

	Monitoring Team's findings.
	Summary of Monitor's Assessment: For Section Q, Facility staff reviewed the databases and determined the information appeared not reliable and unverifiable. This problem was identified prior to the Monitoring Team's visit. At the time of the Monitoring Team's visit, steps had been taken to begin development of a reliable database system for dental services. A new Dental Director recently had been hired to assist in developing quality dental services with quality database management. Additional dental staff might need to be recruited or assigned with a focus on dental hygiene assistance/mentoring and monitoring in the homes. An area of focus should be teaching and monitoring oral hygiene in the residences. Two extensive CAPs had been developed since the Monitoring Team's last visit, one for dental desensitization, and one for suction tooth brushing. These remained in an early implementation phase. The Facility remained in noncompliance with Section Q.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	<u>Staffing</u> One full-time Dentist (date of hire 6/18/14), one part-time Dentist, one Dental Assistant, and one Dental Hygienist staffed the Dental Department. CPR certification was submitted for the Dental Department staff. For four dental staff, submitted information indicated one was current in CPR, and one of four was exempt from CPR certification. <u>Annual Assessments</u> The Facility was unable to provide information concerning annual assessment completion for the past six months. Documentation indicated: "On 6/9/14, the Director had the dental database reviewed. It was noted that the database had errors and data could not be validated. …Therefore, we are unable to submit documentation for this request as we cannot validate and verify information." For similar reasons, the Facility could not provide data concerning the number of individuals residing at SSLC who had not seen a dentist in the prior 365-day time period. Copies of 10 most recent annual dental assessments completed in the prior 30 days, as well as the previous annual dental assessment for the same individuals were requested. These were not provided. Additional copies of annual dental summaries (i.e., not the actual assessments, but the summaries prepared for the IDTs) were provided. No further information was submitted for the annual dental assessment. A copy of 10 annual dental summaries (i.e., the report submitted to the IDT for the ISP process) were submitted for review that had been completed in the 30 days prior to the Monitoring Team's visit along with the prior year's completed assessments were	Noncompliance

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		submitted. The content of this submitted document (i.e., annual dental summary) included the following components: ▪ Ten of 10 (100%) submitted summaries had an entry concerning cooperation, behavioral issues, and need for sedation/restraint use. ▪ Ten of 10 (100%) submitted summaries had entries for oral hygiene rating. ▪ Ten of 10 (100%) submitted summaries for individuals had entries for periodontal condition. ▪ None were edentulous. ▪ Zero of the 10 (0%) submitted summaries had entries for oral cancer screening ▪ A periodontal chart or periodontal screening/probe record was completed/documented in zero of ten (0%) records. ▪ Ten of 10 (100%) submitted summaries documented a summary of findings/treatment by use of an odontogram. Any current treatment at the time of the annual dental exam was also separately listed. ▪ Ten of 10 (100%) submitted summaries included a well-defined dental treatment plan. ▪ Ten of 10 (100%) submitted summaries documented oral hygiene recommendations. ▪ Nine of the 10 (90%) submitted summaries documented risk rating. ▪ Ten of 10 (100%) submitted summaries documented community transition preparedness. However, for one of 10, the statement appeared to need further review as it contradicted itself: "… cannot be served in a less restrictive setting at this time, and I do recommend that the individual be referred for community placement." ▪ Completion of the annual dental summary occurred from zero to seven days following the annual dental assessment for five annual dental assessments. For the other five annual dental assessments, the date of last dental exam was actually after the annual summary date, which was problematic. In these five, it appeared a prior annual exam was used, which might have been up to a year in the past. For these five, the dates of the annual dental summaries ranged from 4/7/14 to 5/12/14, but did not include the information from the most recent annual dental assessment. ▪ It was noted that all 10 annual dental exams referenced occurred on two days. Four annual dental exams occurred on 5/12/14, and six occurred on 5/14/14. The Dental Department was unable to provide evidence of tracking the completion of annual exams on a monthly basis due to lack of ability to validate and verify information. <u>New admissions</u>	

#	Provision	Assessment of Status	Compliance
		Additionally, during the time period from January 1, 2014 through May 31, 2014, there were eight new admissions. Eight of eight had completed an initial dental exam in the first month (from two to 18 days). Additionally, there was a readmission for an individual recently discharged from the Facility with a discharge dental exam on 3/5/14. No readmission exam was completed. It was not determined if this was consistent with the State Office guidelines or LBSSLC policy. Oral Hygiene For the document request for the most recent/current Facility oral hygiene data for all individuals in past the past year, the Facility indicated that: "on 6/9/14, the Director had the dental database reviewed. It was noted that the database had errors and data could not be validated... Therefore, we are unable to submit documentation for this request as we cannot validate and verify information." The following reflects this lack of data:	

	Good Oral Hygiene Rating (#/%)	Fair Oral Hygiene Rating (#/%)	Poor Oral Hygiene Rating (#/%)
All individuals	Not available	Not available	Not available
Dentate individuals	Not available	Not available	Not available

The 4/22/14 QA/QI Quarterly Review for Section Q documented the following information: As of March 2014, 30 percent of individuals had poor oral hygiene. An oral care documentation component had been added to the treatment order record for staff completion in the residences, but completion of this section remained at zero percent.

The Presentation Book for Section Q listed new endeavors to improve oral hygiene. The use of floss holders with long handles, Sensodyne prophylactic paste, fluoride with a bubblegum flavor, and tooth timers for use for those that brush their own teeth had allowed for improved cooperation and quality of tooth brushing by the individual, and increased assistance by the direct support professionals in completing oral hygiene. This appeared to be anecdotal information.

The Dental Department did not submit any data/evidence indicating periodontal probing or periodontal chart completion/updates in the dental record.

Oral Hygiene Training
The Dental Department did not provide information concerning the number of new employees trained in oral hygiene during orientation. The Dental Department did not provide information concerning the number of individuals receiving oral hygiene instruction at the dental office (i.e., chair-side). The Dental Department did not provide information concerning the number of staff receiving oral hygiene instruction at the

#	Provision	Assessment of Status	Compliance
		dental office (i.e., chair-side). The Dental Department did not provide information concerning oral hygiene instruction in the residences. Training rosters for suction tooth brushing were submitted. One hundred fifty-four staff (i.e., nurses and residential staff) completed training for suction tooth brushing. A document entitled: "Suction Tooth brushing – Employees completed training 6/18/14" provided evidence of this training. A second list was submitted, entitled: "Suction Tooth brushing 6/18/14," which listed 232 staff that had not completed the training as of that date. This training was also one aspect of the Suction Tooth brushing CAP. Training began in June 2014, and was to be completed in July 2014. Training included a power-point program entitled: "Suction toothbrush Protocol (PLAK-VAC)." A procedure manual entitled "Oral Suction Toothbrush (Plak-Vac)" was also available, dated 3/1/14. A competency-based evaluation for training of suction tooth brushing was also developed. This training was included in the curriculum of the new employee orientation as of 6/2/14. The Dental Department did not provide information concerning any annual refresher course in oral hygiene for applicable staff. <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: risk of aspiration, history of aspiration, risk of silent aspiration, unable to manage thin liquids safely, unable to spit, and unable to brush independently. A list indicated 62 individuals would benefit from suction tooth brushing. Of these, 53 (85%) individuals received suction tooth brushing, which was 53 of 206 of the population. There were nine individuals identified as qualifying for suction tooth brushing, but not receiving suction tooth brushing. Reasons were listed as: no pump and staff training was needed for implementation. This list had been updated on 4/14/14. The Presentation Book for Section Q included more recent information. As of June 2014, 65 individuals were receiving suction tooth brushing. However, an inventory list dated 6/23/14 indicated 63 individuals had a suction pump. A multi-disciplinary committee was formed to ensure suction tooth brushing was available to those individuals that needed this procedure. This CAP (originally with 13 steps, and subsequently increased to 15 action steps) was approved on 3/26/14. At the time of the Monitoring Team's visit, six action steps had been completed. Components included the following: identification of individuals in need of suction tooth brushing, review of individuals with suction tooth brushing to verify need, review of the suction	

#	Provision	Assessment of Status	Compliance
		toothbrush procedure, retraining of nurses and select direct support professionals on new suction tooth brushing procedures, ordering of 30 new suction machines, assessment of residences to ensure electrical power availability and storage availability, development and implementation of a suction tooth-brush monitoring tool, monitoring of individuals that required suction tooth brushing, provision of retraining during spot check monitoring and for individuals developing pneumonia, collection of oral hygiene scores, and analysis of oral hygiene trends for impact of the suction tooth brushing CAP. QA monitoring for this new program began in April 2014. <u>Individuals with self brushing plans</u> From a document entitled: "Individuals that brush on their own," dated 12/6/13, 67 individuals were reported to brush their own teeth. The oral hygiene scores of 66 individuals were submitted for the prior two or more ratings completed during dental visits. For one individual, only one score was listed, and trending of the oral hygiene rating could not occur. ▪ Forty individuals remained in the same category of oral hygiene rating. o There were three that maintained a good oral hygiene rating. o For 33, the individuals maintained a fair oral hygiene rating. o For four, the individuals continued to have poor oral hygiene ratings. ▪ For 21 individuals that brushed their own teeth, there was improvement in the oral hygiene ratings. o For 16 individuals the ratings improved from poor to fair. o For four individuals the ratings improved from fair to good. o For one individual, the ratings improved from poor to good. ▪ For five individuals, the oral hygiene ratings worsened. o For zero individuals, the rating changed from good to poor. o For three individuals, the ratings changed from good to fair. o For two individuals, the ratings changed from fair to poor. For individuals with continued poor oral hygiene or worsening oral hygiene scores who brushed their own teeth, the Facility had not developed a system to observe and coach individuals in the home in improved oral hygiene. <u>Flossing</u> A list of individuals that flossed their own teeth was requested. Additionally, a list was requested of individuals provided instructions on flossing, with dates of training. The Facility indicated that, "on 6/9/14, the Director had the dental database reviewed. It was noted that the database had errors and data could not be validated." This information was not available.	

#	Provision	Assessment of Status	Compliance
		Pneumonia The Facility documented that: "on 6/9/14, the Director had the dental database reviewed. It was noted that the database had errors and data could not be validated." Information concerning the incidence of pneumonia following dental visits was not available. Preventive, Restorative, Emergency Dental Services There was insufficient evidence to determine whether the Dental Department provided the breadth of services required to care for the individuals at LBSSLC. For requested information concerning preventive dental care, restorative care, dental emergencies, and tooth extraction data, the Facility documented that "on 6/9/14, the Director had the dental database reviewed. It was noted that the database had errors and data could not be validated… Therefore, we are unable to submit documentation for this request as we cannot validate and verify information." The following charts reflect this lack of data which would have been expected through complete and accurate databases:	

Month	# Prophylactic Care Treatments
No information available.	

The following was the number of restorations completed at each visit, along with the number of visits in which this occurred:

# Restorations per Visit	# Visits	# Restorations per Visit	# Visits
No information available			

The following were the number of visits per month for restorations, and the total number of restorations completed per month:

Month	# Visits	# Restorations per Visit	Total # Restorations for Month
No information available			

The following were the number of emergencies per month with the number resolved:

Month	# Emergencies	Resolved	Month	# Emergencies	Resolved
No information available					

#	Provision	Assessment of Status	Compliance

The following provided information about timely response to dental emergencies:

Month	# Emergencies	Seen Same Day	Seen Next Work Day	Month	# Emergencies	Seen Same Day	Seen Next Work Day
No information available							

The following provided the number of teeth extracted per individual:

# Teeth Extracted	# Individuals	# Teeth Extracted	# Individuals
No information available			

The following information provided the breakdown by visit and numbers of teeth extracted per visit.

Month	# Visits with Extractions	1 Tooth Extracted	2 Teeth Extracted	3 Teeth Extracted	4 Teeth Extracted	5 or More Teeth Extracted
No information available						

The following number of annual exams were completed per month:

Month	# of Completed Annual Exams
No information available	

Month	# of Completed Annual Exams with 365 days of prior exam	# of Completed Annual Exams past 365 days of prior exam
No information available		

<u>X-rays</u>
According to the Dental Department, all individuals in need of radiographs had these completed or the risk/benefit ratio did not justify radiographs based on complex medical history. A list of those individuals in which the risk outweighed the benefit was provided. There were a total of five individuals in this category. For a census of 206 individuals and 16 that were edentulous, there were 190 individuals with teeth. From this information,

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		185 of 190 (97%) had radiographs completed. <u>Edentulous individuals/dentures</u> Information submitted indicated 15 individuals residing at LBSSLC were edentulous, for a rate of 15 of 206 (7%). No individual became edentulous since the Monitoring Team's last visit. No individual became edentulous in 2013 or 2012. Two individuals became edentulous in 2011. Three individuals became edentulous in 2010. Two individuals became edentulous in 2009. Two individuals became edentulous in 2008. Six individuals became edentulous prior to 2008. Two of 16 individuals that were edentulous had dentures (the discrepancy between documents listing 15 or 16 individuals with edentate condition was not clarified). One individual had dentures prior to admission to LBSSLC. There were no individuals that received dentures since the Monitoring Team's previous visit. Fourteen individuals that were edentulous did not have dentures. Reasons given were: ▪ One had behaviors considered barriers to denture fabrication and denture use. ▪ Fourteen had complex oral anatomy (i.e., inadequate bone structure, etc.). ▪ Four had inadequate muscle coordination, uncontrolled muscle movements, tongue thrust, or excessive gag reflex. ▪ Nine had dysphagia. ▪ Fourteen had shown no interest in obtaining dentures. ▪ All individuals had more than one reason listed for not having dentures. <u>Oral Sedation</u> The Facility indicated no oral pre-treatment sedation was given in the prior six months. <u>General Anesthesia/TIVA</u> The Dental Department did not submit the general anesthesia/TIVA appointment schedule for the prior six months. The Facility indicated they were "unable to submit documentation for this request as we cannot validate and verify information." As a result, the following could not be completed: The number of appointments utilizing general anesthesia/TIVA completed per month follow: | Month | # Completed Visits with General Anesthesia/TIVA | # Scheduled Visits with General Anesthesia/TIVA Not Completed | Completed at Second Appointment | TIVA Appointment Not Completed |	

#	Provision	Assessment of Status	Compliance

No information available				

Anesthesia Services for Dentistry, which provided general anesthesia services at LBSSLC, submitted a list of completed visits per month:

- November 2013 – 16 completed cases;
- December 2013 – 11 completed cases;
- January 2014 – eight completed cases;
- February 2014 – six completed cases;
- March 2014 – eight completed cases; and
- April 2014 – 14 completed cases.

The active record was submitted for five individuals who had undergone general anesthesia/TIVA from 4/9/14 through 4/30/14. The procedures under general anesthesia/TIVA included one or more aspect of dental care. The list varied in each case, and included one or more of the following: exam, prophylaxis, restorations, radiographs, and gingivectomy. 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 HRC review and approval was submitted in three of five (60%).
- A pre-operative medical clearance was completed and submitted in zero of five (0%) cases.
- A pre-operative anesthesia clearance/review was included in the anesthesia record in five of five (100%).
- NPO status was confirmed in five of five (100%).
- Dental pre-sedation was administered in one of five.
- A pre-visit IPN indicating need was submitted in one of five.
- Pre-operative vital signs were recorded in the anesthesia record in four of five (80%).
- An operative note by the dentist was recorded in five of five (100%) cases.
- The operative anesthesia record was completed in five of five (100%).
- For those with teeth, a periodontal chart/periodontal 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 three of five (60%) of the active records.
- A Dental Department recovery/post-operative note was submitted for zero of five (0%).

#	Provision	Assessment of Status	Compliance
		▪ Post-operative vital signs were documented as stable by the anesthesiologist in five of five (100%). ▪ Documented post–operative vital signs by the nursing staff in the home were submitted in zero of five (0%). ▪ An annual dental assessment was completed while under general anesthesia/TIVA in five of five cases (100%). Concerning injuries reported within 24 hours of general anesthesia/TIVA administration in the prior six months, the Facility indicated: "on 6/9/14, the Director had the dental database reviewed. It was noted that the database had errors and data could not be validated…. therefore, we are unable to submit documentation for this request as we cannot validate and verify information." <u>Oral Surgery (off site)</u> For four individuals that underwent oral surgery consultation off campus, submitted documentation included the following: ▪ Four of four (100%) had a pre-operative plan completed by the oral surgeon indicating the need for the procedure prior to the oral surgery. ▪ Two of four (50%) had a post procedure note by an LBSSLC dentist at the Facility the following day. ▪ Four of four (100) included an oral surgery consult/operative report. ▪ Zero of four (0%) included an anesthesia report. ▪ Zero of four (0%) included a copy of the current consent by the guardian/LAR. <u>Extractions</u> For two individuals that underwent extractions on campus, the dental record was submitted. The following findings were made: ▪ Documentation was submitted for current guardian/LAR consent in zero of two (0%). ▪ A dental IPN/DPN indicating the need for extractions was documented in one of two (50%), either completed pre-operatively or at the time of exam under general anesthesia/TIVA. ▪ For two of two cases, IV sedation/general anesthesia was used. For one of two, there was additional documentation of local anesthesia. ▪ One to two teeth were extracted at a visit. This is informational only. ▪ Submitted information included orders for pain medication in one of two (50%) cases. Standing orders were not included in the submitted information. ▪ A follow-up dental note the following morning in the Infirmary or a phone call to the home (when not admitted overnight to the Infirmary) was documented in zero of two (0%) cases. ▪ A follow-up visit was documented in zero of two (0%) cases to determine healing	

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		or complications. Emergency Treatment Emergency treatment was reviewed for five individuals and eight emergency visits. The reasons for the emergency were as follows: trauma to head, ulcer in mouth, burn in mouth, fillings missing, dental abscess, irritation of gums, worn crowns, and no reason listed for one individual. The following findings are made based on this review: ▪ Five of eight (63%) emergency visits documented the presence or not of pain. ▪ Submitted information indicated pain was treated in two of four (50%) cases. Whether standing orders for pain management were utilized for the other two of four individuals was not reviewed. ▪ Follow-up occurred for seven of seven (100%) applicable cases. ▪ There was documentation of closure of the dental emergency (i.e., either no further visit required or scheduled for procedure) in eight of eight (100%) dental emergency visits. ▪ The length of time from the notification of the dental emergency in the Dental Department to completing a visit could not be determined from submitted information. The Facility remained in noncompliance with Section Q.1.	
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	This section of the report includes a number of sub-sections that address the various requirements of this provision of the Settlement Agreement. These include the development of dental policies and procedures, provision of dental records to IDTs, refusals and missed appointments, tracking of use of sedating medications and restraints, and interventions to minimize the use of sedating medications. Policies and Procedures Policies recently developed and implemented included the following: "LbSSLC – Dental Services –Oral Care," revised 12/13/13. Provision of Dental Records to IDTs The 4/22/14 minutes of the QA/QI Quarterly Review, Section Q, indicated for both February and March 2014, dental documentation was not available in the active record. 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 used to assist in determining whether the IDTs received adequate/complete dental information for the individuals. Documentation for 14 individuals was submitted (one residence was not completed due to infection control concerns). One hundred	Noncompliance

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<tr><td></td><td>strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.</td><td>twenty-five documents were submitted. These documents were derived from the dental office, from the active record IPN section, or from the dental section of the active record. However, there was no identification of the source of each document (i.e., office or active record/IPN section or dental section) to ensure each document in the dental office was located in the active record for 125 of 125 submitted documents. The Monitoring Team's last report documented similar findings.

<u>Refusals/Missed Appointments</u>
The Facility indicated that tracking of refused and missed dental appointments was not available: "On 6/9/14, the Director had the dental database reviewed. It was noted that the database had errors and data could not be validated… Therefore we are unable to submit documentation for this request as we cannot validate and verify information." No information was available to allow completion of the following:

<table>
<tr><th>Month</th><th># Refused Appointments</th></tr>
<tr><td>No information available</td><td></td></tr>
</table>

<table>
<tr><th>Month</th><th># Missed Appointments (Non-refusals)</th></tr>
<tr><td>No information available</td><td></td></tr>
</table>

It was also indicated that there were no IDT minutes for refused or missed appointments. According to submitted documentation, the Dental Department indicated: "Most of the refused or missed appointments were rescheduled and completed at that time." The following could not be completed:

<table>
<tr><th>Month</th><th>% Attendance of all Appointments</th><th>Month</th><th>% Attendance of All Appointments</th></tr>
<tr><td>No information available</td><td></td><td></td><td></td></tr>
</table>

<u>Interventions to Minimize the Use of Sedating Medications and/or Restraints</u>
For information concerning use of restraints for dental procedures, the Facility similarly indicated, "we are unable to submit documentation for this request as we cannot validate and verify information."

