**United States v. State of Texas**

**Monitoring Team Report**

**Lubbock State Supported Living Center**

**Dates of Review:** March 15 through 19, 2010

**Date of Report:** May 21, 2010

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## Introduction

I. **Background** - In 2005, the United States Department of Justice (DOJ) notified the Texas Department of Aging and Disability Services (DADS) of its intent to investigate the Texas state-operated facilities serving people with developmental disabilities (State Centers) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department and DOJ entered into a Settlement Agreement, effective June 26, 2009. The Settlement Agreement covers 12 State Supported Living Centers, including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) component of Rio Grande State Center. In addition to the Settlement Agreement (SA), the parties detailed their expectations with regard to the provision of health care supports in the Health Care Guidelines (HCG).

Pursuant to the Settlement Agreement, on October 7, 2009, the parties submitted to the Court their selection of three Monitors responsible for monitoring the Facilities' compliance with the Settlement Agreement and related Health Care Guidelines. Each of the Monitors was assigned a group of Supported Living Centers. Each Monitor is responsible for conducting reviews of each of the Facilities assigned to him/her every six months, and detailing his/her findings as well as recommendations in written reports that are to be submitted to the parties.

Initial reviews conducted between January and May 2010 are considered baseline reviews. The baseline evaluations are intended to inform the parties and the Monitors of the status of compliance with the SA. This report provides a baseline status of Lubbock State Supported Living Center.

In order to conduct reviews of each of the areas of the Settlement Agreement and Healthcare Guidelines, 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.

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. It is important to note that the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members shared information as needed, and various team members lent their expertise in review of Settlement Agreement requirements outside of their primary areas of expertise. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. When relevant, the Monitor included information provided by one team member in a section of the report for which another team member had primary responsibility. For this baseline review of Lubbock SSLC, the following Monitoring Team members had primary

responsibility for reviewing the following areas: Elizabeth Jones reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, as well as quality assurance; Edwin Mikkelsen reviewed psychiatric care and services, and medical care; Victoria Lund reviewed nursing care, dental services, and pharmacy services and safe medication practices; Patrick Heick reviewed psychological care and services, and habilitation, training, education, and skill acquisition programs; Nancy Waglow reviewed minimum common elements of physical and nutritional supports, as well as physical and occupational therapy, and communication supports; and Maria Laurence reviewed integrated protections, services, treatments and supports, and serving individuals in the most integrated setting, consent and record keeping. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, and at-risk individuals.

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 might 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 SA.

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 March 15 through 19, 2010, the Monitoring Team visited Lubbock 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. This allowed the Monitoring Team to gain some basic knowledge about Facility practices prior to arriving onsite and to expand that knowledge during the week of the tour. The Monitoring Team made additional requests for documents while on site.

Throughout this report, the specific documents that were reviewed are detailed. In general, though, the Monitoring Team reviewed a wide variety of documents to assist them in understanding the expectations with regard to the delivery of protections, supports and services as well as their actual implementation. This included documents such as policies, procedures, and protocols; individual records, including but not limited to medical records, medication administration records, assessments, Personal Support Plans (PSPs), Positive Behavior Support Plans (PBSPs), documentation of plan implementation, progress notes,

community living and discharge plans, and consent forms; incident reports and investigations; restraint documentation; screening and assessment tools; staff training curricula and records, including documentation of staff competence; committee meeting documentation; licensing and other external monitoring reports; internal quality improvement monitoring tools, reports and plans of correction; and staffing reports and documentation of staff qualifications.

Samples of these various documents were selected for review. 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 being implemented.

(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, PSP team 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.

(e) **Other Input** - The State and the U.S. Department of Justice also scheduled calls to which interested groups could provide input to the Monitors regarding the 13 facilities. The first of these calls occurred on Tuesday, January 5, 2010, and was focused on Corpus Christi State Supported Living Center. The second call occurred on Tuesday, January 12, 2010, and provided an opportunity for interested groups to provide input on the remaining 12 facilities.

On March 16, 2010, the Monitor had the opportunity to meet with members of Lubbock's Family Association. During this meeting, the families and guardians present provided the Monitor with information about the Facility, and their and their family members' experiences with the protections, supports and services offered by LBSSLC. The family members present at the meeting shared many positive stories regarding the supports offered their loved ones, and reported that staff at the Facility were responsive to their and their family members' needs and requests.

It was a pleasure for the Monitor to meet the families who attended the meeting, and listen to their input. Their family members who live at LBSSLC are fortunate to have them as strong advocates. The Monitor looks forward to continuing to hear from family members at upcoming monitoring visits during which it is

hoped similar sessions will be scheduled for the purpose of offering families and other stakeholders the opportunity to provide information to the Monitor.

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, and each chapter of the Health Care Guidelines.

The report begins with an Executive Summary. This section of the report is designed to provide an overview of the Facility's progress in complying with the Settlement Agreement. As additional reviews are conducted of each Facility, this section will highlight, as appropriate, areas in which the Facility has made significant progress, as well as areas requiring particular attention and/or resources.

The report addresses each of the requirements in Section III.I of the SA regarding the Monitors' reports and includes some additional components which 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 SA and each of the chapters of the HCG, 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) **Summary of Monitor's Assessment:** Although not required by the SA, 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;

(c) **Assessment of Status:** As appropriate based on the requirements of the SA, a determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement. Also included in this section are detailed descriptions of the Facility's status with regard to particular components of the SA and/or HCG, including, for example, evidence of compliance or non-compliance, 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;

(d) **Facility Self-Assessment:** A description is included of the self-assessment steps the Facility undertook to assess compliance and the results thereof. The Facilities will begin providing the Monitoring Teams with such assessments 14 days prior to each onsite review that occurs after the baseline reviews are completed. The Monitor's reports will begin to comment on the Facility self-assessments for reviews beginning in July 2010;

(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") will be stated for reviews beginning in July 2010; and
(f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. As stated previously, it is essential to note that the SA identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the SA. However, 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 SA.

**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, Individual #45, Individual #101, etc.). The Monitors are using this methodology in response to a request from the parties to protect the confidentiality of each individual. A methodology using pseudonyms was considered, but was considered likely to create confusion for the readers of this report.

## IV. Executive Summary

At the outset, the Monitoring Team would like to thank the management team, staff and individuals served at Lubbock State Supported Living Center for working collaboratively with the Monitoring Team during this first visit to the campus. It was clear that the State's leadership staff and attorneys had encouraged staff to be honest with the Monitoring Team. It also was clear that many, many staff worked diligently to prepare for the Monitoring Team's visit, and to provide requested information before, during and after the visit. This was much appreciated, and helped the Monitoring Team complete its work as efficiently as possible.

During the course of the Monitoring Team's visits, some significant issues that had the potential to place individuals served at risk were identified. The Settlement Agreement requires that the Facility protect individuals from harm, consistent with generally accepted professional standards of care. In general, it appeared that at LBSSLC, sufficient focus had not been concentrated to the extent needed at the residential unit level to correct concerns identified. As was discussed with State Office staff during the review, serious potential for harm was observed during this review. The risk was known because it had been documented in various reports, but it had not been addressed adequately. The risk was found in more than one residential unit, and appeared to have resulted from a number of factors, including:

- Inappropriate groupings of individuals with very different, often unique, needs for support. For example, it was clear from even brief visits to some residences that there were too many individuals with behavior issues grouped together. The opportunity for conflict was high, as was the possibility that one individual's behaviors would exacerbate his/her peer's behaviors;

- Extremely serious staffing concerns, including the assignment of newly hired, inexperienced staff to work with individuals with complex and challenging needs for support;
- As exemplified at 527 N. Cedar Avenue, inadequate staffing levels for the number of individuals with complex needs as evidenced by six staff for 20 individuals, all of whom were totally dependent on staff for every activity of daily living;
- Reliance on overtime, and, as reported by staff, not entirely voluntary overtime, resulting in a reliance on tired staff to implement critical responsibilities;
- An annualized turnover rate of 60 percent among direct support professionals. Although the Facility was engaged in recruiting staff, there had been insufficient attention to date to screening potential candidates, and retaining current staff; and
- Adequate independent safeguards were not in place, for example, monitoring at the State-level. The staff persons who were managing the problematic programs were responsible for making decisions about change. Risk management data was not fully incorporated into the decision-making process. Objectivity did not seem to be present to the extent needed to ensure the adequate protection of individuals, and future compliance with the Settlement Agreement.

It is essential to note that during the course of the review as the Monitoring Team expressed concerns to State Office staff who were onsite, they took swift action to conduct further investigation of issues raised. Since the monitoring visit of Lubbock concluded, the Monitoring Team met on 4/5/10, with State Office staff, who provided an update on actions taken to address the most serious issues identified during the review. The State reported that a number of actions have been taken, including identifying an interim Director to provide management oversight; the development and partial implementation of a plan to decrease the numbers of individuals with intense behavioral issues living on 515 and 516 S. Cedar Avenue, including providing these individuals with additional personal space; and reconfiguring the staffing in these homes as well as providing support from more tenured staff to newer staff. In addition, the State described the efforts that the new administration had developed and begun to implement to increase the State Office's involvement in quality assurance/enhancement activities, as well as follow-up with regard to serious incidents and allegations. The Monitoring Team appreciates the State's immediate and thorough response to addressing the issues identified. The Monitor will continue to request regular updates on the progress that the State and Facility are making in reducing the potential risk for harm to individuals supported by LBSSLC.

As is illustrated throughout this report, LBSSLC has a number of good practices in place, and in a number of the areas in which there is a need for improvement, the Facility has plans in place to make needed changes. The following provides some brief highlights of some of the areas in which the Facility is doing well and others in which improvements are necessary:

**Positive Practices:** The following is a brief summary of some of the positive practices that the Monitoring Team identified at LBSSLC:

Restraints

- There were some excellent interactions observed between the individuals served and staff. Staff provided encouragement, and used teaching approaches that showed respect and patience. This was especially evident with individuals with very challenging behaviors, and was likely a positive factor in reducing the use of restraint at the Facility.
- Reportedly, prone restraint had not been used during the time period sampled. Overall, restraint use had declined and appeared to have reached a plateau of an average of 29 episodes per quarter. There was an aggressive effort to reduce restraint use even further, especially, the use of the horizontal, side-lying hold, the most restrictive hold.

Abuse, Neglect, and Incident Management

- All staff interviewed during the baseline review knew the procedures for reporting abuse and neglect. Some staff reported that they had used the hot line to report allegations of abuse or neglect, and had found the subsequent investigations to be thorough and responsive.
- Overall, the investigation processes at the Department of Family and Protective Services (DFPS) and LBSSLC appeared to be structured effectively, and to be implemented in a consistent manner. The investigators at LBSSLC worked collaboratively with their colleagues at DFPS.

Quality Assurance

- At LBSSLC, there was significant collection of data occurring. For example, a substantial amount of information regarding incidents and allegations was being collected and aggregated. Likewise, the program monitors were utilizing monitoring tools to collect data in a number of different areas. Often, though, these tools did not collect information about the quality of the protections, supports, and services provided to individuals at LBSSLC.

Psychiatric Care

- The communication between the Departments of Psychiatry, Medicine, Psychology, and Neurology was impressive. The Staff Psychiatrist's assessment and ongoing consultation notes were detailed and met established clinical criteria. He also had the capability of consulting on individuals daily, or two-to-three times a week, if they were experiencing a psychiatric deterioration. There also was documentation indicating that he had, on occasion, sought second opinions from other psychiatrists in the community.
- The Facility had made consistent significant progress in reducing polypharmacy with psychoactive medication since 2005, although there continued to be a number of individuals who were receiving multiple psychoactive agents. Concerted efforts to reduce psychoactive medication polypharmacy need to continue, and for any continued use of psychoactive polypharmacy, clear clinical justification needs to be provided.

Psychological Care and Services

- Two of the current psychology staff, specifically, the Director and Assistant Director, were Board Certified Behavior Analysts (BCBAs). Many of the Associate Psychologists were completing the necessary courses and receiving the required supervision to apply to take the BCBA exam.
- Observations and discussion with psychological staff reflected a rigorous internal peer review system.
- Generally, individuals receiving behavioral services had a Structural and Functional Behavioral Assessment written, updated or reviewed within the last year. Overall, it appeared that these reports produced substantial information relevant to providing effective behavioral supports.

Medical Care

- There were a number of sub-specialty clinics held at LBSSLC throughout the month. The most frequent sub-specialty clinics were held for Neurology, due to the number of individuals with seizure disorders. The Neurology Clinic was impressive with regard to the thoroughness of the reviews, and the interaction between the neurologist, medical practitioners, psychiatrist, and the nurses who presented the cases.
- Based on the records reviewed, it appeared that individuals were receiving routine preventative procedures, such as mammograms, PAP smears, colonoscopies, bone density testing, electrocardiograms, monitoring for blood levels of medications, when necessary, and routine laboratory testing. The "Annual Physical Examination and Medical Summary" provided a comprehensive summary of current and past medical problems.