The following table lists reflects this information:

<table>
<tr><th>Month</th><th>Completed Appointments</th><th># with TIVA/GA</th><th>% with TIVA/GA</th><th># with oral sedation</th><th>% with Oral Sedation</th></tr>
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#	Provision	Assessment of Status	Compliance

No information available						

Separately, a list of HRC approved dental and medical restraints was submitted, with scan date of 6/16/14. A total of 27 individuals were listed that had HRC approval for dental physical and mechanical restraint. One hundred twenty individuals were listed that had HRC approval for dental chemical restraint. Under the category of routine procedures, dental sedation was listed as Ativan (route not always documented on the list) for 13 individuals. One hundred twelve utilized TIVA and a few utilized both oral/intramuscular and/or IV sedation, depending on the procedure. Of these, 74 were current with HRC approval and 46 were outdated.

A separate document indicated that LBSSLC did not use any type of restraint in the prior six months. There was no correspondence concerning restraint or sedation use in the last six months. A third document indicated that there were no pre-treatment sedations in the prior six months.

<u>Desensitization</u>
Pre-visit documentation was submitted providing current information concerning desensitization and other behavioral programs to improve individual cooperation and compliance with dental visits.

- There was no information to determine the number of individuals that had been identified as requiring desensitization or another plan to reduce the need for restraint.
- Six individuals had dental desensitization plans developed. One individual had two separate desensitization plans (SAPs). This was a total of seven plans.
- There was no information to determine the number of individuals that had been reviewed for a need for desensitization or another plan to reduce the need for restraint.
- There was no information to determine the number of individuals that had been reviewed and did not meet the criteria for benefiting from desensitization or other plan to reduce the need for restraint.
- Seven of seven (100%) plans were implemented.
- Data showed that for five of seven of these plans that were implemented, three of seven plans had four months of data and two of seven plans had three months of data.
- One of seven had monitoring to ensure plan was completed as written. This occurred for two days for one month only for that one plan.
- Two of seven plans had recently been implemented and no data was available.

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Submitted information indicated that data was analyzed to determine progress or lack of progress in five of seven implemented plans.
Data analysis of current desensitization plans indicated that two had made progress, one made slight progress, and two had made no progress.
Based on analysis, plans for zero individuals were revised.
A quarterly dental report including analysis of progress of the desensitization program was not submitted.

A few observations were noted. There was no information submitted to determine the number of individuals that would benefit from a desensitization/behavioral program. There was no information as to the number of individuals that were screened and found not eligible for desensitization/behavioral plans. The QIDP had not analyzed data each month. When an individual made no progress, prompt review and revision of the plan did not occur. Only one plan indicated there was monitoring to ensure the staff correctly carried out the plan, and that only occurred for two days in one month. None of the other plans indicated compliance with implementation of the plan by staff. There was no information to indicate a quarterly report had been written and presented to the Facility Administration.

A separate document entitled: “List of individuals with desensitization plans and dates the plans were developed” was provided in the Presentation Book for Section Q. Three individuals had a behavior support plan. Eight individuals had SAPs, and one of these eight had two SAPs. All BSPs and SAPs had been developed since 11/2013. Examples of six plans were provided. One plan was submitted that was not from one of the eight individuals on the list. Titles of the SAPs reflected the goal of the SAPs: “Duration of Suction tooth brushing SAP,” “Medical Desensitization Clinic SAP,” “Medical/Dental Sitting in Chair SAP,” and “Desensitization Tolerance SAP.” No data was provided that these had been implemented.

The Dental Department had the following number of appointments for desensitization per month:
<table>
<tr><th>Month</th><th># Individuals</th><th># Appointments</th><th># Successes</th></tr>
<tr><td>No information submitted</td><td></td><td></td><td></td></tr>
</table>
Since the Monitoring Team’s last visit, an inter-disciplinary committee was established to develop and implement a corrective action plan for dental desensitization. The QA/QI Council accepted the plan on 5/15/14. A pilot program was established with 15 individuals with potential benefit from additional supports. A list of probe questions
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#	Provision	Assessment of Status	Compliance
		(entitled "Guidelines to determine if a Dental Desensitization Plan is needed" and "Desensitization Questionnaire") was developed, and responses were requested from individuals' IDTs to determine whether each individual needed further supports, a behavior plan, or a true desensitization plan. The appropriate plan was then developed. All plans were to include a tracking/trending component. Review of the plans was to occur by 5/27/14, with implementation of plans by 6/1/14. Data analysis was a future step to determine impact. A document entitled: "Desensitization Programs" listed routine medical and dental examinations/diagnostic tests for which desensitization programs (i.e., including SAPs, supports, or BSPs) might be required. Once it was determined that a desensitization program was needed, several steps were listed to complete the process. Interim guidelines were developed for those individuals not in the program that might have benefited from additional supports or a desensitization plan. These guidelines indicated that if the individual needed training of a skill (i.e., tooth brushing, etc.), then a skill acquisition objective needed to be developed. If there were "practical" issues such as scheduling conflicts, the IDT was to take action. If there was a behavior component, then a BSP or behavioral health staff were to assist. An "interim desensitization referral" was created to provide needed information from the IDT to the desensitization workgroup. Training was provided to staff utilizing this referral form. Two of 15 in the initial program were subsequently found not to need an additional plan to improve dental compliance. For two individuals, the workgroup indicated the IDT needed to develop an action plan, for three, a training SAP was indicated, and for eight a BSP or desensitization plan was indicated. Recommendations were sent to the Program Developers. Three individuals had recommendations not accepted by the IDT. For 10 individuals, 11 plans were developed and implemented. There were an additional seven plans for individuals not in the pilot program. The first steps in completing the CAP had occurred. The committee needed to continue to monitor, ensure data was accurate and complete, was collected and analyzed at routine intervals, and was followed by further corrective actions based on findings. This was a methodical approach to a multi-disciplinary challenge. Several quarters of data will need to be collected to determine impact if the plans are completed as written. Concerns remained about lack of structure and accountability concerning the staff responsible to monitor the quality of the plan implementation, and how often the responsible staff was to monitor/analyze the findings. There was also concern that not all plans appeared to have a rigorous approach with demonstrated daily (or at least five times a week) intervention and documentation of intervention. Frequency and consistency are	

#	Provision	Assessment of Status	Compliance
		important aspects of such plans. <u>Quality Assurance/Quality Improvement Initiatives</u> The QA/QI Department used the following monitoring tool to review the quality and completeness of dental care: "Assessment Audit: Dental Assessment Quality Checklist," revised 2/3/13. This included 33 clinical indicators for review. The Presentation Book for Section Q included a "Dental Monitoring Tool" for each month from December 2013 through April 2014. It was impossible to interpret this information, as the copy quality was poor. There was also no explanation as to the meaning of the x-axis and y-axis. Following each month's "Dental Monitoring Tool," data was provided by graph format per month for December 2013 through April 2014. An additional graph was also submitted for November 2013. There were 24 indicators graphed. It was not clear if the monitoring tool provided in the Presentation Book for Section Q was the tool (with 33 clinical indicators) used in obtaining the results indicated in the monthly graphs, and the indicators could not be matched to a number on the bar graph for interpretation of findings. Since the Monitoring Team's last visit, there were dental and QA meetings held on 1/22/14, 2/20/14, 3/20/14, 4/17/14, 5/15/14, and 5/27/14. The minutes of these meetings provided clarification of the findings of the monitoring done by the QA Department. There was no inter-rater reliability, as the Dental Department did not provide any monitoring. The 1/22/14 minutes indicated 100 percent of emergencies were seen within one business day, and 100 percent of appointments were kept. There were a considerable number of areas needing improvement listed, including: 50 percent of the annual dental exams were completed within 365 days, 50 percent of new admissions had completed dental exams within 30 days, 50 percent of individuals were provided oral hygiene instructions, and zero percent indicated preventive care was provided by the dentist. It was noted that there was inconsistent documentation of preventive care by the direct support professional/Nursing, with zero percent compliance in December 2013. Although the monitoring process indicated a random sample was selected, it did not indicate the sample size audited. The 2/20/14 minutes indicated a random sample of eight individuals was audited from January 2014. Fifty percent of the annual dental exams were completed within 365 days. Thirty eight percent of records indicated preventive care by direct support staff. Sixty-three percent had a treatment plan completed at the time of the initial or annual exam. There remained problems with lack of availability of the dental information in the active record.	

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The 3/30/14 meeting documented the continuing problem of lack of availability of dental documentation in the active record. A draft-monitoring tool for suction tooth brushing was created.

The 4/17/14 meeting documented that eight records were reviewed. Few details were provided for strengths or weaknesses in the documentation. Mention was only made of overall scores. The Dental Department had made a number of changes to the dental documentation for easier retrieval in the active record. Lack of availability of dental documentation in the active record remained in need of improvement. Direct support professional documentation of preventive care was at 50 percent.

There were two audits completed for the 5/15/14 meeting. The dental QA monitor continued to review a random sample and the sample size was eight. A suction tooth-brushing audit started in April 2014. A 10 percent sample size was to be reviewed monthly. There remained concerns with availability of the dental documentation in the active record. The QA monitoring tool for dental services was undergoing revision.
The 5/27/14 meeting documented that the QA Nurse had developed instructions for completion of the two monitoring tools (i.e., dental services and suction tooth brushing). Results of the Suction Tooth brushing audit were separately reported. Seven indicators were reviewed for four individuals and compliance was 100 percent in four of four cases.

<u>Internal Dental Department quality reviews</u>

The following could not be completed due to lack of information:

<table>
<tr><th>Month</th><th># Indicators Listed</th><th># Indicators with Compliance</th><th>Sample Size</th><th>Inter-rater Reliability %</th><th>Inter-rater Reliability Sample Size</th></tr>
<tr><td>No information provided</td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

The Facility had engaged in a good interdisciplinary planning process to address the issues related to desensitization and other strategies to decrease the need for pre-treatment sedation. The implementation of the resulting plan was in its initial stages. In addition, additional work was needed to address other QA findings related to dental care, and to address problems with data in areas such as missed and refused appointments. The Facility remained in noncompliance with this provision.
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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 15 individuals (i.e., Individual #53, Individual #30, Individual #60, Individual #313, Individual #140, Individual #198, Individual #283, Individual #280, Individual #213, Individual #190, Individual #234, Individual #73, Individual #105, Individual #167, and Individual #299), 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 the following 10 individuals: Individual #30, Individual #187, Individual #267, Individual #17, Individual #147, Individual #321, Individual #239, Individual #8, Individual #284, and Individual #196; 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;

	○ List of individuals with PBSPs and replacement behaviors related to communication; ○ Minutes for Communication committee meetings held since the Monitoring Team's last review; ○ Minutes for Speech Department meetings held since the Monitoring Team's last review; ○ List of all general common area communication devices; ○ Blank communication competency-based performance check-off for individual-specific communication programs; ○ Completed audits of SLP documentation; and ○ Behavior Support Committee minutes and attendance sign-in sheets for meetings held since the Monitoring Team's last review. ▪ **Interviews with:** ○ Linda Thomas, Director of Habitation Therapy; ○ Stacie L. Duda, MS, CCC-SLP; and ○ Samantha M. Russell, MS, CCC-SLP. ▪ **Observations of:** ○ 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 6/20/14. 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: ▪ The monitoring/audit tools the Facility used to conduct its self-assessment included: Facility-developed audit tool for SLP assessments, and Communication Compliance Monitoring form. ▪ 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. ▪ The Facility-based audit tools (i.e., SLP assessment audit tool) did not include adequate instructions, including standards, and criteria. ▪ 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. ▪ 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'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: 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 continued to be in substantial compliance with Section R.1. Eight 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 continued 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 two individuals with an AAC system in the sample. The Facility had policies/procedures related to monitoring communication supports provided to individuals. However, individuals' communication supports had not been monitored per Facility policy, and more work was needed to analyze and respond to the data.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech	**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 10 individuals: Individual #30, Individual #187, Individual #267, Individual #17, Individual #147, Individual #321, Individual #239, Individual	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	#8, Individual #284, and Individual #196; ▪ **Sample R.2:** Four individuals receiving direct speech interventions including: Individual #30, Individual #60, Individual #313, and Individual #140; ▪ **Sample R.3:** Eight individuals with a PBSP and communication deficits, including: Individual #280, Individual #213, Individual #190, Individual #234, Individual #73, Individual #105, Individual #299, and Individual #167; and ▪ **Sample R.4**: Ten individuals with AAC devices including: Individual #53, Individual #30, Individual #60, Individual #313, Individual #140, Individual #198, Individual #283, Individual #280, Individual #213, and Individual #190. 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. **Staffing** The LBSSLC Protocol for Caseload Distribution for SLPs, dated 11/11/13, defined SLP responsibilities, established the SLP-to-individual ratio, and described 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 with adjustments to be considered, as needed, for transition to a new home or the community, discharges, and/or death of an individual. The Section R Presentation Book and documentation submitted in response to the pre-visit request noted the Facility had four full-time SLPs. There were no SLP vacancies. The Facility SLP 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 reported SLP caseloads were as follows: ▪ SLP #1 had a caseload of 56 individuals. Approximately 54% of the individuals on this caseload had severe communication/ language deficits, and 45% of the individuals had moderate to mild communication deficits. The SLP provided supports and services to 46 of these individuals with identified communication	

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		needs. The remaining 10 individuals required a communication assessment every five years. ▪ SLP #2 had a caseload of 61 individuals. Thirty percent (30%) of the individuals had severe communication/language deficits, and 46% of the individuals had moderate to mild deficits. Forty-six (46) of these 61 individuals had identified communication needs. The remaining 15 individuals required a communication assessment every five years. ▪ SLP #3's caseload was 58 individuals. Seventy-four percent (74%) of these individuals had severe language deficits, and 24% of the individuals had moderate to mild deficits. Fifty-seven (57) of these individuals had identified communication deficits. The remaining individual required a communication assessment at least every five years. ▪ SLP #4's caseload had 32 individuals. Ninety-four percent (94%) of these individuals had severe language deficits, and the remaining 6% had moderate to mild communication deficits. This SLP also had PNMT responsibilities, as well as assisting SLP #1 and/or other therapists as needed. A review of the LBSSLC protocol, policies, and SLP caseloads (as well as other information discussed below) indicated LBSSLC had 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: ▪ 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); ▪ Beginning Sign Language Class (10/1/13 to 11/5/13); and	

#	Provision	Assessment of Status	Compliance
		▪ Sign Language Beginning II Class (3/25/14 to 4/29/14). **Facility Policy** The Facility submitted the following policies and protocols: ▪ LBSSLC Occupational Therapy/Physical Therapy/Speech Therapy Use of Consult for LBSSLC Change of Status Protocol, dated 3/11/14; ▪ LBSSLC Consultation Report Form Change of Status, dated 3/11/14; ▪ LBSSLC Compliance/Efficacy Monitoring Guideline for Licensed Habilitation Therapists, dated 10/4/13; ▪ LBSSLC Protocol for Persons Who Have Individual-Specific Training Techniques, dated 10/21/13; ▪ LBSSLC Occupational Therapy/Physical Therapy/Speech Therapy Direct Services Protocol, dated 4/23/14; ▪ LBSSLC Monitoring of Habilitation Therapy Plans, dated 10/4/13; ▪ LBSSLC – IDT Program Development Speech Communication Services, revision dated 5/16/14; ▪ LBSSLC Process to Validate that Staff Responsible for Training Other Staff are Competent to Assess Other Staff's Competency – Individual-Specific Competency Based Training PNM and Communication Skills, dated 11/11/13; ▪ LBSSLC Protocol for Caseload Distribution for Speech Language Pathologists, dated 11/11/13; ▪ LBSSLC Individual-Specific Competency Based Training PNM and Communication Skills, dated 11/11/13; ▪ LBSSLC Protocol for Process of Maintaining of Lists (i.e., Individuals who have received a Modified Barium Swallow study), revised 11/12/13; ▪ LBSSLC Protocol for Pathway for Return to Oral Eating and/or for Least Restrictive Intake, dated 1/8/14; ▪ LBSSLC Consultation Report Pathway to Return to Oral Eating and/or Least Restrictive Intake, revised 4/28/14; ▪ LBSSLC Habilitation Therapy Protocol for Use of Consult for Pathway to Return to Oral Eating and/or Least Restrictive Intake, dated 6/4/14; ▪ LBSSLC Protocol for Checking/Monitoring of Individual's Assistive Devices, dated 1/8/14; ▪ LBSSLC PNMP Revision/Finalization, revised 12/13/13; ▪ LBSSLC Color Code System, dated 11/13/13; ▪ LBSSLC Protocol to Identify Individuals Who Require Individual-Specific Training, dated of 11/12/13; ▪ LBSSLC Guideline for Pharmacy for Texture and Fluids, dated 2/12/14; ▪ LBSSLC – IDT Process – Active Treatment Pulled Staff/Transfer Staff Process, revised 12/11/13; and ▪ LBSSLC Occupational Therapy/Physical Therapy/Speech Therapy Direct	

#	Provision	Assessment of Status	Compliance
		Services Protocol, dated 4/23/14. 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 communication and transferrable to the population served. The Facility SLP policies and protocols included necessary components as discussed within this section. The Facility remained 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	**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. Eight of eight (100%) newly admitted individuals (i.e., Individual #223, Individual #283, Individual #76, Individual #171, Individual #321, Individual #181, Individual #196, and Individual #62) received a	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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 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. **<u>Communication Assessment</u>** 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 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	

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		recommended 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; ▪ 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	

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		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 to collaborate and provide input to assist in the development of communication strategies for behavioral support/interventions. Based on a review of eight individuals in Sample R.3 with Positive Behavior Support Plans the following was noted: ▪ Eight of eight individuals' communication assessments and PBSPs (100%) addressed the connection between the PBSP and the recommendations contained in the communication assessment. ▪ Eight of eight individuals' communication assessments (100%) contained evidence of review of the PBSP by the SLP. Based on review of the Positive Behavior Support Committee meeting attendance sheets from 1/13/14 to 5/8/14, participation by a SLP was noted in 17 of the 17 meetings (100%). 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.	

#	Provision	Assessment of Status	Compliance
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: ▪ Eight of 10 individuals' SLP (80%) (i.e., Individual #53, Individual #30, Individual #60, Individual #313, Individual #140, Individual #198, Individual #283, and Individual #280) attended the annual ISP meeting. ▪ Seven of 10 individuals' ISPs (70%) (i.e., Individual #53, Individual #30, Individual #60, Individual #313, Individual #140, Individual #198, and Individual #283) 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 was to support functional communication with the individual's AAC system. ▪ Communication Dictionaries for one of 10 individuals (10%) (i.e., Individual #53) were reviewed at least annually by the IDT as evidenced in the ISP and/or ISPA. ▪ None of 10 ISPs reviewed (0%) 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. ▪ Six of 10 ISPs reviewed (60%) (i.e., Individual #53, Individual #30, Individual #60, Individual #140, Individual #198, and Individual #280) contained skill acquisition programs to promote functional communication. As appropriate to the individual's needs, ISPs should contain a program (direct or indirect) that is aimed at improving functional communication. Individuals with AAC systems should have skill acquisition programs and/or other specific staff supports to promote the generalization of the use of the AAC system in multiple environments. ▪ None of 10 ISPs reviewed (0%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. The ISPs should provide information on status of goals/programs and recommendations for the future. This information should include data as appropriate. **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 #53, Individual #164, Individual #213, Individual #140, Individual #190, Individual #280, and Individual #283). ▪ Seven of seven observations (100%) found individuals' AAC devices present in	Noncompliance

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		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. **Direct Communication Interventions** Eleven individuals were receiving direct speech therapy. Sample R.2 included four of these individuals (i.e., Individual #30, Individual #60, Individual #313, and Individual #140). A review of these individuals' records found the following: ▪ Four of four individuals' direct intervention plans (100%) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. ▪ For three individuals' records reviewed (100%) (i.e., Individual #60, Individual #313, and Individual #140), the current SLP assessment identified the need for direct intervention with rationale. Individual #30's most recent assessment was completed after the therapy was completed. ▪ For one of four individuals' records reviewed (25%) (i.e., Individual #313), there were measurable objectives related to individual functional communication outcomes included in the ISP. ▪ For none of four individuals (0%), information was present regarding whether the individual showed progress with the stated goal on a monthly basis. Therapists completed a note for each therapy session, but there were no monthly progress notes to summarize an individual's progress. The monthly notes for these 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 four of four individuals (100%), a description was found of the benefit of the device and/or goal to the individual. ▪ For none of four individuals (0%), a report was found regarding the consistency	

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		of implementation. ▪ The following was not applicable for the individuals in the sample: For ___ of four individuals (___%) 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 three individuals' with a therapy discharge summary (0%) reviewed (i.e., Individual #30, Individual #60, and Individual #313), termination of intervention was well justified and clearly documented in a timely manner. There was no ISPA meeting for the IDT members to discuss and approve the recommendation(s) to terminate direct 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 29 individuals would require individual-specific training outside of the content of PNM foundational training. These 29 individuals were identified by a red dot on their PNMPs and dining plans. Staff were required to have individual-specific competency-based training prior to working with these 28 individuals. The staff of two of the 29 individuals within the samples for Section R (i.e., Individual #53 and Individual #30) required competency-based training and performance check-off related to AAC/communication. ▪ Twenty-eight of 28 staff (100%) assigned to Individual #53 had completed competency check-offs in all specialized components of their PNMPs (i.e., non-	