Nursing Care

- LBSSLC had begun to implement a number of QE nursing and medical monitoring tools. Although development of these tools was still in the initial stages, there already was valuable information being generated from these monitoring efforts that the Facility should use to correct issues identified.

Pharmacy Services and Safe Medication Practices

- The Facility's Pharmacy and Therapeutics Committee, headed by the Clinical Pharmacist, had conducted drug utilization evaluation (DUE) in March 2009 for Zyprexa; June 2009 for Risperdal, Seroquel and Geodon; September 2009 for Levaquin; December 2009 for Depakote and Depakene; and March 2010 for Keppra. Compliance data was generated for each DUE conducted.

Dental Care

- From the records reviewed, it appeared that individuals at LBSSLC generally were being seen at least every six months, and more frequently for restorative/preventative care.
- LBSSLC's Dental Director did not support the use of restraints for dental procedures, unless the dentist was in the process of completing a procedure and an individual's behavior necessitated restraint in order for the procedure to be completed safely, or in an emergency situation, when less restrictive procedures could not be

attempted first. The Facility should be commended for this philosophy and practice, and should be used as a model for the reduction of restraints for this purpose at the other SSLCs.

Serving Individuals in the Most Integrated Setting Appropriate to Their Needs

- The CLDPs at LBSSLC were some of the most extensive seen by this Monitoring Team. Clearly, much thought and effort had gone into the development of the plans. Efforts appeared to have been made to include as full a complement of team members at the CLDP meetings as possible. As reported, some of the efforts made even prior to the CLDP meeting were assisting individuals to safely transition to the community. As is described below, though, the CLDPs continue to need to be further enhanced, because they are the documents that define what is provided to the individual by the new provider agency, and are used by Post-move Monitors and Mental Retardation Authorities (MRAs) to ensure the provision of protections, supports and services once the individual leaves LBSSLC.

**Areas in Need of Improvement:** The following identifies some of the areas in which improvements are needed at LBSSLC:

Abuse, Neglect, and Incident Management

- In addition to the significant concerns related to protection from harm that are discussed in detail above, there were relatively few investigations in which recommendations for systemic corrective actions were made for consideration by the Facility's or Department's administrations.

Quality Assurance

- Even though the monitoring and data collection systems needed to be refined, at the time of the review, useful information was being collected, and distributed to decision-making staff. However, although this information was available and appeared credible, it was not consistently used to improve the quality of life, safety and protection from harm of the individuals residing at LBSSLC. It generally did not appear that this raw data was analyzed in any meaningful way, or that responses to these reports, particularly in the form of concrete actions plans, were developed, documented and implemented. In order for the Facility to have a fully functioning quality enhancement process in place, it is essential that this occur.

Integrated Individual Support Plans

- The biggest challenge for LBSSLC with regard to PSPs appeared to be with regard to ensuring that team meetings included interdisciplinary discussions that resulted in one comprehensive, integrated treatment plan for each individual. At LBSSLC, this appeared to be a multi-faceted problem. One issue was that assessments did not appear to be being provided to teams in a timely manner to allow incorporation into the PSPs. In addition, as is noted in other sections of this report, issues with regard to adequate assessments impact teams' ability to identify strengths as well as needs of individuals. As assessment processes improve, teams will have better tools on which to base their discussions, and the resulting integrated plans.

- According to documentation provided as well as a review of requested PSPs, some individuals had not had their PSPs updated on an annual basis. In other cases, it appeared meetings had been held, but plans had not been finalized and were not ready for implementation within 30 days. These are issues that need to be addressed quickly.

At Risk Individuals

- The current risk assessment tools used by LBSSLC did not provide an adequate comprehensive risk assessment for any of the areas addressed, and did not result in the appropriate identification of clinical risk indicators or risk levels for the individuals reviewed. Standardized statewide tools with established reliability and validity should be used by all the Facilities in assessing and documenting clinical indicators of risk to ensure that individuals' risk levels are appropriately identified.
- Once an appropriate risk identification system is developed and implemented, the Facility must develop and implement appropriate assessment tools to perform interdisciplinary assessments of services and supports for at-risk individuals.

Psychiatric Care and Services

- The areas that required improvement were related to the following issues: The diagnosis of either Intermittent Explosive Disorder or Impulse Control Disorder was utilized for 30% of the individuals receiving psychotropic medication, and the diagnosis of Stereotypic Movement Disorder with SIB was the psychiatric diagnosis for 15 individuals (12.5%). These diagnoses were problematic because they did not provide a great deal of etiological specificity, which could be utilized to justify the administration or selection of specific psychotropic medication. The behavior profiles that corresponded to these diagnoses could often be present on a learned or environmental basis.
- Other concerns were related to the degree to which the efficacy of the psychoactive medication had not been empirically established, and the narrative sections of psychiatric reports related to weighing the risks and benefits of psychoactive medication being extremely general in nature, often using terminology that was nearly identical in many of the records.
- An additional concern was the ongoing use of restraint, and relatively high levels of peer-to-peer aggression at LBSSLC, which would suggest that the psychoactive medications prescribed for those individuals with a psychiatric disorder were ineffective, that individuals' Behavior Support Plans were ineffective, and/or there were not enough trained staff members to implement them.

Psychological Care and Services

- According to direct observation and staff verbal reports, data was not always collected in a timely fashion (i.e., immediately), and it was often not recorded as prescribed. When asked to identify factors contributing to inconsistent data collection, staff reported a lack of appropriate staffing ratios, use of untrained relief or pulled staff, recent moves of individuals in residential locations, and the lack of accountability for staff members who

did not collect data as trained. One reason that seemed consistent involved the multiple methods used to collect data and how these varied systems may increase staff confusion or error.

- In general, the PBSPs were very comprehensive, detailed and demonstrated consideration of the individual's strengths, needs and preferences. Areas where the PBSPs were somewhat limited or insufficient included descriptions of previously attempted interventions and outcomes, baseline data for replacement behaviors, and, at times, treatment objectives for replacement behaviors.
- At the time of the review, numerous issues negatively impacted the adequate training of direct support professionals on the implementation of PBSPs. This lack of adequate training, particularly with regard to the PBSPs for individuals with the most challenging behaviors, had the potential to place them as well as staff at risk.

Medical Care

- One of the primary concerns about the medical care at LBSSLC was related to the critical shortage of nurses, which had contributed to a number of systemic problems, including significant medication errors.
- Another area of concern related to the basic provision of care, which primarily derived from the historical Sick Call format used in large facilities. This system relied heavily on direct support professionals identifying changes in the clinical status of an individual, and then initiating the referral process by contacting a nurse, usually a Licensed Vocational Nurse (LVN). This can lead to delays in the identification and treatment of new onset illness, as well as the deterioration of a chronic condition.