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		foundational skills for AAC/sighted guide) prior to the provision of services. ▪ Twenty-nine of 29 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 two individuals 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** 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 (e.g., 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 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	Noncompliance

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		explain risks associated with not implementing programs; that staff acknowledged being trained on individualized program; and that staff demonstrated where to document data correctly. Six months of Communication Compliance Monitoring forms (i.e., January to June 2014) were requested and reviewed for individuals in Sample R.4: ▪ For 10 of 10 individuals (100%) monitoring of communication supports was outlined in the assessment and/or Facility policy. ▪ For six of 10 individuals (60%), (i.e., Individual #53, Individual #30, Individual #60, Individual #140, Individual #198, and Individual #213), 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: "Based on self-assessment this provision is not in compliance. Although the Protocol 'Monitoring of Habilitation Therapy Plans' 10/04/2013 is current and continues to be utilized as further analysis of monitoring results needs to occur." Based on the Monitoring Team's findings, individuals had not consistently received communication monitoring. The Monitoring Team agreed that the Facility needed to conduct further analysis and respond to any problematic trends identified. 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 Stephanie Brasfield, Director of Residential Services; o Vocational Position Description Book (Position Descriptions for Vocational Services and Day Program Class Description); o Vocational Position Description Book (Position Descriptions for Vocational Services and Day Program Class Description), training documentation dates 6/9/14 to 6/13/14; o Vocational and Day Program Packet (updated data and summary descriptions), developed by Laura Anciso, Director of Vocational and Day Programs; o Monthly Vocational and Day Program committee meeting minutes, for the last six months, as available; o For Section S.1, Functional Skills Assessments (FSA), Preferences and Strengths Inventory (PSI), Individual Support Plans (ISP), Pre-ISP Personal Worksheet, ISP Personal Worksheet, Skill Acquisition Plans (SAPs), and SAP raw data and Monthly Reviews for the last three months, as available, for: Individual #70, Individual #154, Individual #213, Individual #235, Individual #73, Individual #68, Individual #167, Individual #254, Individual #280, Individual #34, Individual #284, and Individual #266; o For Section S.1, Dental and/or Medical Desensitization SAPs for: Individual #51, Individual #272, and Individual #109: o For Section S.2, Individual Support Plans, Preferences and Strengths Inventory, Functional Skills Assessments, and Vocational Assessments, as available, for: Individual #70, Individual #154, Individual #213, Individual #235, Individual #73, Individual #68, Individual #167, Individual #254, Individual #280, Individual #34, Individual #284, and Individual #266; o For Section S.3, SAPs and SAP data sheets, as found in records during onsite visit, for: Individual #87, Individual #146, Individual #100, Individual #167, Individual #99, Individual #179, Individual #151, Individual #65, Individual #313, Individual #83, Individual #67, Individual #113, and Individual #240; and o Completed Skill Acquisition Treatment Integrity Forms, as provided following direct observation of SAP Integrity Probes during onsite visits, for: Individual #235 and Individual #267. ▪ **Interviews with**: o Jim Forbes, Assistant Director of Programs, and Beckie Crawford, Director of Behavioral Services, on 7/7/14 and 7/8/14; o Stephanie Brasfield, Director of Residential Services, and Roshadi Moore, Active Treatment Supervisor, on 7/8/14 and 7/9/14; o Sandi Kennedy, QIDP Coordinator, Section F meeting, on 7/8/14;

	○ Desensitization Work Group meeting, on 7/9/14; ○ Marty Jones, Integrated Program Developer, and Regan Harrison, Integrated Program Developer, on 7/9/14; ○ Laura Anciso, Director of Vocational and Day Programs, and Rosie Driver, Supportive Employment Coordinator, on 7/10/14; ○ Raul Jaime Trevino, QA Program Compliance Monitor (Section K), and Marilyn Foster, QA Program Compliance Monitor (Section S), on 7/10/14; ○ Peggy Brown, Administrative Assistant, Behavioral Services, on 7/10/14; ○ Stephanie Brasfield, Director of Residential Services, on 7/10/14; and ○ Beckie Crawford, Director of Behavioral Services, on 7/11/14. ▪ **Observations Conducted**: ○ PBSP competency-based training at Aspen (513), on 7/8/14; ○ PBSP Competency Integrity Check at Oak (518), on 7/9/14; ○ PBSP Competency Integrity Check at Workshop, on 7/9/14; ○ Psychiatric Clinic at Canna (521), on 7/9/14; ○ Desensitization Committee Meeting, on 7/9/14; ○ ISP Preparation Meeting for Individual #75, on 7/10/14; ○ Behavior Support Committee Peer Review Meeting, on 7/10/14; ○ Onsite direct observation and/or interaction with direct support professionals, and other professionals were conducted throughout the morning and/or afternoon hours at the following sites: ▪ Large Workshop, on 7/7/14; ▪ Small Workshop, on 7/7/14; ▪ Educational Building, on 7/7/14; ▪ Lily (524), on 7/7/14; ▪ Zinnia (528), on 7/7/14; ▪ Iris (527), on 7/7/14; ▪ Tulip (526), on 7/7/14; ▪ Aspen (513), on 7/8/14; ▪ Willow (520), on 7/8/14; ▪ Oak (518), on 7/8/14; ▪ Maple (517), on 7/8/14; ▪ Rose (525), on 7/8/14; ▪ Violet (523), on 7/8/14 and 7/9/14; ▪ Fir (516), on 7/10/14; ▪ Elm (515), on 7/10/14; and ▪ Birch (514), on 7/10/14.
	Facility Self-Assessment: Lubbock State Supported Living Center submitted a Self-Assessment for Section S, dated 6/20/14. 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: ▪ As noted in the Monitoring Team's previous report, the monitoring/audit tool the Program Compliance Monitor utilized included the "Section S – Habilitation, Training, Education, and Skill Acquisition Programs." In addition to the PCM, the Integrated Program Developers (IPDs) also completed this tool as part of the self-assessment process. At the time of the previous review, it appeared the Section S monitoring tool, including efforts to estimate inter-rater reliability, were completed in July, August, September, October, and November 2013. At the time of the Monitoring Team's most recent visit, it appeared that the Facility had made a qualitative change in the tools used to monitor compliance. More specifically, based on verbal report, in April 2014, the use of the Section S monitoring tool was reportedly discontinued, and, in its place, the Facility initiated the use of the Skill Acquisition Integrity Monitoring Form. According to verbal reports, observations using this form as part of compliance monitoring began in April 2014 and utilized a similar process to identify a sample. That is, each month, four individuals were randomly selected from the ISP schedule, and, once identified, the PCM and IPD would concurrently and independently complete the Skill Acquisition Treatment Integrity Monitoring Form. Data on the use of this form reflected monitoring, including estimates of inter-rater agreement, in April and May 2014. However, based on provided summary data, it was noted that the inter-rater estimates generated across items appeared inaccurate. The Monitoring Team strongly suggests that the PCM and IPDs review how to accurately calculate inter-rater agreement estimates. ▪ As described in the Monitoring Team's previous report, in addition to efforts completed by the PCM noted above, a second PCM also completed monthly checks of the quality of skill acquisition programs using the "Skill Acquisition Program Quality Assurance Tool." At that time, 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). At that time, generated quality scores as well as inter-rater agreement scores were not provided. Currently, the same process appeared to be in place using a slightly revised quality rubric described as the Skill Acquisition Critical Element Tool – also known as the "SAP QA Rubric." Verbal reports indicated that the use of this tool was initiated in November 2013. Provided summary data revealed examples of how the scores were illustrated each month as well as tracked over time. For example, monthly SAP QA scores from May 2014 were illustrated, and reflected completed quality scores for each of the four separate SAPs completed by each IPD, as well as two quality scores (averaged) per month for the IPD and PCM. Based on the provided example, the PCM still reviewed all 16 of the SAPs reviewed by the IPDs each month. Verbal reports indicated that the number of SAPs reviewed each month could vary depending upon the availability of IPDs. Although quality scores were reported, inter-rater reliability estimates for these reviews were not reported. This was viewed as a highly problematic and consistent with previous finding.

	▪ As noted in previous Monitoring Team reports, the self-assessment process also included examination of engagement through the completion of the "Consumer Support Observation and Interview" rubric. The PCM completed these reviews. Previously, this tool appeared to be completed monthly and included engagement estimates as well as estimates of competence in active treatment. At the time of the Monitoring Team's last visit, inter-rater reliability estimates did not appear to be generated when using this rubric. More importantly, at that time, an ongoing concern was noted regarding the fact that the Active Treatment Staff and PCM were using different engagement rubrics. Since the Monitoring Team's last visit, however, it appeared that the PCM and Active Treatment staff members were now using the same engagement rubric and generating inter-rater reliability ratings. More specifically, provided documentation revealed summary data that illustrated engagement monitoring by Active Treatment Staff and the PCM in March, April, May, and June 2014. This data appeared to include inter-rater agreement estimates for "competence" (based on scores on questions 1 to 13) as well as "engagement." It could not be determined from the available data how the agreement score for engagement was calculated. ▪ The self-assessment process also appeared to prescribe monthly meetings in which the PCM and IPDs discussed ongoing monitoring. Provided documentation reflected meetings in February, March, April, May, and June 2014. Meeting minutes reflected the transition to the new auditing rubrics as well as quality and inter-rater reliability estimates. However, verbal reports with the new Director of Residential Services revealed that inter-rater reliability estimates might not have been accurately calculated. ▪ 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, 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, and the FSA quality assessment tool, as well as several databases (i.e., tracking spreadsheets for vocational assessments, FSAs, engagement, community outings, number of paid positions on- and off-campus, as well as community contacts and newly established contracts). ▪ 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, FSA quality assessment, etc.). Indeed, according to the Director of Residential Services, inter-rater reliability estimates might not have been accurately calculated. Overall, based on provided documentation as well as verbal report, the self-assessment process continued to appear inadequate.
	Summary of Monitor's Assessment: Continued efforts to support the development of quality SAPs were noted. These efforts included interdisciplinary efforts at developing of a new SAP format and data sheet, revisions of SAP quality rubrics, and revision and development of curriculum/instructional guides as well as substantial trainings. Indeed, sampled SAPs revealed that those completed using the new format appeared of higher quality. Noted improvements included a more comprehensive behavioral objective, and

	more specification with regard to generalization and maintenance, prompting and fading, and error correction. In addition, newer SAP formats included more detail with regard to the rationale for the SAP. At times, however, these descriptions were found to be excessive and convoluted. Currently, only a small percentage of SAPs, including those designed for dental and/or medical desensitization, were developed using the most current format. Consequently, as the Facility progresses toward revising current SAPs, the majority of SAPs remained inadequate. In addition, consistent with findings of the Monitoring Team's previous reviews, the adequate daily data collection as well as adequate and timely monitoring of skill acquisition data was not evident. Given the excessive demands on the Integrated Program Developers (IPDs), the Monitoring Team encourages the Facility to closely examine the nature of this position and determine if additional IPDs are necessary to ensure adequate development and implementation of SAPs. In addition, the Monitoring Team continued to encourage the State Office to provide more oversight to ensure that ongoing changes reflect improvements in quality of programming as well as sustainable change, including closely examining the current SAP format, data sheets and monthly progress note formats. The Facility's efforts to improve the SAP QA Rubric also were noted. However, the usefulness of this rubric in consistently estimating the quality of SAPs had not been established due to the lack of inter-rater reliability checks. Consequently, the Facility should initiate these checks as well as consider the limitations in reporting combined scores. Similar inadequacy in conducting inter-rater reliability checks on the use of the Vocational Assessment Quality Checklist, Preferences and Skills Inventory (PSI) Assessment Quality Checklist, and Functional Skills Assessment (FSA) Grading Tool were noted as well. Estimates of engagement appeared significantly lower compared to previous estimates. More specifically, based on data collected during brief visits to program and residential sites, overall engagement was 43%. Consistent with observations during the Monitoring Team's previous visits, the staff-to-individual ratios observed in some settings were concerning, including inadequate staff-to-individual ratios that appeared to impair active engagement or participation in more structured opportunities for skill acquisition. Since the Monitoring Team's last visit, however, the Facility had revised the engagement rubric and initiated engagement probes by both QA and Active Treatment staff using the same engagement tool. Ongoing efforts to improve opportunities for on-campus and community-based employment continued. However, significant declines in attendance at day programs were reported. As a result, the Monitoring Team encourages the Facility to develop and implement a formal comprehensive corrective action plan targeting improved attendance at day programs.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two	As noted in the Monitoring Team's previous report, concerns remained with regard to development of quality SAPs. Indeed, concerns regarding the inadequacy of SAPs as noted at that time were consistent with those noted within previous Monitoring Team	Noncompliance

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	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.	reports. Since the Monitoring Team's last onsite visit, it appeared that the Facility had worked to address some of the observed inadequacies of the SAPs. That is, it appeared the Director of Behavioral Services had provided support to the IPDs and Active Treatment Staff in the form of multiple meetings (on 4/8/14, 4/15/14, and 4/22/14) during which issues related to SAP development and implementation were discussed. This process appeared to result in review and discussion of multiple SAP examples and resulted in the development of revised SAP example (format) and progress note. Discussions appeared centered on Monitoring Team feedback, as well as specific feedback on behavioral objectives, task analysis, prompting and fading, and generalization strategies. In the end, this process resulted in the revision of the SAP format, SAP data format, SAP Critical Element Tool, and the SAP Development curriculum. According to the dates provided within the Section S.1 Action Plan, these revisions were completed in May and June 2014. The rollout of these revisions started through initial trainings (in June 2014) with the Active Treatment Staff on the new standardized SAP format, data sheet, and standardized progress note format. The Facility also reportedly revised the curriculum used to develop SAPs to ensure consistency with the new SAP format. This work was completed as part of LBSSLC collaborative efforts with other SSLCs through the State workgroup. Review of the revised curriculum (dated 6/23/14) evidenced the inclusion of the new/revised (1) Pre-ISP Personal Worksheet, (2) ISP Personal Worksheet, (3) Essential Elements of SAP, and (4) SAP Format. Based on dates provided within the Section S.1 Action Plan, trainings were held with the IPDs, Residence Coordinators, as well as QIDPs and Unit Directors to review recent changes, including a focus on issues related to the revised SAP format, data collection, monthly review, and ongoing monitoring of progress. Similar training was also completed with Active Treatment staff (6/5/14) on all of the recent revisions, new formats and tools, as well as issues related to development and implementation. That is, provided documentation reflected revisions in the blank SAP format, SAP Critical Element Tool, the Competency SAP Training Tool, as well as the SAP QA Rubric. Lastly, it appeared that a new instructional guide, called "Assessment SAP Recommendations," was developed to help ensure that SAPs are individualized. More specifically, the guide contained 11 items asking the rater to consider, for example, if a proposed SAP was based on strengths and preferences, if it was a priority to the individual, it was meaningful and functional, and it would increase their independence without interfering with their rights. This document was emailed to all disciplines and staff were asked to use the guideline when considering recommendations for new SAPs. In addition to the revision of these tools, a spreadsheet was developed to assist IPDs in monitoring SAPs, including required elements (e.g., the source assessment), dates of completion and filing, as well as tracking of peer review (QA scores) and other relevant information. Because developing and reviewing these SAPs was such a large and potentially overwhelming undertaking, this spreadsheet appeared likely to assist IPDs in	

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		remaining organized and vigilant while ensuring adherence to the revised SAP process. Lastly, it appeared that IPDs met (on 6/3/14) to review and train the Section S Program Compliance Monitor (PCM) on the revised SAP Format as well as the revised SAP QA Rubric Tool, including inter-rater reliability. In an effort to examine the quality of current SAPs, a sample of 12 individuals who had an Individual Support Plan meeting since the Monitoring Team's last visit was selected and their SAPs were requested for review. According to provided documentation, it appeared that approximately 95 individuals had an ISP meeting since the Monitoring Team's last visit. Consequently, this sample of 12 individuals reflected 13% of total number of ISPs completed since the Monitoring Team's last visit. Overall, it appeared that a total of 53 SAPs were developed for these 12 individuals. Of these, it appeared that approximately four (range of two to six) SAPs were developed, on average, for each individual sampled. In addition, it appeared that 21 (40%) of the SAPs were completed using the most recent SAP format. 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. Consequently, this included a single SAP for 12 individuals. The selected SAPs are identified below. In addition to the examination of each SAP, available ISPs, Functional Skills Assessments, Preferences and Strengths Inventory, Pre-ISP Personal Worksheet, ISP Personal Worksheet, 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 #70 targeting purchasing; ▪ The SAP for Individual #154 targeting exercising; ▪ The SAP for Individual #213 targeting working on picnic packs; ▪ The SAP for Individual #235 targeting returning to work; ▪ The SAP for Individual #73 targeting getting dressed; ▪ The SAP for Individual #68 targeting suction tooth brushing; ▪ The SAP for Individual #167 targeting object cues/cards; ▪ The SAP for Individual #254 targeting disposal of gloves; ▪ The SAP for Individual #280 targeting hand washing; ▪ The SAP for Individual #34 targeting picnic packs; ▪ The SAP for Individual #284 targeting showering; and, ▪ The SAP for Individual #266 targeting dressing. 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	

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		discussion at ISP meetings. It is important to remember that discussions at ISP or ISPA 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 11 (92%) identified one or more assessments as the basis of the targeted need. One exception was the SAPs for Individual #34 with a rationale that only listed the IDT discussion at a recent ISPA. In addition, exceptions included three SAPs that did not clearly identify the assessments and/or conspicuously identify and recommend the identified need be targeted through a formal SAP (i.e., Individual #73, Individual #68, Individual 284, and Individual #266). Overall, of the 12 SAPs reviewed, it appeared that only seven (58%) clearly identified a need based on an assessment where the need was conspicuously identified and recommended to be targeted as a formal SAP. In general, 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 targeted by sampled SAPs were based on scored items within the assessments and/or recommendations within completed assessments. For example, in some cases, the SAP identified the FSA as the rational for the identified need, but review of the FSA did not evidence that need specifically highlighted as an area of need and conspicuously recommended as an target for formal skill training (i.e., Individual #70, Individual #284, and Individual #266). In addition, identifying the assessment that was the basis for SAP was actually more difficult in some of the SAPs recently completed using the revised format compared to those completed using the previous format. That is, some of the newly formatted SAPs contained so much information in the rationale section that the specific assessment and related need was not clearly and conspicuously identified. Indeed, information in this section was not easily understood (e.g., Individual #284, Individual #266, and Individual #73). An example of where the rational (including conspicuously identifying the assessment and related need) was clearly described was the SAP for Individual #254. Lastly, although the Facility continued to place great emphasis on the adequate completion of the PSI and FSA, which had been established as comprehensive assessments that require significant resources and time to adequately complete, surprisingly only six (50%) were referenced within the rationales of sampled SAPs. 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 four (33%) were completed using the most current SAP format. In an effort to provide a comprehensive review of the current SAPs, all 12 of these sampled SAPs were reviewed and the following was observed:	

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		▪ Five (42%) had an adequate behavioral objective. This included Individual #235, individual #73, Individual #254, Individual #280, and Individual #266, four of which were completed using the new SAP format. It should be noted that these included objectives with 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. However, one SAP with an adequately stated objective had an inadequate task analysis (Individual #280). Consequently only four (33%) had an adequate behavioral objective; ▪ Five (42%) had an adequate task analysis. These included Individual #154, Individual #235, Individual #73, Individual #254, and Individual #266. It should be noted that all of the SAPs appeared to operationally define the targeted skill using the current task analysis. Consequently, if the task analysis was inadequate, the operational definition of the target response(s) was also viewed as inadequate; ▪ Nine (75%) had an adequate description of necessary materials. Those SAPs with inadequate information about materials included those for Individual #70, Individual #213, and Individual #284; ▪ Twelve (100%) had an adequate description of the setting/environment; ▪ Nine (75%) had sufficient opportunities for learning to occur (i.e., adequate schedule of implementation). This finding might 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, one scheduled opportunity per week (Individual #70) as well as vague descriptions [e.g., "both work shifts" (Individual #235) and "when scheduled Monday – Friday" (Individual #34) found in the SAPs 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 three SAPs (i.e., for Individual #70, Individual #213, and Individual #167). Consequently, nine (75%) appeared to be adequate; ▪ Twelve (100%) conspicuously identified the type of chaining (i.e., forward, backward, or total task) utilized in the SAP; ▪ Ten (83%) identified the instructional strategy (e.g., least-to-most). The exceptions included Individual #213 and Individual #167; ▪ Nine (75%) provided adequate descriptions/definitions of the types of prompts found within the listed prompt hierarchy. Exceptions included the SAPs for Individual #70, Individual #213, and Individual #235; ▪ Although 12 (100%) identified an initial prompt level, only seven (58%) indicated a criterion of when to change to a less (or more) intrusive prompt level, if necessary. The exceptions included those for Individual #213, Individual	

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		#235, Individual #73, Individual #167, and Individual #284. It should be noted that 10 (83%) of the SAPs continued to instruct staff to use a prompt two or more times prior to utilizing a more intrusive prompt level; ▪ Of the five SAPs that utilized forward or backward chaining, only two (40%) had instructions on when to change to a different step. These included the SAPs for Individual #280 and Individual #266; ▪ Twelve (100%) described consequences for correct responding. However, only four (33%) utilized supplemental reinforcers in addition to verbal/social praise; ▪ Eleven (92%) described consequence for incorrect responding. However, only four (33%) included specific descriptions regarding error correction (or referenced strategies detailed in another section); ▪ Twelve (100%) described plans for generalization and maintenance. However, only four (33%) provided a level of specificity that would allow these to occur. These included the four SAPs completed in the new format (i.e., Individual #73, Individual #254, Individual #280, and Individual #266); and ▪ Twelve (100%) contained data collection instructions. However, only six (50%) appeared to prescribe sufficient data collection. That is, SAPs requiring data collected three or more times per week (i.e., Individual #154, Individual #73, Individual #254, Individual #280, Individual #284, and Individual #266). Upon review of the three sampled medical and/or dental desensitization SAPs, it was noted that one (33%) was completed using the most current SAP format. In an effort to provide a comprehensive review of the current SAPs, all three of these sampled SAPs were reviewed (for Individual #109, Individual #272, and Individual #51) and the following was observed: ▪ One (33%) had an adequate behavioral objective. This included Individual #51; ▪ One (33%) had an adequate task analysis. This included Individual #51; ▪ Three (100%) had an adequate description of necessary materials; ▪ Three (100%) had an adequate description of the setting/environment; ▪ One (33%) had sufficient opportunities for learning to occur (i.e., adequate schedule of implementation) (i.e., Individual #51). This included at least daily trials; ▪ Three (100%) included discriminative stimuli. However, concerns were noted with the discriminative stimuli used in two SAPs (i.e., for Individual #109 and #272; ▪ Three (100%) conspicuously identified the type of chaining (i.e., forward or total task) utilized in the SAP. However, the Monitoring Team questioned whether or not a total task method was appropriate for Individual #109 and Individual #272; ▪ One (33%) identified the instructional strategy (e.g., least-to-most). This included Individual #51;	

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		▪ Two (67%) provided adequate descriptions/definitions of the types of prompts found within the listed prompt hierarchy. The exception was the SAP for Individual #109; ▪ One (33%) indicated a criterion of when to change to a less (or more) intrusive prompt level, if necessary. This included the SAP for Individual #51; ▪ Three (100%) described consequences for correct responding, and three (100%) prescribed the use of supplemental reinforcers in addition to verbal/social praise; ▪ Three (100%) described consequence for incorrect responding. However, only one (33%) included specific descriptions regarding error correction (or referenced strategies detailed in another section) (i.e., Individual #51); ▪ Three (100%) described plans for generalization and maintenance. However, only one (33%) provided a level of specificity that would allow these to occur. This included the SAP for Individual #51; and, ▪ Three (100%) contained data collection instructions. However, only one (33%) appeared to prescribe sufficient data collection. That is, the SAP requiring data collected three or more times per week (i.e., Individual #51). 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 of all the SAPs reviewed, the SAPs completed in the newer format appeared to be of higher quality. To move in the direction toward substantial compliance, the Facility should adhere to the new format when developing desensitization programs. Currently, IPDs continued to write the majority of SAPs developed and implemented for individuals the Facility supported, and, at the time of the current visit, the same four IPDs continued to be in place. Their responsibilities included developing all of the SAPs (with the exception of replacement behavior SAPs, counseling SAPs, and some pilot desensitization SAPs), as well as attending all pre-ISP and ISP meetings, and conducting staff training and SAP procedural integrity probes. After discussion with some of the IPDs during the onsite visit, it appeared to the Monitoring Team that these professionals were overwhelmed by the many demands placed on their positions. The Monitoring Team encouraged the Facility to closely examine the nature of this position and determine if additional IPDs were necessary to ensure adequate development and implementation of SAPs. In addition, the Monitoring Team continued to encourage the State Office to provide more oversight and support to the IDTs and Active Treatment staff who are developing SAPs to ensure that ongoing changes reflect improvements in quality of programming as well as sustainable change. It should be noted that verbal reports from IDTs continued to reflect a preference by attendees of the State workgroup toward selecting the LBSSLC SAP format as one of the potential formats likely recommended for use in Facilities across the state. Consequently, the Monitoring Team	

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		strongly encourages the Facility and State Office to closely examine the current SAP format, including related data sheets and monthly progress note formats, and ensure continued revision and improvement, as necessary. As discussed in the Monitoring Team's previous report, IPDs collaborated with QA Department staff when implementing the SAP Quality Assessment Rubric or SAP QA Rubric when assessing the quality of SAPs. As noted in the Monitoring Team's last report, this rubric had been revised to include many more items (50 questions) and was formatted similarly to the SAP. At that time, these revisions appeared to reflect a much more comprehensive tool and a substantial improvement over the previous SAP quality assessment. Data provided at that time reflected variable scores with most estimates above 80%, although, lower quality estimates were reported for the PBSP replacement behavior SAPs. Currently, it appeared that the SAP QA Rubric had been slightly revised since the Monitoring Team's last visit. More specifically, the format of the tool was changed from a "yes" or "no" response format to a three-point Likert scale, and items on the document were re-organized and revised to more closely correspond to the revised SAP format. Although the re-organization of the document to more closely adhere to the SAP format was likely helpful to reviewers, the additional benefit of a Likert scale was unclear to the Monitoring Team. Indeed, it might actually decrease correspondence of independent raters during inter-rater reliability checks. Verbal reports indicated that the PCM and IPDs continued to use the SAP QA Rubric to examine the quality of SAPs. Summary documentation revealed that, between November and April 2014, the IPDs and PCM reviewed 20% of the SAPs written each month. For each month, an average total score was provided for IPD and PCM reviews. Overall, an average quality score of 94% 97%, 95%, 95%, 94%, and 100% was reported for November, December, January, February, March, and April, respectively, by the IPDs. Similarly, an average quality score of 96% 96%, 95%, 95%, 92%, and 97% was reported for November, December, January, February, March, and April, respectively, by the PCM. Although these scores appeared to reflect adequate quality based on the SAP QA Rubric, estimates of inter-rater reliability were not conducted. Consequently, the usefulness of this rubric in consistently estimating the quality of SAPs had not been established. To move in the direction of substantial compliance, the Facility will need to initiate inter-rater reliability checks for a sample of these checks. In addition, the Facility should consider the limitations in reporting combined scores (i.e., total scores). That is, these scores are likely limited as select items within the rubric are more critical to the quality of the SAP than others, and, as a result, an overall score is of limited use when determining quality estimates. Also, item analysis will continue to be necessary as the Facility continues to monitor where the strengths and limitations remain in developed SAPs. It should be noted that the quality scores the Facility reported were inconsistent with the Monitoring Team's findings from the current sample of SAPs.	

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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 training curriculum, "The Principles of Active Treatment Services," used to train direct support professionals and other program staff. This revision was completed in March 2014. Revisions included, for example, the inclusion of the revised SAP format and data sheet as well as a new video training vignettes. Evidence of completed trainings by the Active Treatment Supervisor, including attendance rosters, from 5/6/14 through 5/30/14, was provided within the Section S Presentation Book. It reflected 27 trainings on SAP Documentation and included approximately 317 trainees. Addition documentation also reflected staff training during New Employee Orientation and refresher trainer, between 5/1/14 and 5/31/14. It reflected that a total of 301 staff were trained on Skills Acquisition Program and Documentation Training. 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 when in proximity, watching TV when orientated/gazing toward the screen) 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*** Big Workshop / 4:4 / 1:4 Little Workshop / 1:2 / 1:2 Lily / 1:2 / 1:2 Zinnia / 0:2 / 0:2 / 1:5 / 1:5 / 0:3 / 0:3 Iris / 3:5 / 2:5 / 1:1 / 1:1 / 0:1 / 0:1 Tulip / 0:2 / 1:2 / 0:1 / 1:1	

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Aspen	2:3	2:3
Willow	2:2	1:2
Oak	1:1	1:1
Maple	2:6	2:6
	1:1	1:1
Rose	3:4	3:4
	0:2	0:2
Violet	0:7	1:7
	0:6	0:6
	2:2	2:2
	1:2	1:2
Fir	1:1	1:1
Elm	3:4	2:4
	0:1	0:1
Birch	2:2	3:2

Based on data collected during brief visits to program and residential visits, overall engagement was 43%. This reflected a significant decline in the estimated level of engagement compared to the previously estimated level (67%) 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, including 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 reports, the Active Treatment Department had been utilizing the Engagement Monitoring Form 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. This form was revised (in March 2013) to target whether or not daily activity schedules were followed. Data reported in previous reports reflected variable levels of engagement as well as noted missing engagement data for several months. At the time, it was reported that this missing data was due to necessary emphasis being placed on other training issues (i.e., developing and implementing group activity schedules). Overall, previously reported data from September 2012 through November 2013 reflected monthly average estimates (collapsed across all programs) ranging from 62 to 90%.

Since the Monitoring Team's last visit, it was reported that the rubric used to estimate

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		engagement had been revised. More specifically, documentation revealed that the rubric had been revised to include data on staff-to-individual ratios, an item to assess whether or not direct support professionals were utilizing residents' Individual Activity Cards (IACs), and to include more opportunities to observe engagement across individual residents. The new rubric, the Active Engagement Monitoring Form, was revised and implemented in April 2014. In addition, to changing the form, the Director of Active Treatment reported that the number of monthly engagement probes conducted on the 2 p.m. to 10 p.m. shift had been increased. Currently, it was reported that approximately 50 engagement probes were collected each month (i.e., one during 6-2 shift, two during 2-10 shift, and one in each program area per week). As discussed below, the frequency of engagement probes, although recently increased on the 2-10 shift, continued to appear insufficient, especially given the low estimates of engagement recently noted. Currently, provided summary data reflected engagement estimates of 90%, 84%, 72%, 87%, 85%, 86%, and 59% for November, December, January, February, March, April and May, respectively, as reported by Active Treatment Staff. Overall, these engagement scores demonstrated continued variability in scores, with a decreasing trend in the last four months, as reported. The reason for the substantial decline in May might have been based on use of the newly revised engagement rubric. However, this new tool was reportedly revised in March and rates of engagement only appeared reduced in April. It should be noted that the reported scores reflected average scores for Unit 1, Unit 2, and Programs, per month, provided by the Facility. As noted within the Monitoring Team's previous report, 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. This database reflected an efficient system to track not only the scores on each completed form, but also other relevant information as well. Unfortunately, scores from this database were not provided for the Monitoring Team's review. This made closer analysis of engagement rates difficult, especially when attempting to more fully understand recently reported lower engagement estimates. In addition, as noted in the Monitoring Team's last report, inadequacies were reported in maintaining the completion of the required number of probes per month that, as the Monitoring Team highlighted at that time, appeared insufficient. Consequently, it could not currently be determined if this issue had been resolved. Overall, analysis of summary data provided by the Facility over the last three Monitoring Team reports reflected an estimated monthly average of 89%, 65%, and 78% for September to December 2012, January to December 2013, and January to May 2014, respectively.	

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		As described above, in addition to estimating individual engagement, the Active Engagement Monitoring form also estimated the competency of staff to promote active engagement. As noted in the Monitoring Team's previous report, competency scores of 78%, 84%, 92%, and 93% were estimated for July, August, September, and October 2013, respectively. Currently, provided summary data reflected competency estimates of 91%, 91%, 87%, 92%, 91%, 87%, and 90% for November, December, January, February, March, April, and May 2014, respectively, as reported by Active Treatment Staff. Verbal report and provided data also evidenced that the PCM continued to collaborate with Active Treatment Staff in conducting engagement probes as well. That is, provided summary data reported by the QA Department reflected engagement estimates of 81%, 81%, 48%, and 86% for March, April, May, and June 2014, respectively. These engagement estimates were similar to those Active Treatment Staff reported (as noted above). Reported inter-rater reliability estimates, however, generated during these engagement probes were unacceptable for the last four months (i.e., 100%, 33%, 67%, and 50% for March, April, May, and June, respectively). The Monitoring Team assumed that these lower scores were related to the recent initiation of the new Active Engagement Monitoring Form. In addition, provided summary data reported by the PCM reflected competency scores of 71%, 83%, 80%, and 93% for March April, May, and June 2014, respectively. Inter-rater reliability estimates for these items were a bit higher and within a generally acceptable range of agreement, that is, above 80% (i.e., 92%, 85%, 98%, and 82% for March, April, May, and June, respectively). More consistency in scoring of these items was expected as the recent revision only included the change to one item. 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, 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 January through July 2014. Based on provided documentation, the Facility had created a database to track ongoing recreational activities across 14 different types of activities (e.g., open gym, open swim, movie night, Scouts outing, party) as well as monthly attendance by residents (across residential programs) at these events since February 2014. This information appeared to be helpful to the Facility in determining which events might promote the greatest	

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		attendance over time. Summary data from February through July 2014 reflected an average (and range) monthly attendance at recreational activities of 40 (21 to 61) and 55 (33 to 66) individuals from Unit 1 and Unit 2 residential programs, respectively. It should be noted that the July data was likely incomplete when it was submitted concurrent with the onsite visit. In addition, it was unclear to the Monitoring Team if this recreational data overlapped with provided community outing data as some of the recreational activities were off campus. 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. As reported in the Monitoring Team's previous report, 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. At that time, 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). Currently, based on provided summary data, a slight increase (less than 10 individuals) in the number of individuals supported in day programs was noted since the Monitoring Team's last visit. This was related to the addition of a second specialty classroom, as well as efforts to integrate individuals who had not participated in day programs previously. In addition, some variability in the number of individuals in supportive off-campus employment was noted. That is, increases were noted in January (three positions added) and February (two positions added), but three positions were lost in April 2014. Increases in the number of individuals supported in the client worker (i.e., approximately 20 individuals) and enterprise programs (i.e., 12 individuals) were noted since the Monitoring Team's last visit. These substantial increases were related to the Facility redefining how residents who worked on campus were counted (i.e., the Facility was now counting individuals with flexible work schedules) as well as attendance at additional craft shows that created more opportunities within Hearts and Hands. However, continued decline in the number of individuals served in the on-campus workshop was observed. Lastly, slight improvement was maintained in off-campus competitive employment (i.e., two positions were briefly added in February and March). As of April 2014, two individuals were competitively employed off-campus. Overall, the number of individuals in paid work positions had generally increased since November 2013. That is, summary data reflected 96, 96, 105, 111, 111, and 106 individuals in paid employment positions (on or off campus) in November, December, January, February, March, and April 2014. According to documentation provided and verbal reports from the Director of Vocational and Day Programs, ongoing efforts to improve opportunities for on-campus and	

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		community-based employment continued. These efforts included the continuation of the Community Outreach Committee. As described in previous reports, 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 meeting minutes evidenced continued monthly meeting in five (83%) of the last six months (January to June 2014). One recent change facilitated by this committee included how staff tracked business contacts within the community. This was completed in an effort to more accurately monitor efforts at improving work opportunities for residents. In the past, only the number of business contact and new contracts were tracked each month. Since May 2014, however, the Facility was now tracking the (1) number of initial contacts made, (2) number of follow-up contacts made, (3) number of maintenance contacts made, and (4) the number of employment opportunities secured. Other efforts to promote and facilitate paid work included increasing access to individuals at local community Job Fairs as well as promoting the opportunities on campus through the development and dissemination of an informational book (Position Descriptions for Vocational Services and Day Program Class Description) to campus QIDPs. Analysis of provided attendance data over the Monitoring Team's last three reports reflected an estimated monthly average of attendance at day programs of 70%, 68%, and 70% as reported for September to December 2012, January to December 2013, and January to February 2014, respectively. Similarly, estimated monthly average of attendance at vocational programs of 86%, 87%, and 87% as reported for September to December 2012, January to December 2013, and January to February 2014, respectively. It should be noted that March, April, and May data were not included in these comparisons because the Facility changed how it was defining attendance in March 2014. More specifically, individuals who were not at work due to sickness, weather, or Facility issues were not counted as absent in the past. Consequently, this method appeared to overestimate the number of individuals attending programs as reported in the past. The new legend will only classify individuals as present, absent or absent due to Holiday or Medical appointment. Since the change in legend used to classify attendance, the reported attendance percentage had dropped significantly given the number of individuals with medical complexities who do not regularly attend programs. More specifically, provided attendance data reflected an estimated monthly average of attendance at day programs of 34%, 48%, and 49% as reported for March, April, and May 2014, respectively. These estimates were very concerning compared to previous estimates that the Monitoring Team had already determined to be problematic. That is, as noted in previous reports, rates of attendance at day programs had consistently	

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		remained below 76%. In the past, the Monitoring Team had strongly encouraged the Facility to "raise the bar" regarding attendance at day programs and consider challenging IDTs to provide rationales for any individual that does not participate for the majority of the day. In response, earlier attempts included the collaboration between vocational and day program staff members and an assigned Behavior Analyst to ameliorate behavioral issues that limited individuals' work or program attendance. Indeed, two trainings by the Behavior Analyst were held in an effort to address concerns related to attendance. In addition, as previously noted, 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.). Provided meeting minutes evidenced continued monthly meeting in five (83%) of the last six months (January to June 2014). Current verbal reports and provided documentation indicated that this committee was still active in facilitating improved attendance. Recent efforts appeared to include meetings with select IDTs to discuss the attendance of six individuals. However, the previous and current intensity of intervention did not appear systemic enough to produce a level of meaningful change. Currently, a more robust intervention is required. The Facility should consider developing and implementing a formal comprehensive Corrective Action Plan targeting improving attendance at day programs. In addition, the Facility should consider appointing a chair of the committee from a department external to the vocational department in an effort to bring independence and new perspective to facilitate effective problem-solving. 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, identifying vocational visions, and identifying and facilitating the completion of vocational and/or situation explorations. Provided meeting minutes evidenced continued monthly meeting in five (83%) of the last six months (January to June 2014). As reported in previous Monitoring Team reports, provided summary data 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 from July through December 2013 indicated that, on average, 15 (ranging from 11 to 19) assessments were completed each month, with 99% submitted on time. Data since the Monitoring Team's last visit (January to April 2014) indicated that, on average, 20 (ranging from 18 to 22) assessments were completed each month, with 97% submitted on time. Overall, data from September 2012 through April 2014 reflected a decreasing trend in the number of assessments completed each month.	