Nursing Care

- LBSSLC had 105 positions allotted for the Nursing Department, and at the time of the review had 50 vacancies. The Facility had struggled for a number of years to fill its existing nursing positions. The lack of consistent nursing staff was having a negative impact on the continuity of care, and appeared to be one of the causes for negative outcomes experienced by individuals served by the Facility, such as increased medication errors.
- The Nursing Care Plans at LBSSLC generally did not include appropriate and measurable objectives. As these are improved, it will be necessary for nursing quarterly assessments to include a discussion of the progress an individual is making or not making, interventions that are working or not working, and to recommend changes, if needed, in these interventions.

Pharmacy Services and Safe Medication Practices

- Although the Facility had been conducting Drug Regimen Reviews (DRRs) that were overall very comprehensive, the Facility needed to develop a system to ensure that the DRRs are timely completed, that there is documentation addressing the acceptance or refusal of the pharmacists' recommendations, and that there is specific supporting documentation that the recommendation was implemented by the physician or practitioner or justification for not implementing it.
- There appeared to be significant underreporting of medication errors. Nursing staff at the Facility did not consistently agree on what constituted a medication error that needed to be reported. Since medication error reporting was not yet reliable, increasing medication observations and a spot check system should be initiated.

Physical and Nutritional Supports

- Although the Nutritional Management Team (NMT) met regularly, risk levels were assigned to individuals that were not consistent with the Nutritional Management Screening Tool. Individuals who were identified at high risk did not receive a comprehensive assessment resulting in recommendations for measurable, functional outcomes, and leading to the development of strategies to minimize and/or remediate identified health concerns. Individual-specific monitoring was not implemented for those individuals at highest risk.
- The reviewer observed significant mealtime errors that had the potential to place individuals at risk. There were a number of factors that appeared to impact this. The time allotment for mealtime foundational training was not sufficient for new employees. Mealtime observations showed that staff had not acquired the foundational knowledge and skills to follow dining plans to support safety at mealtimes. Dining plans within each home needed to be analyzed to determine the appropriate staffing ratio to ensure their consistent implementation. Oversight was needed during mealtimes to support staff and individuals, and to provide a safe mealtime environment.

Dental Care

- A system needed to be developed and implemented to accurately identify individuals who refuse dental care. At the time of the review, there were a number of desensitization programs that had been developed for individuals. However, psychology had just started collaborating with dental regarding dental refusals. In addition, other disciplines needed to collaborate with dental, such as the Physical Nutritional Management Team regarding individuals who are at risk for aspiration/choking.

Communication

- At the time of the review, per report, twenty-six (26) percent of the individuals living at LBSSLC had an augmentative device (low tech or high tech). Based on observation, there were a significant number of individuals who needed communication systems, but did not have a system.
- The Speech Language Pathologists submitted a listing of multiple generic communication systems that were available in individual's homes, and throughout the Facility. In homes and day programs, Monitoring Team members observed that generic, and potentially valuable systems were available for use. Unfortunately, staff and individuals were not engaged using these systems.
- A review of AAC Individual Monitoring Forms documented unresolved issues that were not resolved on repeated individual monitoring forms. The current monitoring system did not review the utilization of individual systems throughout the Facility or in the community.

Habilitation, Training, Education, and Skill Acquisition Programs

- Based on verbal reports from staff, the Personal Focus Worksheet: Individualized Assessment Screening Tool (PFW), as well as the Positive Assessment of Living Skills (PALS) were completed annually to assist with the development of the PSP. However, record review showed the implementation of these assessments to be

inconsistent. In addition, psychological assessments did not consistently result in recommendations for prioritized training on skills.

- In general, Specific Program Objectives (SPOs) followed a prescribed format. They all typically included basic elements such as an objective; baseline data; a plan for implementation, including setting, schedule, materials, reinforcement, and teaching procedures; and evaluation criteria. However, the detail and comprehensiveness of the plans varied greatly. Many of these elements, as written, were relatively vague and did not provide enough specificity for their consistent and complete application across staff. More importantly, many of the sampled SPOs did not include an operational definition of the target behavior (i.e., what was being taught), specific detailed steps based on a task analysis, use of differential reinforcement, a plan regarding maintenance and generalization, and/or sufficient trials per day (or week) to promote acquisition.

<u>Serving Individuals in the Most Integrated Setting Appropriate to Their Needs</u>

- The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility was still refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways.
- Some level of post-move monitoring had been completed for all of the individuals who had transitioned to the community. However, according to the documentation provided, 50 percent of the required visits had not been completed.

<u>Guardianship</u>

- LBSSLC had taken a number of steps to attempt to identify guardians for individuals whose teams had identified a need for a guardian. Despite these efforts, LBSSLC had had extremely limited success identifying guardians for individuals who need them. Based on the information provided, without additional resources, such as a funded guardianship program, it seemed unlikely that guardians would be identified for the 114 individuals whose teams had determined a need.

<u>Recordkeeping</u>

- During the review, issues were noted with regard to the availability and quality of the individual records. This had the potential to impact staff's ability to utilize records in making medical treatment and training decisions. Interestingly, the Facility's QE staff had identified some similar issues. Again, though, it was unclear that the QE reports resulted in actions being implemented to correct existing problems.

In summary, the Facility already had undertaken a number of performance improvement activities that will assist it in achieving compliance with the Settlement Agreement and Health Care Guidelines. The Monitoring Team encourages the new management team at LBSSLC to develop and implement the additional activities necessary to continue to move the Facility forward on the path to improvement. The Monitoring team looks forward to an ongoing collaborative and productive relationship with LBSSLC.