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		As reported in previous Monitoring Team reports, 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) explorations completed each month, with 88% completed as expected. Data from July through December 2013 indicated that, on average, five (ranging from three to nine) assessments were completed each month, with 100% completed as expected. Data since the Monitoring Team's last visit (January to April 2014) indicated that, on average, five (ranging from one to eight) explorations were completed each month, with 94% submitted on time. Overall, data from September 2012 through April 2014 reflected decreasing trends in both the total number of explorations identified and the number completed each month. 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. Data provided since the Monitoring Team's last visit (January through June 2014), reflected scores at or above 89% each month across two raters. However, it should be noted that the Facility had not yet demonstrated the reliability of the quality tool. That is, inter-rater reliability estimates had not yet been reported. It should be noted that, based on information presented in Section S.3 of the Self Assessment, the Facility recently revised the Vocational Assessment Quality Checklist "… to include inter-rater." Upon review of the revised checklist, it was not clear how the rubric had been revised to facilitate completion of estimates of inter-rater reliability. Overall, although data produced through the use of this rubric reflected high estimates of quality, these were based on a limited number of completed assessments (four per month, on average). As noted in the previous report, identifying, reviewing and analyzing vocational data continued to be an ongoing challenge for the Monitoring Team because the Facility continued to change how variables (e.g., job descriptions, attendance criteria) were defined and/or categorized. Indeed, ongoing comparisons of some data might be limited due to these changes. Overall, changes that were made appeared to reflect the Facility's sincere pursuit of the most accurate information. 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 for all	

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		individuals, increase levels of engagement across the Facility, and ensure that individuals were provided with day and vocational activities that met their needs and preferences.	
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 previous Monitoring Team reports, the Facility used the PSI 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. However, findings noted in previous Monitoring Team reports have found the quality of completed PSI assessments to be inadequate. These findings occurred despite efforts at improving the quality rubrics designed to facilitate the development of higher quality assessments. More specifically, an initial PSI Quality Measure Grading tool (five-items) was developed but was found to include a limited number of items that appeared too broad in scope. At that time, the Facility was encouraged to consider developing additional items that would allow more specification in examining the quality of completed assessments. At the time of the Monitoring Team's last visit, it was noted that the Facility was responsive to these recommendations as a revised version of the PSI Quality Measure Grading tool was developed. And, although this revised version (dated August 2013) contained five additional items that improved the comprehensiveness of the review, the new format eliminated an item that actually examined whether or not 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. At that time, examination of summary data revealed an average (and range) quality rating of 48% (30 to 90%) for PSIs the Facility sampled. In review, it was noted that both these quality tools estimated lower than acceptable ratings of quality. However, the recently revised version appeared to produce more conservative quality scores than the previous rubric. Overall, however, inter-rater reliability estimates were never reported for either of the PSI Measure Grading Tool versions. Currently, it was reported that the quality rubric was once again revised. The new rubric, the Preferences Strength Inventory Assessment Quality Checklist, dated March 27, 2014, appeared to be qualitatively different from previous quality tools. More specifically, this revised format was a 2.5 page document that included items that targeted preferences and strengths across all sections of Section I of the PSI, and contained specific items targeting the quality of other responses within Section II and Section III. In addition, items were included that examined the quality of Recommendations and Factors for Community Placement, and was formatted to include space to record the compliance score and plans of correction, if needed. Documentation evidenced a training (on 5/15/14) to train the QIDP Educator on the use and instructions of the new PSI Assessment Quality Checklist, and a second training (on 6/12/14) to introduce the new checklist to QIDPs, as well as initiate its implementation. However, only two QIDPs attended the training. Verbal reports indicated that this new quality	Noncompliance

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		checklist was currently being utilized. Indeed, reports in the Section F Presentation Book indicated that the QIDP Coordinator and QIDP Educator were to review a sample of PSIs each month to ensure quality completion and meet with QIDPs if a PSI quality score fell below 80% for two consecutive months. However, the Facility currently provided no data to evidence its use in ensuring the quality completion of PSIs. In addition, verbal reports indicated that inter-rater reliability had not yet been initiated to estimate agreement between raters when completing these checklists. As noted in the Monitoring Team's previous report, in addition to revisions within the quality tool, the PSI format had been revised in March 2013. That is, at that time, 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. Currently, this PSI format was reportedly still in effect. 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 and PSI as provided, were examined. That is, in an attempt to examine the adequacy of currently completed PSIs, a sample of 12 individuals was selected and their PSI as provided, was reviewed. Currently, of the 12 individuals reviewed, documentation evidenced completion of PSIs for 12 (100%) individuals within the last 12 months. Seven (58%) appeared to be completed using the most current PSI (dated 11/1/13) format. The exceptions were Individual #73, Individual #167, Individual #34, individual #284, and Individual #266. Of these 12 individuals, however, only eight (67%) had PSIs that were completed (i.e., based on the signature date) 10 days prior to the ISP Preparation meeting as prescribed by the current ISP process. Exceptions included Individual #213, Individual #167, Individual #284, and Individual #266. Although not completed 10 days prior to the ISP Preparation meeting, three additional PSIs were completed on or prior to the ISP Preparation meeting – these included the PSIs for Individual #167, Individual #284 and Individual #266. However, it should be noted that the Facility highlighted that, in order for all IDT members to have access, PSIs were required to be electronically submitted 10 days prior to the ISP Preparation meeting. Consequently, closer examination of each PSI's "filed" date (as stamped on the first page of the PSI) was conducted to determine if these assessments were available 10 days prior to the ISP Preparation meeting as prescribed by the current ISP process. Of the 12 individuals sampled, only 10 PSIs had a filed date stamped on the first page. The exceptions were Individual #280 and Individual #266. Closer examination of the 10 PSIs	

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		with filed dates revealed that only one (10%) PSI was filed 10 days prior to the ISP Preparation meeting. This included Individual #70. Although not filed 10 days prior to the ISP Preparation meeting, six additional SAPs were filed on or prior to the pre-ISP meeting. These included the SAPs for Individual #154, Individual #235, Individual #73, Individual #167, Individual #254, and Individual #34. In general, of the 12 individuals sampled, two (17%) appeared to be adequately completed. More specifically, Section I and/or II appeared to be adequately completed in the PSIs for six (50%) individuals. The exceptions included Individual #154, Individual #73, Individual #167, Individual #34, Individual #284, and Individual #226. Section III appeared to be adequately completed for four (33%) of the individuals sampled. The exceptions included Individual #70, Individual #154, Individual #235, Individual #73, Individual #68, Individual #167, Individual #284, and Individual #226. However, four (33%) of the PSIs included measureable goals. This included Individual #213, Individual #254, Individual #34, and Individual #266. In addition, as prescribed by the most current PSI Quality Measure Grading Tool, six (50%) of the sampled PSIs contained specified recommendations for SAP/training objectives, and five (42%) contained recommendations regarding living in a less restrictive setting as found within the Comment section in Section III. It is currently unknown whether or not the findings reported here, based on the current sample, are consistent with the Facility's findings related to PSIs. As noted above, the Facility did not provide data estimating the quality of recently completed PSIs. As described in previous Monitoring Team reports, the Facility used the Functional Skills Assessment (FSA) 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. This information could then be utilized to inform the development of objectives and goals, including targeted skill acquisition programs. However, as noted in previous Monitoring Team reports, findings related to sampled FSAs had found the quality to be inadequate. These findings occurred despite efforts at improving the quality rubrics designed to facilitate the development of higher quality assessments. That is, the Facility initially developed the FSA Quality Measure Grading Tool to monitor the quality of developed FSAs. Summary data based on this tool indicated that estimates of quality were below 80% (ranged from 20 to 100%) for the majority of FSAs sampled, and reported inter-rater reliability estimates were inadequate. As noted in the Monitoring Team's last report, efforts to improve the FSA Quality Measure Grading Tool were observed. These included developing the FSA Quality Tool, a computer-based assessment, designed to closely correspond to the skill areas of the FSA. As previously described, the tool targeted 13 skill areas that corresponded to skill areas on the FSA and included 13 scoring categories. Instructions for the use of this tool also were developed and 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. At the time, data the Facility provided reflected	

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		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. As reported in the previous report, the lack of inter-rater reliability estimates limited the confidence in the tool and the lack of sufficient description/definition of each scoring category was problematic. In addition, the tool did not include any items that examined the supplemental content areas targeted by the new FSA summary pages. Overall, this new tool did not provide enough specificity in scoring, and required additional items to completely assess the revised FSA. Currently, since the Monitoring Team's last visit, the Facility had responded to earlier recommendations and made revisions to the FSA Quality Tool, now called the FSA Grading Tool. Revisions included the discontinuation of the elaborate scoring system and implemented a five-point Likert scale for each section. In addition, scores were also provided for timeliness as well as adequate completion of information at the top of the document (dates, names, etc.) and at the end in the Functional Skills Summary section. Detailed instructions for scoring the FSA Grading Tool were provided as well. These revisions appeared to be have been completed in May 2014. Although reports indicated the use of this new tool (as discussed below), inter-rater reliability estimates were not provided. Once again, the continued absence of inter-rater reliability estimates for the FSA quality rubric remained of concern. As noted in the Monitoring Team's previous report, in October 2013, the format of the FSA had been revised. At that time, the State Office released the new FSA and the Facility implemented it. According to documentation provided at that time, 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. Currently, this format appeared to be in use, and the format was now computerized (since March 2014). 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 documents, including the ISP and FSA, as provided, were examined. Currently, in an attempt to examine the adequacy of currently completed FSAs, a sample of 12 individuals was	

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		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 10 (83%) of the FSAs were completed in the current format. Exceptions included two individuals with sampled FSAs that were completed in the older format (Individual #70 and Individual #73). 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 Individual #73. Based on the "Assessment Date" as recorded on the first page of the FSA, of the 12 FSAs sampled, nine (75%) appeared to have been completed 10 days prior to the ISP. The exceptions included Individual #213 (not dated), Individual #235 (not dated), and Individual #73. Based on the "Filed" date as recorded on the first page of the FSA, of the 12 FSAs sampled, seven (58%) appeared to have been completed and filed 10 days prior to the ISP. The exceptions included Individual #70, Individual #154 (no filed date), Individual #73, Individual #167, and Individual #254. Of the 12 FSAs, zero (0%) appeared to be adequately completed. More specifically, the FSAs for nine (75%), eight (67%), eight (67%), seven (58%), six (50%), five (42%), nine (75%), and zero (0%) appeared to have been adequately completed for Section I, II, III, IV, V, VI, VII, and VIII, respectively. In addition, adequate recommendations for skill acquisition as well as service objectives were found in eight (67%) and six (50%) of the SFAs sampled, respectively. Lastly, of the 12 SFA sampled, seven (50%) and six (50%) were signed and dated, respectively. As noted above, the FSA Grading Tool was recently revised. Provided documentation indicated that this revised tool was utilized recently to examine the quality of four FSAs, each month, during April and May 2014. More specifically, provided summary data based on reviews using the FSA Grading Tool reflected an average (and range) quality estimate of 88% (76% to 99%) and 94% (83% to 99%) for the two Unit Directors, respectively, in April 2014. Similarly, an average (and range) quality estimate of 76% (45% to 90%) and 79% (67% to 90%) for the two unit directors, respectively, in May 2014. These results reflected, at times, unacceptable estimates of quality as well as considerable variability between raters. It should be noted that inter-rater reliability estimates were not reported with these scores and did not appear to have been generated. It should be noted that the Facility used a second quality checklist to examine the quality of developed FSAs. More specifically, in collaboration with the QA Department, selected FSAs were reviewed each month using the FSA Assessment Quality Checklist. This checklist was completed monthly on a small sample (N=4) the QA Department selected. Summary data using this checklist was not provided for review. It is unclear why two quality rubrics were currently in place to evaluate the quality of the FSA. It appeared that the FSA Assessment Quality Checklist was originally in place and monitoring by the PCM had continued. The Monitoring Team encourages Facility staff (e.g., Section S PCM,	

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		Residential staff) to evaluate which quality check produces the highest inter-rater agreement as well as provides information with the most utility. 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. The Monitoring Team recommends continued use and revision, when necessary, of the quality tools used to examine the quality of PSIs and FSAs. This includes the completion of inter-rater reliability during this process to ensure that the tools facilitate adequate agreement across raters and over time.	
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. The sample reviewed was the sample previously described with regard to Sections S.1. 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 11 (92%) of the sampled SAPs reviewed, concerns were noted with regard to the assessments cited within these rationales. That is, each of the SAPs included rationales that listed one or more assessments (e.g., PSI, FSA, Vocational, OT/PT, etc.) as the basis/rationale of the skill programming, with the exception of one SAP (Individual #34). And, all of the SAPs appeared to be based on discussion by the IDT at meetings in 12 (100%) of the sampled individuals' ISPs or ISPAs. However, of these 12, only seven (58%) appeared based on findings and recommendations within the assessments identified within the rationale. The Monitoring Team found the role of individual preference less than conspicuous in the identification of skills (or needs) and the development of corresponding SAPs. That is, only one (8%) of the sampled SAPs listed the PSI as one of the source assessments	Noncompliance

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		within the rationale section (i.e., Individual #254). However, based on the Monitoring Team's review of the sample, it could be inferred from other documents (e.g., ISP) that skill programming was based on individual's preference within seven (58%) of the SAPs sampled. Preferences, in these cases, were just not conspicuously identified in the rationale of the SAPs. More specifically, only one 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 (Individual #254). Overall, however, the role of individual preferences in the identification of needs and/or the development of specific SAPs was not conspicuous when reviewing the sampled SAPs. In an effort to examine whether or not SAPs were implemented within 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=53) for the 12 individuals sampled, only one (8%) individual had a SAP that identified the community as the primary or targeted setting for implementation (Individual #70), and seven (58%) had at least one SAP targeting implementation in a community setting as part of planned generalization. The exceptions (with no SAPs targeting any community implementation) included Individual #68, Individual #254, Individual #280, and Individual #266. In addition, nine (75%) individuals had at least one SAP targeting completion in a vocational/work or classroom/day program settings (the exceptions were Individual #70, Individual #167, and Individual #284), and all 12 (100%) had one or more SAPs targeting implementation in the home setting. In addition, the 12 sampled SAPs were reviewed to examine whether or not they were practical and functional. Overall, it appeared that 11 (92%) of the sampled SAPs targeted (or intended to target) skills that were meaningful and potentially useful for the individual. The exception included a SAP that the IDT described at the ISP as not functional (Individual #70). Overall, 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 the Monitoring Team's previous reports, observations had been completed to estimate staff knowledge and skills in implementing SAPs. Over the Monitoring Team's last few visits, the observational tool used to complete these integrity observations had been revised multiple times. At the time of the Monitoring Team's previous visit, the "Skill Acquisition Treatment Integrity Monitoring Form" had been revised, but it did not appear that added items targeted previous concerns including whether or not staff could	

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		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. Currently, this form was once again revised (on 3/31/14) and the revision included three items that targeted decisions when to change training steps, the instructional methods, and fading strategies. Overall, the most recent revisions addressed previous inadequacies and seemed like an improvement. Consequently, the revised form appeared likely to improve the ability of IPDs and Active Treatment staff in estimating direct support professionals' ability to implement SAPs with integrity. Currently, documentation indicated that 76 SAPs were monitored each month using the Skill Acquisition Treatment Integrity Monitoring form. These probes were reportedly conducted at random in residential and program areas and produced both competence and documentation scores. That is, based on provided descriptions, the competence score was derived from the demonstration and knowledge items on the monitoring form. In addition, the documentation score was derived from the records review items on the monitoring form. Based on provided documentation, it appeared that four monitoring sessions were conducted in each residential and program area each month, including two observations on the 6 a.m. to 2 p.m. shift and two observations on the 2 p.m. to 10 p.m. shift. Based on probes completed since the last Monitoring Team visit, provided summary data, reflected an average competence score of 89%, 89%, 94%, 84%, and 80% for January, February, March, April, and May 2014, respectively. Similarly, summary data reflected an average documentation score of 83%, 73%, 91%, 70%, and 76% for January, February, March, April, and May 2014, respectively. In addition, based on provided descriptions, inter-rater reliability estimates were generated for 16 probes completed each month by IPDs and Active Treatment Coordinators. However, the data presented appeared to reflect average competence scores between raters and not actual inter-rater reliability agreement estimates. As noted in the Monitoring Team's previous report, in an effort to examine the adequacy of procedural integrity of SAP implementation, a member of the Monitoring Team observed the completion of two integrity checks while on site. Observations at that time reflected the need for ongoing support and training for IPDs and Active Treatment staff members who conduct these sessions. That is, 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 concerns with regard to integrity monitoring. 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 Oak residence (with Individual #235) and at the	

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		Workshop (with Individual #267). Overall, current observations reflected the need for ongoing monitoring of this process, including potential revision of current practice. More specifically, observation of the integrity probe conducted by Active Treatment staff indicated that several items (i.e., Items 14 to 18) were scored on the questionnaire despite the fact that the observed staff did not complete (including recording data) these steps on the SAP data sheet. It was later explained that these items were scored as completed accurately by the Active Treatment staff because the observed staff was not supposed to collect data at that time (i.e., it was not a day identified as a data collection day). This practice appeared likely to overestimate the degree to which these SAPs are implemented with integrity. In addition, it was a missed opportunity for Active Treatment staff to observe the entire SAP implementation, including data collection as prescribed. Lastly, the observed SAP integrity probe evidenced poor agreement across raters. That is, the two raters disagreed on the score for five of the 18 items (i.e., an inter-rater estimate of 72%). As a result of the above findings, it is strongly recommended that integrity probes be fully scored, based on direct observation of all data collection procedures as prescribed by the SAP (i.e., including Items 14 to 18) when the Facility implements SAP integrity checks and that inter-rater reliability estimates be based on all of the completed items as well. The Facility should consider requiring the completion of SAP integrity checks by pairs of independent raters to ensure concurrent estimates of quality as well as inter-rater reliability 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 March, April, and May, 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 March (n=4), April (n=5), and May (n=3) and, consequently, SAPs for six and three individuals were not implemented until May or during or after June 2014, respectively. As a result, nine (75%) of those reviewed might only include data from less than one or two complete months. It should be noted that June 2014 data sheets were not requested due to the close proximity with the current onsite visit dates, but June data sheets were provided for Individual #34. Review of the 12 sampled SAPs as well as corresponding raw data sheets for these months, as provided, indicated: ▪ For individuals with ISPs in March (n=4), completed data sheets for all three months (March, April, and May) were provided for one (25%) of the selected SAPs. That is, the data sheets were only provided for Individual #154; ▪ For individuals with ISPs in April (n=5), completed data sheets for two months (April and May) were provided for two (40%) of the selected SAPs. That is, data sheets were only provided for Individual #70 and Individual #68; ▪ For individuals with ISPs in May (n=3), completed data sheets for one month (May) were provided for two (67%) of the selected SAPs. That is, data sheets	

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		were only provided for Individual #213 and Individual #254; ▪ Of the 12 individuals, one or more data sheets were provided for nine (75%) of the SAPs. Exceptions included Individual #73, Individual #280, Individual #266); ▪ One (8%) of the SAPs appeared to be completed in the most current (recently revised) format. This included Individual #254. It should be noted that, although three additional individuals' SAPs were completed in the new format (Individual #73, Individual #280, and Individual #266), data sheets were not provided for review (it was likely that these had only recently been implemented); ▪ Of the 12 individuals, data appeared to be recorded as prescribed (i.e., according to schedule, and completely) for two (17%) of the SAPs. This included Individual #167 and Individual #284; and, ▪ Of the 12 individuals, data appeared to be recorded accurately (i.e., consistent with the specified teaching methodology) and completely on the available data sheets for none of the SAPs sampled. Overall, based on provided documentation, it appeared that completion of timely data sheets for sampled SAPs was inconsistent. More concerning, however, was the quality of data collection reflected on completed data sheets. More specifically, closer examination of available data sheets revealed inadequacies with regard to the how the data was collected. The current review found that, even when data was collected, it was not collected as prescribed. In addition, only a small percentage of the SAPs sampled were completed in the most current format, including the new formatted data collection form. Overall, all of the 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 an effort to examine the nature of progress monitoring as reflected through Monthly Reviews, samples from March, April, and May 2014 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 March, April, and May 2014 were available for 12 (100%) of those sampled; ▪ Of the 12 individuals, 10 (83%) monthly notes for May contained content that identified the specific SAP sampled for review. The exceptions included Individual #154 and Individual #213. However, accurate descriptions of current status based on actual collected data appeared to be in place for only	

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		one (8%) of the sampled SAPs. This included Individual #68. All the other SAPs did not reflect data based assessments of progress either because the SAP was too new and/or data was not available. In some cases, progress descriptions did not appear to accurately reflect the collected data. For example, the monthly note indicated that the performance of Individual #70 had regressed, but this determination was made on graphed data from January. That is, as noted in the May monthly note, data from February, March, April, and May were not reported. In other cases, raw data appeared to be available, but was not accurately graphed or discussed in the text (e.g., Individual #235) or statements in the note suggested that performance could not be determined due to insufficient data and yet zeros were graphed for two consecutive months. Consequently, accurate graphing and interpretation of collected data appeared problematic; ▪ One or more graphic displays of the selected SAP appeared in eight (67%) individuals' monthly notes. The exceptions were Individual #213, Individual #254, Individual #34, and Individual #266; ▪ One or more graphic displays across all SAPs illustrated in sampled monthly notes had complete data in one (8%) of the individuals' monthly notes (i.e., Individual #284); ▪ 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; and ▪ Lastly, sampled monthly notes appeared to be completed within a timely manner (within a 30-day period) for only two (17%) of the individuals sampled. These included Individual #68 and Individual #284. Overall, consistent with findings of the Monitoring Team's previous reviews, the adequate and timely monitoring of skill acquisition data was not evident. 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	

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		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 six randomly selected direct support professionals across five residential programs (i.e., Iris, Violet, Elm, Birch, and Willow). Of the six staff interviewed, only two (33%) were able to immediately produce the data index card and two (33%) indicated that it was acceptable to fill out the card at the end of the shift. Consequently, it appeared that only a small percentage of sampled staff had their data cards at hand and ready to closely adhere 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 and vocational 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 13 individuals from across eleven residential programs (i.e., Willow, Oak, Birch, Elm, Fir, Maple, Rose, Zinnia, Tulip, Aspen, and Iris) and two vocational programs (i.e., Little Workshop and Big Workshop) and reviewed available SAPs and SAP data sheets as found within their records. Overall, data appeared to be collected within 93 of 111 (84%) prescribed opportunities across selected SAPs for 13 individuals. It should be noted that these percentages reflected whether or not data was actually recorded on data sheets consistent with the schedule prescribed within the SAP methodology. That is, the Monitoring Team was looking to determine if data was recorded as scheduled. However, closer inspection found that, although data was collected as scheduled, it was not recorded adequately. More specifically, data sheets were examined with regard to whether or not data was collected consistent with the prescribed teaching strategy (i.e., forward, backward, total task), as well as whether or not the number of trials and if trials were correct or incorrect. Overall, it appeared that only 23 of 41 (56%) SAPs were completed fully and accurately. Most of these included data (or omitted data) that was inconsistent with the teaching methodology currently in place. Overall, although direct support professionals appeared to be collecting data when prescribed, recorded data evidenced considerable difficulty in accurately recording this data. In summary, to move in the direction of substantial compliance, the Facility needs to ensure that SAPs are based on findings and recommendations of assessments as well as on individual preferences, as identified in the PSI. In addition, efforts to improve the quality of SAP integrity probes as well as the utilization of SAP quality rubrics, including	

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		inter-rater reliability, appeared necessary. Continued emphasis on the timely and accurate data collection for PBSPs and well as SAPs is necessary. Lastly, timely and accurate monitoring of SAP data, using Monthly Notes, appeared to require considerable improvement.	
	(b) Include to the degree practicable training opportunities in community settings.	As detailed in the Monitoring Team's previous reports, only a very small percentage of developed SAPs targeted the community as the primary setting for instruction. Indeed, in the last two Monitoring reports, only 5% or less of the sampled SAPs targeted the community as the primary setting for instruction. Of the 53 SAPs currently sampled (i.e., as previously discussed with regard to Section S.1 of the Settlement Agreement), one (2%) targeted the community as the primary setting for instruction. Overall, since the Monitoring Team's last visit, opportunities for formal instruction in community settings did not appear to increase. And, although community settings continued to be identified as part of generalization strategies, the inadequacy or omission of specific plans to support generalization appeared to limit training opportunities in the community. That is, many of the SAPs appeared to have "boiler plate" generalization strategies that did not appear appropriate given the identified SAP (e.g., Individual #167 and Individual #34). Lastly, the Facility provided a listing of individuals with SAPs targeting completion in the community. Based on this listing, SAPs designed for community settings were developed for 28 individuals. This list was not, however, wholly consistent with findings from the current sample as the one individual identified in the current sample (i.e., with a SAP that targeted the community as the primary setting for instruction) was not listed (i.e., Individual #70). It should be noted, however, that newly revised data sheets were noted to have a method to monitor and record when SAPs were implemented in the community. This appeared to be an improvement since the Monitoring Team's last report. It was unclear if the Facility was still moving toward developing a monitoring system to effectively track progress on these community-based training opportunities. 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 more frequent opportunities for generalization both during and following formal 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. 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, ongoing monitoring consistently showed several programs with typically no (or minimal) community outings each month. These typically	Noncompliance

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		included Quail, Sparrow, Iris, Zinnia, and Willow. This was based on the 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. At the time of the Monitoring Team last visit, reported data reflected a slight improvement in the number of community outings compared to previous observed rates. However, provided data also reflected decreasing trends over time in the number and percentage of individuals participating in community outings each month. Based on data collected over the last year (May 2013 to May 2014), it appeared that the number of total community outings each month varied dramatically from month to month. That is, total monthly outings across all residential programs ranged from 62 to 196 per month (average of 116 outings per month). In addition, it appeared that the total number of individuals that went out on outings each month varied over time as well. That is, total individuals per month across all residential programs ranged from 78 to 181 per month (average of 116 individuals per month). A similar variable trend was found in the percentage of individual who went out in community outings. More specifically, the percentage of individuals who went into the community averaged (and ranged) 51% (37% to 85%) of residents per month. Overall, 61% or less of the individuals supported by the Facility experienced community integration in 10 (77%) of the 13 months during this time period. Consistent with previous findings, the same programs continued to be significantly lower that other residences with regard to opportunities for community integration, including Quail, Sparrow, Zinnia, Willow, and Iris. Data provided by the Director of Vocational and Day Programs reflected efforts to monitor community outings facilitated by Vocational and Day Program staff when individuals attend programs. This evidenced an effort to monitor the nature of monthly community integration across several categories of trips, including those associated with vocational and vocational explorations as well as the enterprise program and new employment. Similarly, data collection was initiated on outings primarily associated with residences from day programs as well as those outings related to the arts (music, etc.). Analysis of this data was currently limited, as the nature of the data collection had changed. More specifically, prior to January 2014, data was collected on the number of outings completed. Starting in January 2014, data collection targeted the number of individuals included across these various types of community outings. It was unclear to the Monitoring Team why both measures could not be concurrently collected and reported. 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, and that significantly more work be done to	

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		increase the number of SAPs targeted for implementation in community settings. 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, as of 5/15/14; 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 November 15, 2013 to May 15, 2014, 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 11/15/13 to 5/15/14; o List of individuals transferred to the community since the last onsite review, from 1/11/14 to 5/31/14; o Note that since the last onsite review through 5/31/14, no individuals were discharged pursuant to an alternate discharge; o Note that since the last onsite review through 5/31/14, no individuals were transferred to other SSLCs; 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 11/19/13, 12/18/13, 1/14/14, 2/19/14, 3/9/14, 4/11/14, and 4/25/14; 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 5/15/13 to 5/15/14; 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 11/15/13 to 5/15/14; 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, from 11/15/13 to 5/15/14; o Community Living Discharge Plan, related assessments, sign-in sheet, most recent ISP CLDP Assessment Logs, and ISPAs related to transition of the past year for Individual #94,

	Individual #245, Individual #155, and Individual #103; o State Office reviews of the CLDPs for Individual #94, Individual #245, and Individual #103; o ISP Meeting Guide, dated 11/21/13; o Lubbock State Supported Living Center Fiscal Year 2013 Obstacles to Referral and Transition Report; 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 #94); 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 CLDP, assessments, and post-move monitoring report for Individual #259 who died after transitioning to the community; o Community Placement Report, from 11/15/13 through 5/15/14; 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 #22, Individual #273, Individual #70, Individual #76, Individual #235, Individual #254, Individual #168, Individual #4, Individual #242, and Individual #223; o Pre-Move and/or Post-Move Monitoring Checklists for: Individual #19, Individual #79, Individual #259, Individual #106, Individual #94, Individual #245, Individual #155, and Individual #103; 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 The Roaming Mustangs: A Newsletter about Community Living, July 2014 issue; o Application for Individual #134's re-admission; o ISP Action Plans related to education about community for Individual #98;

	○ Death Certificate for Individual #259; ○ ISPAs related to rescinded referrals for Individual #97, Individual #27, and Individual #90; ○ For the last six months, ISPAs related to transition for Individual #240, Individual #140, and Individual #282; ○ For the last one-year period, total number of individuals that would have been referred to the community except for LAR choice; ○ Provision Action Information; ○ Self-Assessment for Section V, updated 6/20/14; ○ Action Plans: Section V, updated 6/18/14; 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 Soliz, QIDP Coordinator. ▪ **Observations of**: ○ ISP meeting for Individual #290.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T, dated 6/20/14. 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 Facility submitted some completed monitoring tools for Living Options discussions, but not for CLDPs or post-move monitoring visits. Based on the samples submitted and review of the Self-Assessment, the data were not being collected reliably, and it was unclear that the data were valid. ○ The tools being used did not define the standards used, and did not result in valid findings. ○ In addition, inter-rater reliability had not been established between the QA Department and the Admissions Placement Department. Facility staff explained that for the new tools State Office had issued, a database was not available to calculate inter-rater reliability. ○ 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. As the Self-Assessment indicated, some of the samples were small due to a change in responsibilities for completing the monitoring. ○ The QIDP Coordinator, Admissions Placement staff, and QA staff were responsible for monitoring. The staff responsible for conducting the audits/monitoring had not been deemed competent in the use of the tools. Although all of the staff responsible had some

	experience with developing ISPs, completing transition plans, and/or conducting post-move monitoring, no formal methodology was in place to ensure they programmatically competent in the relevant areas. o Although some relevant data from other sources was sometimes included (e.g., data related to number of community education tours), the data was not linked to outcome measures or goals to determine whether or not the Facility was doing well. The Self-Assessment frequently did not review the quality of supports or activities (e.g., for T.1.b.2, there was no review of the quality of individualized plans to address education on community options; or for T.1.b.3, the Facility did not assess whether team decisions were justified). ▪ The Facility rated itself as being in compliance with nine subsections (i.e., Section T.1.c.2, Section T.1.c.3, T.1.h, T.2.a, and T.4). The Monitoring Team did not rate T.4, because there had not been any alternative discharges. The Monitoring Team found the Facility in substantial compliance with three subsections. Largely, it appeared that the issues related to the Monitoring Team assessing the quality as well as presence of items, and, in some instances, the Facility viewing certain Settlement Agreement requirements as falling into different subsections of Section T than the Monitoring Teams do. However, the Facility is encouraged to review the Monitoring Team's report in comparison with its self-assessment to further identify the discrepancies. ▪ The Facility data identified areas in need of improvement. For these areas of need, the Facility Self-Assessment provided some limited but incomplete analysis of the information, identifying, for example, potential causes for the issues. The description of actions being taken was generally a reference to portions of the Facility's Action Plans.
	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 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 addition, these systemic issues appeared to have an impact on LARs' willingness to consider transition to the community, and it was not clear that Facility and/or Local Authority staff were equipped to offer options to illustrate that sufficient supports could be offered in a community setting. For example, Individual #22's LAR expressed concerns about a referral to the community. One of her stated concerns was his going to jail if he moved to the community. Based on the documentation in the ISP, instead of providing the LAR with an explanation of the types of supports that could be in place in a community setting to protect Individual #22 and address his behavioral issues, the Local Authority staff "explain[ed] in Lubbock if consumers with a diagnosis of IDD or Behavioral health goes to jail, they are not placed in the general population, there is a separate population."

	Although teams were identifying obstacles to referral, 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. With regard to education of individuals about community options, most individuals had a plan in their ISP, and progress was made in that a couple of the plans were individualized. More work was needed, but 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. 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. As noted in the last report, four individuals that had transitioned to the community since the Settlement Agreement was signed had returned to the Facility, and two of these individuals were in jail before returning. Since then one individual returned from community placement due to police contact to address behavioral issues, and another individual, who had transitioned to the community in September 2011, also returned due to behavioral issues; and one death occurred following community placement. 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. On a positive note, the Incident Management Coordinator was planning to assist the Admissions Placement Department with reviews. Although it was clear that efforts were being made to conduct thorough post-move monitoring, the Post-Move Monitor needed to review all evidence listed as necessary in the CLDP and base findings on the supports as written. Reports submitted identified few issues, but the Facility had followed up on the few issues that were identified.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined	Based on the Community Placement Report, for the time period between 11/15/13 and 5/15/14, as well as other lists the Facility provided, the transition-related numbers were as follows:	Noncompliance

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	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.	▪ Five individuals completed transitions (2% of population); ▪ Referrals for community placement: o Seven individuals were on the active referral list (3% of population); o Four individuals were referred since last visit; o Three individuals had been on list more than 180 days; and o One individual had been on the list for more than one year; ▪ Reportedly, during the last six-month period, no individuals had requested placement, but were not referred; ▪ For ISP meetings held between 7/1/13 and 6/30/14, 42 individuals would have been referred except for LAR preference (i.e., the IDT would refer). This represented 21% of the 204 individuals residing at the Facility; ▪ Three 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 (i.e., Individual #94) returned from community placement due to police contact to address behavioral issues. Of note, In January 2014, another individual (i.e., Individual #134), who had transitioned to the community in September 2011, also returned due to behavioral issues; o One death occurred following community placement (i.e., Individual #259); and o Two other potentially negative outcomes (e.g., Individual #64 changed community provider or residences twice since the last review, due to the guardian's dissatisfaction with providers. This represented a total of three changes since the individual transitioned to the community.); 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 #94, Individual #245, and Individual #155), three (100%) individuals and/or LARs did not oppose transition to the community.	

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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 #97, and Individual #90). ▪ Of these, the reasons for the rescinding appeared to be reasonable for two (100%) (i.e., Medical for Individual #97, and LAR Choice for Individual #90). ▪ Further, an adequate review to determine if changes were needed in the referral and transition-planning processes at the Facility was conducted for two (100%) of the rescinded referrals (i.e., for Individual #97, his health changed since the referral, and refusals to eat and weight loss were the concerns the team agreed required stabilization before transition; and for Individual #90, for whom his new guardian declined to move forward with the referral despite the Transition Specialist's efforts to explain the successes with the process thus far). ▪ Because no recommendations resulted from the reviews, the following indicator was not applicable: 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 ___ (%). 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: ▪ 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 #76, Individual #168), and/or complex behavioral needs (e.g., Individual #22, Individual #4, and Individual #70) 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. In addition, these systemic issues appeared to have an impact on LARs' willingness to consider transition to the community, and it was not clear that Facility and/or Local Authority staff were equipped to offer options to illustrate that sufficient supports could be offered in a community setting. For example, Individual #22's LAR expressed concerns about a referral to the community. One of her stated concerns was his going to jail if he moved to the community. Based on the documentation in the ISP, instead of providing the LAR with an explanation of the types of supports that could be in place in a community setting to protect	

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		Individual #22 and address his behavioral issues, the Local Authority staff "explain[ed] in Lubbock if consumers with a diagnosis of IDD or Behavioral health goes to jail, they are not placed in the general population, there is a separate population." ▪ In addition, LBSSLC teams were not addressing barriers to transition to the community in a consistent and aggressive manner. For example, Individual #273 often refused to leave his home on the LBSSLC campus, which was seen as an obstacle to his moving to the community. However, an aggressive plan to address this issue was not in place, according to review of his ISP and related action plans. 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. <u>Pace of Transitions</u> h. At the time of the review, transitions were not occurring at a reasonable pace. As discussed below, this was due to a lack of action and/or documentation for one individual that had been on the referral list for over 180 days. In addition, it should be noted that the Facility had very few referrals. As referrals increase, the rate at which transitions occur might change. ▪ Of the five individuals placed since the time of the last onsite review, four (80%) were placed within 180 days of their referral. The one that was not was Individual #94. ▪ At the time of the review, seven individuals had been referred for community transition. Three of these eight individuals had exceeded the 180-day timeframe (i.e., Individual #240, Individual #140, and Individual #282). 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 two of the three (67%) individuals (i.e., Individual #240, and Individual #282). 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	

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		updates on the status of the guardianship proceedings. However, for Individual #140, the ISPAs for the time period beyond the 180 days did not provide sufficient detail to determine what actions the Facility had taken. For example, the last three monthly updates repeated that the guardian had selected a provider, but the provider did not have an opening, and was going to purchase a new home. No information was provided regarding Facility staff's contact with the provider or the Local Authority to determine actions the provider had taken to purchase a new home. j. There were no gaps of time (e.g., multiple months) during which little or no activity occurred for one of the two (50%) individuals (i.e., Individual #282). For Individual #240, this was not applicable, because the Facility did not have control over the legal proceedings. For Individual #140, for the last three months, no activity was documented, such as contact with the provider or Local Authority to determine the status of the purchase of a new home, or searches for other providers that could meet his needs. k. Adequate justification was provided for the lengthier transition process for two of the three (67%) individuals (i.e., Individual #240 and Individual #282). 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 Office policy for most integrated setting practices was recently issued. It did not address all of the items in section T of the Settlement Agreement. Below are comments from the Monitors: ▪ The policy was missing a complete description of the process used to "assess" individuals for referral to the community. The ISP policy described the process of team members making recommendations in their assessments (at III.C.5.c), but did not address having discipline members make a recommendation to the individual and LAR, followed by a full team recommendation being made. The ISP policy addressed, in very global terms, a "living options discussion," and referred the reader to the Most Integrated Setting policy for more details. T.1.b.3 states: "Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices." Neither policy, however, fully spelled out how this would be done. ▪ There was nothing requiring an individualized plan for the education of the individual and LAR. Such efforts are probably the most important aspect of addressing the primary reason for individuals not being referred (i.e., about 50% of the individuals across the state were not referred due to LAR preference). ▪ The policy did not thoroughly address the IDT and Facility's responsibility in regard to identifying and addressing obstacles to referral and obstacles to transition.	Noncompliance

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		▪ There was no requirement that Facilities take action within their purview to overcome obstacles (e.g., working with local authority). ▪ After referral, there was no description of expectations regarding roles of Facility staff (e.g., assessing potential community options, providing training to staff) or of potential transition activities, such as visits to potential homes, provider staff visiting Facility, etc. ▪ The policy did not mention the Settlement Agreement requirement that action be taken prior to the individual's move if pre-move supports are not in place. ▪ The policy did not address the quality of CLDPs. ▪ There was no mention of need for IDTs to use CLDP to ensure supports are in place. ▪ There was no standard that the Facility exert its best efforts to address concerns identified through post-move monitoring. ▪ The policy should draw from, and line up with, the metrics submitted by the Monitors and the content of the monitoring reports. b. Due to the fact that the State policy was not yet adequate, the following metric could not be assessed: There **were/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 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	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	Noncompliance

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	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.	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. <u>Identification of and Plans to Overcome Obstacles to Referral and Transition to Community</u> Regarding referral at the individual level: b. Of the 10 ISPs reviewed, nine should have had obstacles to referral defined (the other individual, Individual #254, was referred for transition to the community). For Individual #235, pages were missing from the ISP the Facility submitted, so this could not be determined. Of the remaining eight ISPs, six (75%) included an adequate list of obstacles to referral (i.e., Individual #70, Individual #223, Individual #242, Individual #168, Individual #22, and Individual #4, all of whom the obstacle was LAR Choice, and as noted below, although this was accurate, the teams often had not identified the specific reasons). The problems associated with the obstacles in the plans included the following: ▪ When guardians objected, adequate inquiry generally did not occur with regard to specifically what their concerns were (e.g., Individual #223, Individual #22,	

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		Individual #4, and Individual #168). This is very important information to collect and analyze, but it did not appear it was being captured regularly. The exception was for Individual #70, for whom the team identified and attempted to address some of the guardian's specific concerns; and ▪ For some individuals, the teams' justifications for identifying some obstacles were not clear (e.g., for Individual #242, Individual #22, Individual #168, Individual #76, and Individual #4, obstacles were medical issues and/or behavioral/psychiatric issues, but the specific issues/missing 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%) (i.e., LAR Choice, including some discussion of the specific reasons). Regarding a plan to address obstacles at the individual level: d. Of the eight ISPs, two (25%) (i.e., Individual #70 and Individual #273) included an action plan to address/overcome obstacles identified. Of these two, one (50%) (i.e., Individual #70) was adequate (i.e., individualized, measurable, and comprehensively addressed the obstacles). For Individual #70, the plan for education included information about some of the LAR's specific concerns, and included a feedback loop to provide the team, including the LAR information about Individual #70's reaction to the community exposure tours. An action step also was built in for the team to meet after six months to discuss possible referral again. Many examples are provided in previous reports of concerns related to these plans, and limited 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, Medical Issues, etc.). Generally, although plans were measurable, they were not individualized. 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, none (0%) appeared adequate. Regarding transition at the individual level: f. Of the three CLDPs and related ISPAs reviewed, one (i.e., Individual #94) should have had obstacles to transition defined. Of this one CLDP and ISPAs related to transition, none (0%) included an adequate list of obstacles to transition.	

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		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. As individuals go through the transition process, it is essential for teams to identify and document any obstacles to transition the individual encounters, as well as the team's plans to overcome them. 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 nine ISPs (i.e., Individual #22's LAR refused to allow discussion with the individual), two (22%) (i.e., Individual #235 and Individual #254) 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 #290 did not yet have a good idea of what his preferences were. Preferences of LARs: j. Of the seven ISPs for individuals with guardians, two (29%) included an adequate description of the LAR's preference and how that preference was determined by the IDT (i.e., Individual #70 and Individual #22, 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 one (100%), but 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 #290 had been determined through an informed consent process, during which the team had discussed the risks and benefits with the guardian. Although the guardian clearly was concerned about a community provider's ability to address Individual #290's seizure disorder, the team did not provide sufficient information about how medical supports could be configured in a community setting to ensure the LAR's decision was an informed one. 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 most of the plans teams had developed to overcome such obstacles remained	

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		inadequate. Plans were generally measurable, which was positive. However, they often 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 individuals and their families or guardians to enable them to make informed choices.	<u>Individualized Plans</u> a. In reviewing 10 recently completed ISPs, one individual (i.e., Individual #254) had been referred for placement, and was engaged in the CLDP process. Individual #242's LAR refused to allow further education. For the remaining eight, six (75%) had a plan that addressed education about community options. The exceptions were Individual #22 and Individual #273. Of these six, two (33%) (i.e., Individual #70 and Individual #235) were adequate. Individual #235's action plan was tailored to meet his specific needs: "will have the opportunity to visit at least two facilities in the community that deal with eating disorders and/or brain trauma and/or aggressive-medical behaviors over the next 12 months. As noted above, for Individual #70, the plan for education included information about some of the LAR's specific concerns, and included a feedback loop to provide the team, including the LAR information about Individual #70's reaction to the community exposure tours. An action step also was built in for the team to meet after six months to discuss possible referral again. For the remainder, although they were measurable, they were not individualized. As noted in the Monitoring Team's last report, 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. Based on interview with staff, the LBSSLC Transition Specialists presented some of these materials at a recent State Office meeting. On 1/31/14, subsequent training was held with QIDPs, and on 3/21/14, new QIDPs participated in on-the-job training. Information included in the Presentation Book for Section T indicated that the QIDP Coordinator and Admissions Placement Coordinator were planning additional training on action plans for QIDPs. Staff indicated that because LAR Choice remained one of the most frequently cited obstacles to referral, staff planned to provide some examples of action plans to address LARs' concerns to teams. 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. It was positive that during this review, some improvement was seen. However, more work was needed. Many examples of concerns related to the plans have been discussed in previous reports. As indicated in the Monitoring Team's previous reports, in developing the action plans, it will be important to target specific types of providers for community tours, identify research that the team could do to	Noncompliance

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		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 beginning to be included in action plans, which was positive. 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 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 September 15, 2013, and the most recent one was held on 3/25/14. According to information the Facility provided, prior to the most recent fair, one of the Local Authorities sent invitations to all of the local providers. A flier was sent to all individuals' correspondents advertising the Fair, which had a Mardis Gras theme. An email was sent to all LBSSLC staff, and flyers were posted in the residences and other buildings on campus. Seven providers 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 March 2014 fair included 59 individuals, one Legally Authorized Representative, 20 direct support professionals, 121 "professional staff," and 27 provider staff/guests. Facility staff had graphed this data to show comparison across this most recent Provider Fair, and the last three fairs. One notable statistic was an almost doubling of professional staff's participation. 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). Based on interview with staff, one of the results of the evaluations from the most recent fair was that many staff reported not learning new information about the community. The Admissions Placement staff and Transition Specialists indicated this would be an area of focus in planning upcoming events.	