## V. Status of Compliance with the Settlement Agreement

| **SECTION C: Protection from Harm-Restraints** | |
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| 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. | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o Medical records for the following individuals: Individual #106, Individual #1, Individual #288, Individual #82, Individual #33, Individual #167, Individual #125, Individual #94, Individual #213, Individual #134, Individual #60, Individual #298, Individual #25, Individual #51, Individual #220;<br>o Facility's list of Individuals for Medical Restraints and Pre-sedation;<br>o Facility's list of Injuries During Use of Restraints;<br>o Facility's list of Individuals who received Chemical Restraints;<br>o Positive Behavior Support-Limitation of Restraint as a Crisis Intervention;<br>o Facility's restraint data and trends analyses;<br>o Restraint Audit Report Clarifications from the Director of Behavioral Services;<br>o Multiple Restraint Analysis data from August 2009 through January 2010;<br>o Restraint Analysis data and Quarterly reports from June 2009 through January 2010;<br>o LBSSLC Crisis Intervention Restraints, July 1, 2009 through March 12, 2010;<br>o Restraint Report for 1st Quarter FY10; and<br>o Safety Plan for Crisis Intervention, PSPs, PBSPs, Structural and Functional Behavior Assessments (SFBAs), PSP Monthly Review notes, and/or Integrated Progress Notes, as available, for the following individuals: Individual #213, Individual #82, Individual #288, and Individual #33<br>▪ **Interviews with**:<br>o Jim Forbes, MEd, CBA, Director of Behavioral Services;<br>o Don Minnis, RN, BSN, Chief Nurse Executive; and<br>o Jeremy Ellis, RN, QE Nurse<br>▪ **Observations of:**<br>o Restraint Reduction Committee, on 03/18/10 |
| | **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| | **Summary of Monitor's Assessment:** There were some excellent interactions observed between the individuals served and staff. Staff provided encouragement, and used teaching approaches that showed respect and patience. This was especially evident with individuals with very challenging behaviors, and was likely a positive factor in reducing the use of restraint at the Facility.<br><br>Reportedly, prone restraint had not been used during the time period sampled. Overall, restraint use had declined and appeared to have reached a plateau of an average of 29 episodes per quarter. There was an |

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| | aggressive effort to reduce restraint use even further, especially, the use of the horizontal, side-lying hold, the most restrictive hold. Staff training in positive behavior support was being provided in an attempt to change the culture at LBSSLC. A protocol had been developed to ensure that proper procedures were used for the application of chemical restraint. Based on the new protocol, the psychologist had to affirm that there was no other alternative before chemical restraint could be authorized.<br><br>The behavior analysts and the campus coordinators were now performing restraint monitoring. Nineteen staff persons had been trained to serve as restraint monitors. These staff persons were trained to know proper restraint techniques, and were expected to intervene if a restraint was not being applied correctly. Restraint use had been restricted to a maximum of thirty minutes.<br><br>The Director of Behavioral Services was both knowledgeable and highly motivated in his efforts to replace restraint with program practices that build on the individual's strengths and interests. He was focused on active treatment. Examples of successful outcomes were beginning to be seen, for example, in the reduction of restraint use.<br><br>The daily meeting of the Incident Management Review Team was well organized. Participants were familiar with the at-risk individuals. The Risk Manager incorporated systemic analysis of risk into the discussions about the use of restraint.<br><br>A list of individuals who could not be restrained has been promulgated. The primary reason for inclusion on this list was osteoporosis.<br><br>The ongoing efforts to reduce restraint were impeded by the structure and operation of certain residential units. High turnover rates and overtime contributed to the instability of staffing in the residential units. Furthermore, the congregation of large numbers of individuals with challenging behaviors helped to create situations that were difficult to manage, and placed both individuals and staff at risk of harm. |

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| C1 | Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable | Reportedly, prone restraint had not been used during the time period sampled, and is prohibited by State and Facility policy. Based on a review of 46 restraint records involving 15 individuals, there was no indication that prone restraint was used.<br><br>The documentation indicated that there was one episode that was precipitated by staff not providing a requested snack. The Facility recognized this as an issue and provided retraining for the staff. In addition, the documentation for two episodes indicated that staff members did not use the correct technique during the restraint episodes and again, the Facility provided retraining addressing this issue. A review of the documentation describing events leading to the restraint found that 14 contained appropriate documentation showing that restraints were not being used for the convenience of staff or as punishment. In the remaining 32 episodes, the documentation did not reflect the | |

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| | manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used. | events leading to the restraint episode, and thus the reviewer was not able to determine if the restraints were being used for the convenience of staff or as punishment.<br><br>Restraint use was monitored on a daily basis at the Unit meeting, and at the Incident Management Review Team meeting. In these meetings, observed during the week of the baseline review, the events leading up to the restraint episode were summarized, and the length and type of restraint was reported. Discussion was noted to be fairly limited in these two forums.<br><br>The monthly Restraint Reduction Committee meeting also was a forum in which restraint use was reviewed with a focus on both individuals, and the overall patterns of restraint at the Facility. Overall, since the first quarter of Fiscal Year 2009 (September, October, and November 2008), when there was a high of 52 restraints, and a total of 144 restraints for the Fiscal Year, restraint use had declined, and appeared to have reached a plateau of an average of 29 episodes per quarter.<br><br>Based on interviews with staff, the Director of Behavioral Services, the Risk Manager and the Director of Incident and Risk Management conferred on an ongoing basis about the rate of restraint and its use with certain individuals. Since December, the Director of Behavioral Services had reviewed each use of restraint at the micro and macro levels. He also had been engaged in designing and implementing strategies to increase active treatment across the Facility.<br><br>A protocol had been developed to ensure that proper procedures were used for the application of chemical restraint. Based on the new protocol, the psychologist had to affirm that there was no other alternative before chemical restraint could be authorized.<br><br>The report issued on the use of restraints from 7/1/09 to 3/12/10 documented the use of crisis intervention chemical and physical restraints for 23 individuals. Five of these individuals (Individual #213, Individual #82, Individual #106, Individual #33 and Individual #288) had more than three restraints documented in this report: Individual #213 had 14 episodes; Individual #82 had 13 episodes; Individual #106 had five episodes; Individual #33 had 20 episodes; and Individual #288 had six episodes. Interestingly, Individual #288's restraint use had decreased over time through the creative use of individualized activities that correlated with his interests in three dimensional puzzles and models. At the time of the review, this individual resided on the unit designed for individuals for whom community placement transitions were anticipated in the near future.<br><br>According to a list provided by the Facility dated 2/10/10, Safety Plans had been implemented for seven individuals. Four of the five individuals referenced above had | |