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		Meeting minutes for the meeting Facility staff had with the Local Authority after the March 2014 event showed discussion of the event as well. <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 review of the minutes, a group of Facility staff was meeting with Local Authority staff monthly. From the Facility, this generally included the Admissions Placement Coordinator, a QIDP Department representative, and Transition Specialists. <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, and identified all individuals and whether or not each went on a tour). However, based on staff report, the QIDP Coordinator planned to develop a mechanism for measuring this indicator. Based on data the Facility provided, between December 5/15/13 and 5/15/14, 49 individuals attended tours, or approximately 24 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. At the time of the review, 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. f. Of the nine individuals in the sample for whom their teams had determined a tour was appropriate (i.e., Individual #223, Individual #242, Individual #4, Individual #168, Individual #235, Individual #70, Individual #273, Individual #22, and Individual #76), none (0%) went on a tour tailored to their needs within the past year. Although a number of these individuals had documentation that they went on a community tour, 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 12 peers to the individual's home in the community. This appeared to have occurred during the Thanksgiving holiday, which was before the Monitoring Team's previous review. Another individual invited and hosted five individuals at her new home. However, this was not evidence of a systematic process to identify individuals who would benefit, and facilitating 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 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 November, December, January, February, and March, the related topic covered was the community exposure tours. ▪ The Admissions Placement Coordinator also presented information to the Family Association, including through mailings, and at the Family Association meeting on 12/8/13. ▪ On 12/4/13, 12/10/13, 2/5/14, and 3/5/14, Transition Specialists visited individuals' residences to share the CLOIP DVD presentation. ▪ Between 11/15/13 and 5/15/14, three Diner Discussions occurred. Transition Specialists shared the provider directory, and educational DVDs. In addition, they shared information about how to contact them. ▪ As noted in the last report, 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	

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		various community options. 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 5/15/13 and 5/15/14, 61 staff had participated in CLOIP tours. In addition, the Facility reported that on 1/31/14, a handout on the Olmstead decision was sent to all direct support professionals and residential staff. New Employee Orientation included a component on the most integrated setting, which the Transition Specialists recently had revised. Nurses also completed training on the CLDP process. The employee newsletter entitled: "What's Happening" also included information about community exposure tours. Diner Discussions were open to staff, as were self-advocacy meetings, and provider fairs. As noted in the last report, 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, two individuals that had moved to the community from LBSSLC were present to share their experiences. ▪ Since the last review, an important addition was the development of "The Roaming Mustangs: A Newsletter about Community Living." The newsletter was distributed to individuals' correspondents, emailed to staff, placed in the Diner, and handed out at the Family Association meeting. Two editions had been issued, and included information about options for learning more about community living opportunities, the referral and transition process, the	

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		Olmstead decision, and success stories. For example, in the first issue in April 2014, Individual #59's transition was highlighted, including his ability to participate in an in-home day program, and the supports that helped him maintain his weight, which was an initial concern of his LBSSLC team. In July 2014, the second edition included Individual #2's success story. Since moving to the community in late 2012, he had moved from a group home to a foster care home. Positive outcomes of his transition included living in a quieter environment, walking more using a walker and trailing techniques (because he was blind), decreasing challenging behavior, and sleeping through the night. 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; and individuals who have experienced successful transitions could potentially speak in other forums, such as at the Diner discussion. Some progress had been made. In addition to more individuals having a plan in their ISP, a couple of the plans related to education were individualized. More work was needed, but 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. 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	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, for none (0%), all of the assessments included the applicable statement/recommendation. Assessments that often did not include recommendations included nursing and day program. It appeared that the Facility might not have included the assessments requested for nursing (i.e., the physical assessment as opposed to the annual assessment). Although some improvement was seen with ISPs clearly stating the recommendations from residential staff and the QIDP, who did not complete separate	Noncompliance

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	policies, procedures, and practices.	assessments, this was not consistent, and often, direct support professionals' opinions were not documented. b. In four of the eight (i.e., for Individual #70 and Individual #235, this could not be determined due to missing pages) (50%) (i.e., Individual #22, Individual #273, Individual #168, and Individual #4) written ISPs reviewed, and during one of the one (100%) 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. d. For two of the 10 individuals (i.e., Individual #235 and Individual #70), pages from the ISP were missing, and, as a result, the following indicator could not be assessed. Of the remaining eight ISPs reviewed, seven individuals' ISPs (88%) included a clear recommendation from the professionals on the team to the individual and LAR. The exception was Individual #4. For Individual #4, the discipline members did not make a recommendation independent of the LAR. The first recommendation listed included the LAR as one of a number that said "no." Many other discipline team members said "yes," but these discrepancies were not reconciled. However, for none of these individuals (0%) was adequate justification provided for the discipline team members' recommendation. Many examples of problems have been explained in detail in previous reports, and should be referred to as Facility staff continue to work towards improvements in this area. e. For one of the 10 individuals (i.e., Individual #235), a page was missing from the ISP, and, as a result, the following indicator could not be assessed. 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, of these, six (67%) included appropriate justification (i.e., Individual #22, Individual #70, Individual #168, Individual #4, Individual #242, and Individual #223, whose guardians chose not to pursue transition). Examples of concerns have been included in previous reports, and should be referred to as Facility staff continue to work towards improvements in this area. As the Monitoring Team had recommended, for some individuals for whom their teams believed transition would be appropriate "if appropriate supports were available," teams should consider an exploratory phase prior to making a decision about a referral or no referral. During this time, the team could ensure that it had an exhaustive list of protections, supports, and services the individual required, and use this list to determine which community providers might be able to support the individual. The team could support the individual and his/her guardian to explore these different options to	

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		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. 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 individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	Since the Monitoring Team's last onsite review, five individuals transitioned to the community. Three of these individuals' CLDPs were reviewed (i.e., Individual #94, Individual #245, and Individual #155). This represented 60% of the relevant CLDPs. Based on review of these CLDPs: ▪ Two of the three (67%) (i.e., Individual #94 and Individual #155) CLDPs were initiated within 14 calendar days of referral. ▪ 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 teams 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 during which 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 consistently	Noncompliance

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		involved in the meetings related to decisions about the appropriateness of specific community providers or sites. On a positive note, Behavioral Health Services staff frequently attended meetings for individuals with behavioral concerns. However, in other instances, individuals clearly had 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 the CLDP meetings, they infrequently attended ISPA meetings leading up to transition and documentation did not clearly indicate what collaboration occurred. The Facility remained in noncompliance with this provision.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	a. The Community Living Discharge Plans reviewed included a number of action steps related to the transition of the individuals to the community. However, none of the three 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, as dictated by the individual's needs and preferences: ▪ Training of community provider staff, including staff to be trained and level of training required: 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. The plans also generally indicated that day and residential staff needed to complete the training. Similarly, the CLDPs generally identified 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 or other method of determining competency 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. For example, for Individual #94, no coordination was required between BCBAs or psychiatrists. Similarly, no coordination was required for Individual #245 between BCBAs, habilitation therapy staff, and/or medical personnel; ▪ Assessment of settings by SSLC clinicians (e.g., OT/PT): Individual #245 had	Noncompliance

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		issues with gait, but it was unclear whether or not the new environments were assessed to ensure they met his needs. Individual #94 had a history of suicidal threats, but it was unclear if the team assessed the new environment to determine, for example, if she made threats and/or required increased monitoring, whether the environment was configured to allow for such monitoring. ▪ 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. For example, for Individual #94, no coordination was required between LBSSLC day/workshop staff and/or residential staff. Such coordination might have assisted in uncovering some of the routines to which Individual #94 was accustomed that when not planned for as part of the CLDP caused issues with her transition; ▪ 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.	Staff Names for All Pre- and Post-move Supports ▪ a. For three (100%) CLDPs, the Facility identified all Facility staff and other staff (e.g., LA, community provider staff) by name and title for each pre-/post-move support. Completion Timeframes/Dates for All Pre-/Post-Move Supports ▪ b. For three (100%) CLDPs, the Facility identified specific timeframes/specific dates for completion and/or implementation for each pre-/post-move support.	Substantial Compliance

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	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.	<u>Evidence of Individual/LAR Participation</u> • a. Based on review of three CLDPs, two (67%) (i.e., Individual #94 and Individual #155) included documentation that the plans had been reviewed with the individual and/or the LAR as evidenced by: o Signatures on CLDP: and/or o Narratives in the CLDP. Problems noted included the individual's signature not on the sign-in sheet, and no explanation for their absence (e.g., Individual #245). This individual did not have a guardian. The Facility was in substantial compliance with this provision for six previous reviews. Given that during this review, there was a lack of documentation to show involvement of only one individual, the Facility has maintained its finding of substantial compliance. However, to maintain substantial compliance, the Facility must ensure that individuals or their guardians are involved in the transition planning process, and if not, an explanation is documented.	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 risk, were sufficiently addressed. ▪ For three of the three CLDPs reviewed (100%), all remaining assessments were completed no more than 45 days prior to the date the individual moved to the community. ▪ For three of the three CLDPs reviewed (100%), all completed assessments were available to the Admissions Placement Coordinator/Transition Specialist and IDT prior to 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,	Noncompliance

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		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 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, some 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. Regarding the nursing documentation for	

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		four discharges/individuals transitioning to the community, a review of the nursing notes and CLDP-Comprehensive Nursing Review for four individuals including: Individual #259, Individual #106, Individual #245, and Individual #103 found the following: ▪ None (0%) of the CLDP-Comprehensive Nursing Review adequately addressed the health/mental issues of the individuals. ▪ There was adequate information contained in none (0%) of the CLDP-Comprehensive Nursing Review 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 three (75%) of the individuals. Individual #259's documentation did not include a nursing assessment at the time of the discharge. ▪ 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 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.	<u>Adequacy of Pre-Move and Post-Move Required Supports</u> The CLDPs reviewed included pre-move and post-move required supports. Since the last review, limited to no progress had been made. However, 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, 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, some 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	Noncompliance

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		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 #155, Individual #94, and Individual #245 had behavioral issues that could have required staff intervention, but no plan was articulated for what supports community providers would have in place should such behaviors occur after transition to the community; and ▪ 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 #94 with a number of target behaviors, including aggression, or Individual #245 who exhibited pica behavior). 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	

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		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 (e.g., Individual #155 was at medium risk for constipation, osteoporosis, behavior, dental, and gastrointestinal, but these risks were not sufficiently addressed; or Individual #245 was at risk behaviorally and medically due to pica, and was at medium risk for choking, aspiration, constipation, osteoporosis, and fractures, and at high risk for dental, but these risks were not sufficiently addressed); ▪ 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 for Individual #245), a number of such supports were missing, and parameter for reporting issues to health care staff were often missing (e.g., despite a number of areas of risk for Individual 155, only his weight was identified as requiring monitoring, and weight was not an area of risk for him; for Individual #94, the only indicator identified as monthly weights, but the only parameter for referral to a dietician was "significant weight changes"); ▪ 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 supports were consistently missing. For example, individuals had nursing care needs, psychology/behavioral health needs, therapy needs, etc. However, clinical services were often absent from the CLDPs (e.g., for Individual #155, no reference was made as to how his nursing supports would be transitioned, and no requirements for the involvement of a behaviorist were included; for Individual #245, who had multiple medium healthcare risks, no reference was made regarding how his nursing care plans/IHCPs would be transitioned, or how Habilitation Therapy involvement would be addressed, and no requirements were included for the involvement of a	

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		behaviorist; and for Individual #94, the only definition of the role of a BCBA was "monthly monitoring of her PBSP"); ▪ 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; 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. 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., staying in touch with a family member, going out to eat, etc.), but clear reference to what was important to the individual was generally missing. At times, team appeared to have overlooked significant preferences in developing CLDPs (e.g., Individual #94's preference to "sleep in, and work in the evenings"). 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 defining day and vocational supports. Just like residential supports, day/vocational supports should be defined with	

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		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" or "will establish employment services at ____ workshop" was the support included in relation to day/vocational supports. As one example, according to her ISP, Individual #94 was employed in the LBSSLC workshop and in a supported employment position in the Diner. However, her CLDP did not effectively transition these supports to the community. In addition to a generic support for her to be involved in a workshop in the community, the only other support related to employment read: "[Individual #94] should be employed in an area that she willingly participates in and does not exhibit challenging behaviors." This support was not individualized, and did not specifically define the steps that would be taken to ensure that Individual #94 would be able to maintain the level of independent work she had access to at LBSSLC. As written, the support also did not address how behavior supports would be provided to Individual #94 in her new work setting(s). ○ 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. Although Individual #94's CLDP included a support to continue her token economy system, it was unclear whether or not any modifications needed to be made. Individual #94's team also incorporated purchasing a soda at least three times a week. This was positive, but as the team learned after her return to LBSSLC, Individual #94 was used to purchasing a soda daily at LBSSLC, and the team's failure to identify this prior to her	

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		transition caused significant issues after her transition. Similarly, for Individual #245, his ISP indicated that the team was identifying incentives to increase his willingness to walk, but these efforts were not transitioned to the community through the CLDP; ○ 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. ○ 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. For example, it appeared for Individual #94, that the team included only partial implementation of her PBSP (i.e., just the token economy system). Similarly, for Individual #245, it appeared that only portions of his PNMP and dining plan were included. In addition, other plans that required implementation were not identified as post-move supports, 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 consistently clear whether or not such action steps were needed. However, one example of a team's failure to plan for continuation of action steps begun at LBSSLC was Individual #245's plan to increase his walking through the collaboration of Behavioral Health Services staff and residential staff, which was not transitioned through clear action steps in the CLDP;	

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		○ All recommendations from assessments should be included, or if not, a rationale should be provided. For all three individuals, the CLDPs indicated that the teams had chosen not to include some recommendations as supports (e.g., OT/PT recommendations), and gave rationales such as 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 the individual's daily routine. These were all inadequate justifications, and resulted in numerous important post-move supports not being included in CLDPs. ▪ 2) <u>The wording of every pre-/post-move support should be in measurable, and observable terms</u>: Although improvements were seen, problems continued to be noted with regard to the lack of measurable supports. For example, for Individual #245, some of the supports that were not measurable included: "continue monitoring for bowel movements," "continue surveillance for pica," or " continue attending day program." Although, at times, specific times or shifts were noted (e.g., for surveillance for pica), such parameters were not consistently identified. In addition, it was unclear what was a day program versus residential responsibility, and/or whether communication between the two was expected. ▪ 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 what the criterion were, or at what level/frequency/amount the supports should occur. In addition, it was unclear in some instances if specific forms were to be utilized (e.g., for Individual #245, environmental surveillance for pica was an important support the team had included, but it was unclear what the surveillance would entail, or if a certain environmental check sheet would be used to ensure items that placed him at risk were identified). In summary, since the last review, limited to no 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.	

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		As noted in previous reports, the Facility was having the Post-Move Monitor conduct a pre-move site visit designed specifically to determine if the pre-move supports were in place. 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 #155, Individual #245, Individual #103, Individual #106, and Individual #94): ▪ 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. State Office had issued a revised tool for conducting audits of CLDPs. However, the tool being used did not define the standards used, and did not result in valid findings. Although the tool for the CLDP audit identified the methodologies (i.e., where to look for	Noncompliance

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		the information), no standards or guidelines were included to facilitate consistency between reviewers. Inter-rater reliability had not been established between the QA Department and the Admissions Placement Department. Facility staff explained that the audit tool for the CLDPs did not have an associated database, and so inter-rater reliability could not be established. 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 #94) 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. Because an adequate review was not completed, the following could not be accurately assessed: Of these reviews, actions were recommended in ___ cases. Of these ___ cases, actions were implemented for __ (%). For Individual #94, an ISPA – Potentially Disrupted Community Transition meeting was held after her return. Some recommendations were made regarding Individual #94's current staffing and treatment. The only recommendation resulting from the review related to modification to the transition process was: "Instruct provider staff that the daily schedule during the pre-selection visits needs to be consistent with the expectations and schedule for a community placement." Although this was an important recommendation, it was unclear how it was being memorialized to change Facility practice (e.g., a change in procedure). In addition, the team did not critically review the CLDP. One example of concerns the team should have addressed was the community provider's inability to manage a crisis that occurred as a result of a behavioral incident, and led to police contact. A critical question that the team should have asked, but based on the documentation, did 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 thoroughly review the existence in the CLDP and/or the provider's implementation of behavioral supports. Although the team reviewed the provider's implementation of the LBSSLC behavior plan, it was not clear of what this review consisted. In other words, it was not clear if the review was only of the community provider staff's implementation of the plan in relation to the incident that led to her return, or more broadly. Other areas of behavioral support for which there was no documentation to show the team's review included involvement	

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		of an appropriately credentialed behavior analyst, particularly in the days prior to the incident that led to her return when her behaviors were escalating; 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 answered to potentially improve the CLDP development and implementation processes in the future. e. One individual (i.e., Individual #259) 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 none of the one case (0%). As a result, the following were not assessed: Of these reviews, actions were recommended in ___ cases. Of these ___ cases, actions were implemented for ___ (%). Based on the death certificate, Individual #259 died of sepsis, with the other causes of death listed as urinary tract infection, hypernatremia, and dementia. He was 49 at the time of his death. No documentation was submitted to show a critical review of the CLDP and/or transition process. f. Over the past year, of the 12 individuals transitioned, four (33%) experienced one or more potentially negative outcomes since transition (i.e., Individual #94 and Individual #124 who returned to the Facility due to community providers' inability to address crisis behavior incidents, Individual #259 who died, and Individual #64 changed community provider or residences three times, due to the guardian's dissatisfaction with providers). Of the one individual 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 ___ (%). On a positive note, Facility staff recognized the need to pull in some internal expertise to assist with the process of conducting critical reviews of potentially disruptive incidents following transitions to the community. Specifically, the Incident Management Coordinator, who has experience with root cause analyses, planned to work with Admissions Placement staff and teams on conducting critical reviews. 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	

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		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 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.	<u>Facility Efforts</u> a. Although Facility staff verbally reported that they were maintaining a list of the obstacles to individuals' transition, the only document in which obstacles to transition were summarized was the Fiscal Year 2013 Obstacles to Referral and Transition Report. It was not clear that the system to collect information about obstacles to transition was adequate. In order for this information to be complete, teams should report information about obstacles once the individuals' referrals exceed 180 days, as well as "compromises" to meeting the individuals' 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 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. This is essential to ensure that State Office has information to identify areas in which community capacity should be expanded. b. The Facility 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. Some examples of problems included: ▪ As noted above, it was not clear that teams were thoroughly and/or correctly identifying obstacles to referral or transition. As a result, the data on which the report was based was not considered valid. ▪ One of the most significant obstacles to referral was identified as LAR Choice. However, the action plan largely reiterated methodologies similar to those already in place, which to-date had been largely ineffective. Table 3, which broke down the reasons for LAR Choice, clearly did not provide information for all 119 LARs that were reluctant. It was positive that the Facility's analysis recognized this issue. As has been indicated in past reports, until this is done, it will be difficult to meaningfully address this obstacle. It was also positive that the Facility recognized that the CLOIP process was not particularly effective, and	Noncompliance

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		included an action step to work with the LAs to improve the process. ▪ Similarly, a significant obstacle was Individual Choice. However, the report did not set forth an aggressive plan to ensure individuals were educated about their options. Except for implementing processes already in place, there was no indication of what steps Facility staff were taking to ensure that education was really individualized, or how teams were being taught to determine individuals' preferences, particularly individuals whose teams had indicated were unable to provide consent/make informed decisions. ▪ With regard to community supports needed for individuals with complex medical and/or behavioral/psychiatric needs, the Facility made no recommendations to State Office regarding specific supports that are missing from the community system that would be necessary for individuals from LBSSLC to transition to the community. LBSSLC's report provided no analysis of the capabilities or capacity of the local providers for these groups of individuals. <u>Annual Narrative by DADS State Office</u> c. The State 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. DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/13 from all 13 Facilities. The report was issued to the Monitors and DOJ on 3/27/14, seven months after the data collection period ended. The following summarizes some positive aspects of the report: ▪ The statewide report listed the six obstacles to referral categories and 12 obstacles to transition categories used in FY13. ▪ DADS included a list of 14 initiatives it was continuing to support. ▪ The report included attachments with each of the Facilities' annual reports. ▪ The validity of the obstacles to referral data appeared to be more accurate than in previous years' reports. However, as noted in the Monitoring Teams' reports, concerns still existed with teams' accurate identification of obstacles. The following concerns were noted with regard to the report: • <u>Transition Data:</u> In the report, the State Office provided overall data related to transition of individuals from SSLCs, and the overall census from fiscal year to fiscal year. However, the data was fairly meaningless, because the data was not broken down sufficiently or analyzed. For example, although Facility censuses had decreased over the years, data was missing and no analysis was provided	