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| | | Safety Plans. These six individuals had a history of behavior concerns leading to the use of restraint or other restrictive practices. Each of these plans was submitted to the Human Rights Committee for approval.<br><br>During the week-long review, it became apparent to the Monitoring Team that positive practices on the behalf of individuals with challenging behavior were being undermined daily by the lack of stable staffing, and the crowding and unpredictable routines observed in certain residential units. The lack of engagement in individualized activities that build on strengths and interests also appeared to be a major barrier to the reduction of restraint and the provision of active treatment. In order to ensure that individuals are not restrained unnecessarily, are protected from harm, and receive the training they require, these underlying issues will need to be addressed. | |
| C2 | Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others. | In November 2008, guidelines for restraint documentation were issued for SSLCs. A standardized restraint checklist had been instituted at this Facility for each use of chemical or physical restraint. The checklist template clearly stated: "Released immediately when no longer immediate and serious risk of harm to self and others," and another standard/criteria on the form was "Met Safety Plan definition of calm and was released."<br><br>Checklists were reviewed for the last three chemical restraints that involved Individual #51, Individual #60 and Individual #167, and for the last three physical restraints, that involved Individual #82, Individual #33 and Individual #94. The notations regarding release referred to the individual being "calm," rather than "no longer a danger…" An additional review was conducted of 46 incidents of restraint involving 15 individuals. The documentation on the Restraint Checklists indicated that for all episodes reviewed the individuals were released as soon as they were noted to be calm, or if they were experiencing any type of distress.<br><br>Staff need to have clear definitions or criteria for releasing an individual from restraint to ensure that this occurs as soon as the individual is no longer a danger to self or others. | |
| 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 | The DADS' Policy Number:001, entitled Use of Restraint complied with these requirements. It appeared to have been the model for the policy in use at LBSSLC.<br><br>The policy on restraint use at the Facility was entitled "Limitation of Restraint as a Crisis Intervention." It was revised on 11/25/09. The policy's statement of general principles emphasized that restraint is not therapeutic, is potentially traumatizing, and should be avoided unless absolutely necessary.<br><br>According to Facility policy, staff training was required, and a Restraint Monitor must be | |

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| | 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. | on duty at all times. It was reported in interviews with the Director of Risk Management and the Director of Behavioral Services that Facility staff had been trained as dictated by this policy, and a Restraint Monitor was scheduled to be on duty at all times.<br><br>During upcoming monitoring visits, training data will be reviewed to ensure that all staff responsible for applying restraint have successfully completed the required training.<br><br>The behavior analysts and the campus coordinators were now performing restraint monitoring. Nineteen staff persons had been trained to serve as restraint monitors. These staff persons were trained to know proper restraint techniques, and were expected to intervene if a restraint was not being applied correctly. Restraint use had been restricted to a maximum of thirty minutes. | |
| C4 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint. | According to the Facility policy entitled "Limitation on Restraint as Crisis Intervention, restraint use was limited to crisis intervention, and could only be instituted for the shortest amount of time necessary. The maximum amount of time permitted for a single restraint episode was thirty minutes. A list of individuals who may not be restrained under any circumstances had been promulgated. The primary reason for an individual's inclusion on this list was osteoporosis.<br><br>According to the Director of Dental Services, his office did not use mechanical restraints. He also described some desensitization techniques that were used to assist individuals to become more comfortable with visiting the dentist's office, and having the dentist or hygienist work in their mouths. These efforts are described in further detail in the section of this report that addresses Section J.4 of the SA.<br><br>As noted in that section of the report as well, there appeared be a continued need to develop strategies to assist individuals in tolerating dental procedures. The Quality Assurance Review of Dental Services, dated 10/30/09, reviewed a random sample of five individuals for evidence of desensitization plans in the PSP and noted: "Desensitization plans for the three individuals identified are either non-existent or do not have specific goals listed to show progress or when to discontinue the plan," and arrived at a compliance rate of 40 percent.<br><br>In upcoming monitoring visits, the team will look in more depth at the plans in place to assist individuals with other types of medical appointments. | |
| C5 | Commencing immediately and with full implementation within six months, staff trained in the | The Restraint checklist documented the use of restraints and enumerated the level of supervision that must be provided in every episode. As noted above with regard to Section C.2 of the SA, the six restraint checklists reviewed indicated adherence to these | |

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| | application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required. | requirements.<br><br>However, with regard to the nursing component of the restraint checklist, a review of 46 episodes of physical restraint for 15 individuals found that there were significant problematic issues regarding the required documentation conducted by nursing. In 34 episodes (74%), the vital signs were taken or an attempt made to take every 30 minutes from the start of the restraint. In 24 episodes (52%), there was an appropriate mental status documented. Episodes that contained inappropriate documentation of the mental status indicated that the individuals "refused" which is not appropriate since cooperation is not warranted to make an observation of mental status. In addition, the documentation for mental status by nursing for Individual #213 stated in repeat episodes "calm for [Individual's name]," without any type of description of the individual's actual behaviors. In addition, the documentation for 23 episodes (50%) demonstrated an adequate assessment of injury after the restraint episode. Also, in only 26 of the 46 episodes (57%) was the name and title of the nurse documenting on the Restraint Checklist legible. | |
| C6 | Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is | As noted above with regard to Section C.5 of the SA, the documentation for 23 out of 46 episodes (50%) demonstrated an adequate assessment of injury after the restraint episode. In addition, in episodes where an injury was found, the documentation contained no specific description of the injury, such as exact location of the injury or description and length of scratches. | |

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| | 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. | | |
| 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: | Sampled documentation, including PSP, PBSP, Safety Plan for Crisis Intervention, Integrated Progress Notes, PSP Monthly notes, and Safety Plan Progress Notes, as available, of individuals restrained more than three times within 30 consecutive days were reviewed for four of five individuals (i.e., that met this criteria according to data provided on the number of restraints between July 1 2009 and March 12, 2010). Individuals identified included Individual #213, Individual #82, Individual #288, and Individual #33. The following provides a summary of the findings for each individual:<br>▪ It appeared that the use of three or more chemical restraints within a 30-day period were reported for Individual #213 in August 2009, as well as physical restraints in October 2009, and March 2010. Data on the August and October incidents were reported in subsequent monthly Safety Plan Progress Notes. However, chemical restraints were not graphed. No recommendations, other than to continue the Safety Plan for Crisis Intervention as written, were noted. Integrated Progress Notes were unavailable for March. Therefore, it is unknown if multiple episodes of restraint were accurately reported. Information provided in the Structural Functional Behavior Assessment (SFBA) indicated ongoing psychiatric monitoring, including two appointments in August and November 2009, and psychotropic medication changes. It is unclear if behavior programming was updated, because no implementation date appeared on provided PBSP, although data reflected information on targeted behaviors through August 2009.<br>▪ It appeared that the use of three or more restraints within a 30-day period occurred for Individual #82 in the months of August, October, and December 2009. PSP Monthly Review notes indicated inpatient hospitalization in October 2009, due to the increase in target behaviors, implementation of a PBSP in November 2009, and psychiatric follow-up in November and December 2009. Review of Integrated Progress notes, however, indicated that target behaviors | |

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| | | leading to restraints in December 2009 were not reflected in collected data. The data were not found in table or graphs in the January 2010 Integrated Progress Note. It did not appear, however, that the SFBA was updated following the incidents in October or December 2009.<br>▪ Individual #288 had three physical restraints within a 30-day period in December 2009. Information provided on the Safety Plan Progress Note included quantitative information on frequency and duration, as well as descriptive accounts (e.g., what appeared to precipitate these events) of these restraints. No recommendations other than to continue the Safety Plan were noted. These episodes were also noted on Integrated Progress Notes for December, and included recommendations to continue the PBSP, and included additional strategies (e.g., transition warnings). The PBSP, implemented on 11/4/09, and SFBA, completed on 8/26/09, did not appear to have been updated following these incidents.<br>▪ Individual #33 had multiple holds within 30-day periods in the months of July and December 2009. These restraints were documented in December Safety Plan Progress Notes. The precursor behaviors (SIB) also were accurately documented in January Integrated Progress Note. Recommendations included continuing PBSP as written. Psychological assessment, as well as the SFBA did not appear to have been updated following these incidents. | |
| | (a) review the individual's adaptive skills and biological, medical, psychosocial factors; | For this baseline review, information regarding the review conducted for individuals with three or more restraints within a 30-day time period is summarized above in the section that addresses Section C7 of the SA. | |
| | (b) review possibly contributing environmental conditions; | For this baseline review, information regarding the review conducted for individuals with three or more restraints within a 30-day time period is summarized above in the section that addresses Section C7 of the SA. | |
| | (c) review or perform structural assessments of the behavior provoking restraints; | For this baseline review, information regarding the review conducted for individuals with three or more restraints within a 30-day time period is summarized above in the section that addresses Section C7 of the SA. | |
| | (d) review or perform functional assessments of the behavior provoking restraints; | For this baseline review, information regarding the review conducted for individuals with three or more restraints within a 30-day time period is summarized above in the section that addresses Section C7 of the SA. | |
| | (e) develop (if one does not exist) and implement a PBSP based on that individual's particular | For this baseline review, information regarding the review conducted for individuals with three or more restraints within a 30-day time period is summarized above in the section that addresses Section C7 of the SA. | |

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| | 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; | | |
| | (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 | For this baseline review, information regarding the review conducted for individuals with three or more restraints within a 30-day time period is summarized above in the section that addresses Section C7 of the SA. | |
| | (g) as necessary, assess and revise the PBSP. | For this baseline review, information regarding the review conducted for individuals with three or more restraints within a 30-day time period is summarized above in the section that addresses Section C7 of the SA. | |
| 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 | As noted above, each restraint episode reportedly was reviewed at the next Unit meeting, and the next Incident Management Review Team meeting. During the week of the review, it appeared that this was occurring, but not with the thoroughness necessary. It was not clear if there was any additional review occurring. The Facility's activities in this regard will be further reviewed during upcoming monitoring visits. | |

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| | restraint. ISPs shall be revised, as appropriate. | | |

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

1. The ongoing efforts to reduce the use of restraint are to be commended. The Restraint Reduction Committee should continue with an emphasis on discovering the underlying causes for individuals with the most frequent use of restraint. The Facility's efforts to examine the use of and find alternatives to the most restrictive restraint, the horizontal side-lying restraint, should continue.
2. Immediate attention should be given to those individuals for whom restraint is employed frequently. This should include a review of the individuals' Behavior Support Plans, with revisions made accordingly. Ongoing review of data is essential, and should occur as part of the systems developed to reduce the overall use of restraint. Independent external consultation should be considered in the review of individuals with a continuous pattern of restraint or challenging behavior, including self-injurious and aggressive behavior.
3. Criteria for release from restraint should make it clear to staff that release is based on safety considerations, not on an individual being calm and quiet.
4. Consideration should be given to tracking chemical restraints in graphic display, similar to the graphing completed on the use of physical restraints.
5. The Facility should develop and implement monitoring instruments addressing the elements in this requirement to ensure appropriate practices and documentation regarding the use of restraints, and initiate plans of correction addressing problematic trends.

| SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management | |
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| Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below. | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o LBSSLC policies relating to: Abuse, Neglect and Exploitation, revised 12/21/09; Managing Unusual Incident(s) Other than Abuse, Neglect or Exploitation Allegations, revised 12/21/09; Completing Incident Information Reports for Discovered Injuries and Unusual Incidents, revised 10/01/09; Critical Incident Team, revised 8/03/09; Reassigning Alleged Perpetrators, revised 12/23/09; Human Rights Committee; Ensuring Staff Coverage, dated 12/09/09; and Ensuring Staff Coverage with Pulled Staff, dated 8/28/08;<br>o DADS Policy Number 002.1 entitled Protection from Harm—Abuse, Neglect and Incident Management;<br>o Incident Management Review Team meeting minutes for 8/09, 9/09, 10/09, 11/09, 12/09, 1/10, 2/10, and 3/15 through 3/19/10;<br>o Seventy-five (75) investigation reports for 49 individuals;<br>o Three death reviews;<br>o List of Unauthorized Departures for 7/09through 2/10;<br>o List of Peer-to-Peer Caused Injuries;<br>o Client Injury Trending for 12/09 through 2/10;<br>o Centers for Medicare and Medicaid (CMS) deficiency statements for 4/30/09, 5/08/09, 6/17/09, 7/7/09, 7/30/09, 10/14/09, and 1/15/10;<br>o Thirty-eight (38) Individual Injury Assessments for 3/16 through 3/18/10;<br>o Injury Reports from 7/09 through 12/09;<br>o Investigator Training Curricula;<br>o Training module for the reporting of abuse and neglect;<br>o Unit Staffing Report for Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) Facilities for 2/17 through 2/18/10;<br>o Active Position Status Report, dated 3/18/10;<br>o FY 10 Fill and Turnover Summary Report for Fiscal Year-to-Date through 2/10; and<br>o Abuse/Neglect/ Exploitation (A/N/E) Employee Report, dated 3/5/10<br>▪ **Interviews with**:<br>o Bob Robbins, Director of Incident and Risk Management;<br>o Juli Brown, Investigator;<br>o Mindy Voight, Risk Manager;<br>o Diane Gillit, MS, RD, Assistant Director for Administration;<br>o Jim Forbes, M.Ed., C.B.A., Director of Behavioral Services; and<br>o Informal discussions with staff in each of the residential and workshop areas listed below in the observation section<br>▪ **Observations of**:<br>o Incident Management Review Team meetings on 3/15 through 3/18/10; |