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		regarding how many individuals had died, how many admissions occurred, the numbers of individuals that died shortly after transition to the community, the numbers of individuals transferred to other large facilities, etc. • Transition obstacles data: Adequate methodologies were not described as to how data regarding obstacles to transition were determined and collected. For example, it was not clear if one individual could have had more than one obstacle, and/or if different obstacles presented themselves at different times during the transition process. Further, the data should describe whether these obstacles to transition were overcome. As a result, the validity of the data provided in the report was questionable. Further, it would be useful to formalize the process to identify obstacles far ahead of the 180-day goal (i.e., not wait until 180 days have passed before identifying and documenting obstacles). o State Office staff reported during recent discussion with the Monitors, that anytime the IDT identified an obstacle to transition, it should be included into the database. Further, State Office staff said that their data system allowed for an individual to have more than one obstacle to transition and indeed many individuals did have more than one obstacle in the data. The data system, however, did not track, or report on, whether obstacles were successfully addressed (i.e., whether the individual had not yet moved and/or whether compromises had to be made). The Monitoring Team believes that this information should be included in the report. • DADS' strategies: DADS included a list of strategies and actions, however, they did not thoroughly address some of the most frequently cited obstacles that the Facilities had identified. For example, according to the 2013 Annual Obstacle Report Data spreadsheet, 353 individuals were not referred due to "Behavioral health/psychiatric needs requiring frequent monitoring...," 308 individuals were not referred due to "Medical needs requiring 24-hour nursing…," and 1698 individuals were not referred due to "LAR's reluctance for community placement" (almost 50% of the population of all of the Facilities). Most of the 14 strategies/actions described general activities, such as to improve the ISP process, the coordination of transition activities, data collection, or special projects at Austin SSLC. Although these appeared to be worthwhile activities, few strategies specifically addressed the above three categories: behavioral/psychiatric (strategies 7 and 8), medical-accessibility (strategies 9 and 10), and LAR preference (perhaps strategies 1 and 12b). Moreover, given that many of the strategies were repeated (or slightly modified) from last year's report, an update on the status of each would be appropriate to include in this report. o During recent discussion with State Office staff, the staff agreed that better overall analysis was needed in order to tie identified obstacles to	

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		their set of statewide strategies, and/or to ensure that there were strategies to address the most-often identified obstacles to referral and to transition. • Assistance: In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). o The Monitoring Team was unable to determine this because there was no information in the report addressing it. The Facility remained in noncompliance with this provision.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing Facility. The Facility need not generate a separate Community Placement Report if it complies	a. The Facility provided an accurate Community Placement Report for six months 11/15/13 through 5/15/14 that included the following information: ▪ Number and names of individuals transitioned to the community. This included individuals who had transitioned to the community, including their name, date of referral, and date on which their transition to the community occurred. This included five individuals. As noted above, one individual had moved since the list was produced. In addition, one of these individuals had returned to the Facility. ▪ Number and names of individuals on active referral list. This included individuals who had been referred by their teams for community placement and had an open referral, including the individual's name, the date of referral, and the status of the referral. Eight individuals were included on this list. One of these individuals had moved since the report was produced. ▪ Number and names of those who would have been referred by the IDT, but were not due solely to LAR preference. For the six-month period, this included a list of 16 individuals. According to State Office staff, this report also had been provided to the United States Department of Justice. The Facility remained in compliance with this provision.	Substantial Compliance

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	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 supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	<u>Timeliness of the Checklists</u> Post-move monitoring documentation was reviewed for 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 #259, Individual #79, Individual #19, Individual #155, Individual #245, Individual #103, and Individual #106). For these individuals during the time period reviewed, the LBSSLC Post-Move Monitor should have conducted 11 reviews. Of the 11 required visits, 11 (100%) had been documented as having been completed on time. <u>Visits to All Sites</u> The Facility continued to ensure that visits had been made to both the residential and day sites of the individuals, and that this was clearly documented in the reports. <u>Content of Checklists</u> Based on a review of 11 post-move monitoring reports, four (36%) were completed thoroughly (i.e., those for Individual #259, and the seven-day reviews for Individual #245 and Individual #106). The following problems were noted: ▪ The PMM did not address the specific support for Individual #79 to have a follow-up consultation with an endocrinologist. Rather, the evidence listed indicated her PCP was following her endocrinology needs, and the support was marked as having been completed. There was no indication this issue was returned to the LBSSLC team for review to determine if this was an acceptable alternative to the original support listed. ▪ At the 90-day review, the PMM determined that Individual #19's new PCP had deferred the support that he see an endocrinologist. However, the PMM rated this support as completed, and there was no evidence this was brought back to the IDT at LBSSLC, or that the PMM consulted the PCP at LBSSLC to determine if the LBSSLC PCP needed to confer with the new community PCP. In addition, for Individual #19, it was unclear whether the PMM reviewed the support related to food texture at the day program. ▪ For Individual #155, at the seven-day review, it was not clear that the PMM had reviewed the required evidence for the support related to his diet order (i.e.,	Noncompliance

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		review of the menu and an observation of a meal). ▪ At the 45-day review for Individual #245, it was unclear whether the PMM reviewed: 1) a meal at the day program; and 2) the environmental sweep documentation at the day program. ▪ Individual #103 was supposed to attend a specific work center program, but due to staffing issues was not attending. Although it was appropriate that alternative arrangements were made until staffing was in place, the Post-Move Monitor had marked these supports as completed, which they were not. ▪ Individual #106 had a support for skill acquisition training, and according to the narrative, the community provider was not completing the training. However, the Post-Move Monitor had marked it as "N/A." <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, one of them (i.e., Individual #103) had needs identified for follow-up to be conducted to ensure supports were implemented. ▪ For one of the one individual (100%), documentation was presented to show that adequate action had been taken. For Individual #103, LBSSLC staff had followed up with the day program provider in relation to staffing issues that prevented the individual from attending. In the meantime, the residential provider had identified other options that Individual #103's LBSSLC team believed were appropriate (e.g., volunteer activities). At the time of the Monitoring Team's review, it was unclear whether or not the issue had been resolved. Although it was clear that efforts were being made to conduct thorough post-move monitoring, it is essential for the Post-Move Monitor to review all evidence listed as necessary in the CLDP and base findings on the supports as written. In addition, as the CLDPs continue to include more detailed protections, services, and supports, care will need to be taken to ensure that monitoring adequately confirms the existence of the supports. Reports submitted identified few issues. The Facility had followed up on the few issues that were identified. The Facility remained out of compliance with this provision.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community	For the week of the onsite review, a post-move monitoring visit was on the schedule the Facility submitted. During the onsite review, Facility staff informed the Monitor that the visit was not a full post-move monitoring visit, but a partial review was being conducted,	Not Rated

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	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.	and the Post-Move Monitor was to complete an additional visit later to complete the review. Although it was helpful for the Monitor to observe the Post-Move Monitor conduct a partial visit, because the Monitoring Team did not observe a full review, the Monitoring Team could not rate this subsection. On a positive note, generally, it appeared that the Post-Move Monitors conducted thorough follow-up on the items that were reviewed.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the	The parties agreed that in addition to the categories listed in the Settlement Agreement, other circumstances of an individual moving from a SSLC might fall under the category of "alternate discharges." For example, reasons such as a LAR choosing to discharge an individual from the Facility without formal transition planning occurring, or an individual transferring to another SSLC would be considered alternate discharges. These would be situations in which the Facility would be expected to follow the Centers for Medicare and Medicaid (CMS) discharge procedures. However, since the previous review, there had been no alternate discharges of individuals served by the Facility. As a result of no alternate discharges having occurred, this provision of the Settlement Agreement was not rated.	Not Rated

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	expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.		

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 6/11/14; o New Guardians since January 2014, revised 6/27/14; o Contact Log regarding guardianship from 1/14/14 to 6/11/14; o Performance Review Team information, including performance measures; o ISPs for Individual #22, Individual #273, Individual #70, Individual #76, Individual #235, Individual #254, Individual #168, Individual #4, Individual #242, and Individual #223; o Presentation Book for Section U; o Self-Assessment for Section U, updated 6/20/14; and o Action Plans: Section U, updated 6/18/14. ▪ **Interviews with**: o Shelia Powell, Human Rights Officer.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section U, dated 6/20/14. 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. o 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. o 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. 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.
    - The Self-Assessment consistently included 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 60% and 99%. 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 had begun to use performance indicators, including one related to guardianship. It read: "# of residents who need a legal [sic] authorized representative (LAR) – and no LAR has not yet been secured." Data was entered beginning in September 2013, and for March, April, and May 2014, the numbers were 63, 62, and 62, respectively.
- 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 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 a consulting group reviewing a revised draft. 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 two reports, LBSSLC had begun to work with teams to identify current assessments that would assist in this process. 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. Since the last review, the ISP template included a section to prompt the team to discuss the potential need for guardianship. These discussions generally were not based on objective data. The updated prioritized list, dated 6/11/14, included names of 58 individuals served by LBSSLC. At the time of the review, Lubbock supported 204 individuals, of whom approximately 28% were estimated to need guardians, and 72% were identified as having guardians. Although it was unclear how individuals' lack of capacity to make decisions had been determined, based on the list, 36 individuals had a Priority I need for guardianship, 18 individuals were in the Priority II category, and four were in the Priority III category. In addition to reviewing the prioritized list, the Guardianship Committee provided ideas related to recruiting potential guardians. 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 four individuals, with another five 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 guardians for individuals who needed them.

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U1	Commencing within six months of the Effective Date hereof and with	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	Noncompliance

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	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.	Office had a consulting group reviewing a revised draft. 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. The Rights Assessments, with its related instructions, was inadequate to determine an individual's functional capacity to make decisions. 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, particularly full guardianships. As noted in the last report, 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. Based on a review of 10 ISPs (i.e., Individual #22, Individual #273, Individual #70, Individual #76, Individual #235, Individual #254, Individual #168, Individual #4, Individual #242, and Individual #223), three did not have guardians (i.e., Individual #254, Individual #76, and Individual #273. Based on this review: ▪ In none, the need for the individual to have a guardian was documented as having been discussed in any detail or justification provided for the team's decision the individual required a guardian;	

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		▪ In none, there was evidence the team considered alternatives to guardianship. ▪ Although prioritization was discussed in two (i.e., Individual #254 and Individual #273, the team identified a Priority Level 1, in none was justification for the Priority Level provided ▪ In none, was an action plan included to assist in identifying a guardian. 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. However, as noted above, this process did not appear to have been clearly included in the individual annual ISP process. Based on a review of the revised prioritization list and team sign-in sheets, since the last review, a number of individuals' priority levels had changed. The priority list indicated these changes were based on team reviews, but 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 6/11/14, included names of 58 individuals served by LBSSLC. At the time of the review, Lubbock supported 204 individuals, of whom	

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		approximately 28% were estimated to need guardians, and 72% were identified as having guardians. Although it was unclear how individuals' lack of capacity to make decisions had been determined, based on the list, 36 individuals had a Priority I need for guardianship, 18 individuals were in the Priority II category, and four were in the Priority III category. 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 was in process. 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 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.	

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U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	According to documentation and interview with staff, since the last review (i.e., July 2013), four 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 five individuals. As noted above, the list the Facility provided showed that a total of 58 individuals of the 204 individuals served by the Facility (28%) had been identified as needing guardians. LBSSLC had and continued to take a number of steps to attempt to identify guardians for individuals whose teams had identified a need for a guardian. The Monitoring Team's previous reports illustrated many of the Facility's ongoing efforts to work with families, as well as local groups to identify additional resources for guardianship, as well as legal resources at reduced rates should potential guardians be identified. In addition, some previous employees had petitioned for and/or obtained guardianship for individuals at the Facility. The Facility's Guardianship Committee continued to meet. The Guardianship Committee discussed and 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. The Human Rights Officer had reached out to other SSLCs to solicit ideas for the brochure, and an individual had volunteered his picture for the project. 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. 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. It was good that these resources had been identified. Based on the Contact Log the Human Rights Officer maintained, 2014 changes in guardianship law linked the ability to pay court costs with the potential guardian's ability to pay, as opposed to the individual.	Noncompliance

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		Costs were estimated to be approximately $1100. LBSSLC was not in compliance with this provision of the Settlement Agreement. Facility staff continued to take actions to identify guardians for individuals for individuals with interested families or other interested persons, but not necessarily based on prioritized need or even an assessed need for guardianship. In addition, although the Facility was trying to identify guardianship resources for individuals without involved family, given that the Facility estimated that many additional individuals required guardians, these efforts were not adequate. As has been discussed in previous reports, identifying guardianship resources likely will need to involve collaboration between DADS State Office and the State Supported Living Centers.	

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS policy #020.1 entitled "Recordkeeping Practices," dated 3/5/10; o The following LBSSLC Policies: ▪ Recordkeeping, revised 2/14/14; ▪ 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 Plans of correction related to record audits; o Correspondence and documentation to confirm completion of plans of correction resulting from record audits, various dates; o In response to document request for follow-up, statement that: "No follow-up checks to confirm completion of corrective actions;" o Additional Section V monitoring results, various dates; o Emails related to training on policies, various dates; o Exception reports for training on policies, various dates; o Procedure Training Completion Tracking Log from 11/1/13; o List of SSLC Policies and Local Procedures with date training was completed, updated 6/6/14; o Draft Master Records Guidelines Monitoring tool; o Samples of practice exercises staff complete at New Employee Orientation; o Self-Assessment for Section V, updated 6/20/14; o Action Plans: Section V, updated 6/18/14; and o Presentation Book for Section V. ▪ **Interviews with**: o Kristen Dickerson, Unified Records Coordinator; and o Dawn Ripley, Director of Quality Assurance.
	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section V, dated 6/20/14. 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 had determined that to assess the accuracy of the information in the records, discipline heads would complete audits of assessments. Audit tools were developed for this purpose, and in June 2014, implementation began. The Facility staff also drafted a tool for review of the Master Record. 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. Although Facility staff had added some guidelines, further definition was needed of the standards used to determine compliance, and the methods for completing the audits 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 not been established between the new 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. ▪ 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, for most months during the review period, at least five audits were being completed of records each month. The exception was when a new Unified Records Coordinator was hired. These audits were identifying a number of problems with the records. Although at the time of the last review, the Facility had taken steps to formalize the process for requesting corrective actions related to specific record reviews, a decision had been made to review and revise the process to make it more efficient. In addition to finalizing an individual record corrective action process, 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. The Unified Records Coordinator continued to provide a training session as part of New Employee Orientation. The new Unified Records Coordinator made changes to the presentation to include more written exercises, practice completing observation notes, discussion about the various tabs in the Active Record, as well as practice using the check-in and check-out sheet. These appeared to be good, practical modifications to the curricula that addressed some common documentation problems. LBSSLC had a working system for policy and procedure development and the completion of related training. Specifically, as noted in the last report, 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.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with	As noted in previous reports, a review of the LBSSLC policy on recordkeeping, revised in 2/14/14, revealed that it was consistent with the DADS policy on recordkeeping, and	Noncompliance

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	full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	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. ▪ 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. The Unified Records Coordinator had started with the Department in May 2014. 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. ▪ The Unified Records Coordinator continued to provide a training session as part of New Employee Orientation. The new Unified Records Coordinator made changes to the presentation to include more written exercises, practice completing observation notes, discussion about the various tabs in the Active Record, as well as practice using the check-in and check-out sheet. These appeared to be good, practical modifications to the curricula that addressed some common documentation problems. ▪ 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. ▪ In an effort to address the requirements of Appendix D related to the quality of information contained in the records, Facility staff had developed audit tools to assess the quality of assessments. Beginning in June, a sample of four ISPs was selected per month, and discipline leads were responsible for reviewing the assessments. The Unified Records Coordinator also included these individuals' records in her monthly sample of audits. The fifth record review was for another randomly selected individual with an ISP meeting that month. 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 was reworking the process for requesting corrective actions related to record reviews. In addition, Facility staff recognized that further work was needed to trend and analyze data. Some patterns had become apparent and were addressed through corrective actions. For example, dental consents were not consistently filed in Active Records, and	

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		when it was discovered they were in the Dental Office, this was corrected. However, more work was needed to conduct formal analyses. 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 maintained the progress it had made 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: ▪ The Facility continued implementing its policy on Developing/Revising Policy or Procedures. 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 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	Substantial Compliance

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		monitoring for a sample of staff. ▪ As previously reported, the Operating Procedures Manual Committee met regularly to review and approve policies and procedures. As appropriate, the group made recommendations to the policies' authors, and approval for policies was provided when recommendations had been addressed. As noted in the last report, 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. Since the last review, for most/all of the policies and procedures that had been developed or updated, the training had been appropriately identified as requiring staff review of the materials. However, as noted in the last report, other options included competency-based training, development of materials to facilitate training, and/or classroom training. ▪ 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 sent 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,	

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		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, 57 policies and procedures had required staff training. At the time the documentation was submitted, training had been finalized for all but one. 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 upon their return. Review of email correspondence illustrated that for outstanding training reminders had been sent to managers/discipline heads requesting follow-up. 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 remained in substantial compliance with this provision.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at	Progress had been made and/or sustained with this provision of the Settlement Agreement. Positive developments included: ▪ Based on documentation submitted and interview with staff, for most months in the review period, the Unified Records Coordinator completed at least five record audits per month. However, due to a change in staff, no audits were done in May 2014. Inter-rater reliability also was still being established between the Unified Records Coordinator and Lead File Clerk. ▪ 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	Noncompliance

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	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.	results were then reflected on the State Office tool. This data was then graphed by question on the tool. Based on review of data contained in the Facility Self-Assessment, consistent problems were seen in such areas as the completeness, accuracy, and currency of information in the records. ▪ As noted in the last report, 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. ▪ Since the last review, Facility staff developed a Master Records audit tool with guidelines. This was an important addition, and its implementation already had identified some areas that required attention (e.g., copies of social security cards and birth certificates). ▪ 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. 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. Areas in which improvements should be made in order to achieve compliance, included: ▪ Since the last review, LBSSLC developed some additional guidelines/instructions for the monitoring tool. Although this was an important undertaking, more work was needed to define standards (i.e., what criteria would auditors use to determine compliance), and instructions regarding what would be reviewed (i.e., specifically, which portions and what percentage/portion of the record would the auditor review). ▪ At the time of 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 a process for notifying staff of the need to take specific corrective actions in relation to individuals' records. However, after implementing the system for a few months, it was determined it was too	

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		overwhelming for the staff to whom the reports were sent. The new Unified Records Coordinator was working on a revised system. ▪ 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. Although the quarterly QA summaries described some of the data collected through auditing, full analyses (i.e., to determine potential commonalities or underlying causes) had not occurred. As just one example, the data had not been analyzed to determine whether specific disciplines or residences had repeated deficiencies. Such findings would lead to different types of proposed corrective actions. Although progress continued to be made with regard to this provision of the Settlement Agreement, LBSSLC was still in the process of developing/revising its system to make needed changes based on individual record reviews, looking more formally at and analyzing in more depth 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 previous reports, 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, the Facility had 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 the Facility's data, between February and April 2014, auditing showed timely monthly filing rates between 90 and 100%. However, as	Noncompliance

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		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 zero out of 30 records (0%) reviewed between November 2013 and April 2014, documents were 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. 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. ▪ **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 individualized the checklist for their assessments. Beginning in June 2014, discipline leads were reviewing the assessments for four of the records the Unified Records Coordinator reviewed each month, and data related to the quality of the assessments was expected to be included in data related to the accuracy of the records. More comments are provided regarding these audits in relation to Section F.1.c. 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. o As noted with regard to Section F, it was often difficult to determine the timeliness of assessment submission prior to ISP meetings, because of the multiple dates included on the assessments. 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 a month 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 question why assessors had not submitted paper copies of assessments for filing sooner, or why they had not been timely	

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		filed. ▪ **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 ask staff 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, 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 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. 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
GE	Gastroesophageal

GERD	Gastroesophageal Reflux Disease
GI	Gastrointestinal
G/J-tube	Gastrostomy/Jejunostomy Tube
G-tube	Gastrostomy Tube
HCG	Health Care Guidelines
Hgb	Hemoglobin
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMP	Health Management Plan
HMT	Health Monitoring Tools
HOBE	Head of Bed Elevation
HRC	Human Rights Committee
HRO	Human Rights Officer
HSM	Health Status Meeting
HST	Health Status Team
HT	Habilitation Therapies
IAC	Individual Activity Card
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
IPD	Integrated Program Developer
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
PMTP	Psychoactive Medication Treatment Plan
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical Nutritional Management Team
PNMPC	Physical and Nutritional Management Plan Coordinator
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
PTSD	Post-Traumatic Stress Disorder
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
SFA	Structural and Functional Assessment
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