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| | o Restraint Reduction meeting on 3/18/10;<br>o Unit II meeting on 3/16/10;<br>o Site visits to residential units, including 513 S. Cedar Avenue, 514 S. Cedar Avenue, 515 S. Cedar Avenue, 516 S. Cedar Avenue, 523 N. Cedar Avenue, 524 N. Cedar Avenue, 525 N. Cedar Avenue, 526 N. Cedar Avenue, 527 N. Cedar Avenue, and the workshop located at 536 Magnolia Boulevard. In general, site visits included observation of the living environment, interactions between employees and individuals served, interactions between individuals, interactions between employees, implementation of active treatment, observation of any potentially problematic behavior, and informal discussions with employees as well as with some of the individuals. Site visits were made on three successive days to 515 S. Cedar Avenue; and<br>o During site visits, heightened observations of Individual #289, Individual #174, and Individual #239. Individual #174 and Individual #239 were observed on three successive days |
| | **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| | **Summary of Monitor's Assessment:** The Monitoring team met many staff that appeared to be capable, caring, and knowledgeable at various levels of the organization.<br><br>All staff interviewed during the baseline review knew the procedures for reporting abuse and neglect. Some staff reported that they had used the hot line to report allegations of abuse or neglect, and had found the subsequent investigations to be thorough and responsive.<br><br>There was evidence of continuous review of reported incidents at the Incident Management Review Team meetings held every weekday morning, as well as at the monthly Restraint Reduction meeting, and through the Risk Management data. However, as is discussed in further detail below, not all incidents, allegations, and injuries were reported consistently.<br><br>The Director of Incident and Risk Management, the Investigator, and the Risk Manager were knowledgeable about their responsibilities. During interviews, they provided thoughtful observations and recommendations for further reduction of harm at LBSSLC.<br><br>Overall, the investigation processes at DFPS and LBSSLC appeared to be structured effectively, and to be implemented in a consistent manner. The investigators at LBSSLC worked collaboratively with their colleagues at the Department of Family and Protective Services (DFPS).<br><br>Employees alleged to have committed abuse, neglect or exploitation, or who were allegedly involved in an incident in which an individual sustained serious injuries were routinely assigned to other locations, pending the completion of the investigation. At least 13 employees have been dismissed since 7/09 as the result of investigations finding abuse, neglect or exploitation. |

There were relatively few investigations in which recommendations for systemic corrective actions were made for consideration by the Facility or Department's administrations. For example, in the investigation of an injury to Individual #79, staff was found to have been placed in an "impossible" situation caring for several individuals, but no recommendations were made about the adequacy of staffing. There were no systemic recommendations made about staffing as a result of investigations into incidents involving Individual #107, Individual #266, or Individual #151. The first two incidents involved a lack of staff supervision, and the latter incident involved a failure to instruct "pulled" staff.

Concerns were raised about the volume of work assigned to the staff responsible for investigations at LBSSLC. Slippage in the completion of reports was acknowledged. Some investigation reports had been delayed up to two months, apparently due to the workload. The issuance of correspondence related to investigation findings, and the review of final reports had been affected as well.

The development and initial implementation of processes to track and trend data about incidents and injuries was promising. However, despite this documentation, there appeared to be a failure by the Facility to follow-up, and resolve the potential for harm, particularly in certain residential areas. This was particularly evident in 515 and 516 S. Cedar Avenue, where numerous individuals with challenging, complex behavior issues were residing.

The Settlement Agreement requires that the Facility protect individuals from harm, consistent with generally accepted professional standards of care, as defined in the provisions of Section D. In general, it appeared that sufficient focus had not been concentrated to the extent needed at the residential unit level to correct concerns identified. As was discussed with State Office staff during the review, serious potential for harm was observed during this review. The risk was known because it had been documented in various reports, but it had not been addressed adequately. The risk was found in more than one residential unit, and appeared to have resulted from a number of factors, including:

- Inappropriate groupings of individuals with very different, often unique, needs for support. For example, it was clear from even brief visits to some residences that there were too many individuals with behavior issues grouped together. The opportunity for conflict was high, as was the possibility that one individual's behaviors would exacerbate his/her peer's behaviors. This will continue to present serious challenges to protecting individuals from harm, including protecting individuals from injury, as well as peer-to-peer aggression. In addition, due to the potential for individuals' behaviors being exacerbated in such situations, restraint may be used at a higher rate than it would in a setting with fewer individuals that afforded individuals additional personal space;
- Extremely serious staffing concerns, including the assignment of newly hired, inexperienced staff to work with individuals with complex and challenging needs for support;
- As exemplified at 527 N. Cedar Avenue, inadequate staffing levels for the number of individuals with complex needs as evidenced by six staff for 20 individuals, all of whom were totally dependent on staff for every activity of daily living;

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| | ▪ Reliance on overtime, and, as reported by staff, not entirely voluntary overtime, resulting in a reliance on tired staff to implement critical responsibilities;<br>▪ An annualized turnover rate of 60 percent among direct support professionals. Although the Facility was engaged in recruiting staff, there had been insufficient attention to date to screening potential candidates, and retaining current staff; and<br>▪ Adequate independent safeguards were not in place, for example, monitoring at the State-level. The staff persons who were managing the problematic programs were responsible for making decisions about change. Risk management data was not fully incorporated into the decision-making process. Objectivity did not seem to be present to the extent needed to ensure the adequate protection of individuals, and future compliance with the Settlement Agreement.<br><br>It is essential to note that during the course of the review as the Monitoring Team expressed concerns to State Office staff who were onsite, they took swift action to conduct further investigation of issues raised. Since the monitoring visit of Lubbock concluded, the Monitoring Team met on 4/5/10, with State Office staff, who provided an update on actions taken to address the most serious issues identified during the review. The State reported that a number of actions have been taken, including identifying an interim Director to provide management oversight; the development and partial implementation of a plan to decrease the numbers of individuals with intense behavior issues living on 515 and 516 S. Cedar Avenue, including providing these individuals with additional personal space; and reconfiguring the staffing in these homes, as well as providing support from more tenured staff to newer staff. In addition, the State described the efforts that the new administration had developed and begun to implement to increase the State Office's involvement in quality assurance/enhancement activities, as well as follow-up with regard to serious incidents and allegations. The Monitoring Team appreciates the State's immediate and thorough response to addressing the issues identified. The Monitor will continue to request regular updates on the progress that the State and Facility are making in reducing the potential risk for harm to individuals supported by LBSSLC. |

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| 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. | LBSSLC had implemented policies that stated clearly that abuse, neglect or exploitation of any individual served was prohibited. Employees were required to report abuse or neglect, and failure to do so would result in disciplinary action. In discussions during the baseline review, numerous staff members emphasized that there was zero tolerance for abuse or neglect. Investigations reviewed during the baseline period confirmed that staff found culpable of abuse or neglect were terminated from employment. | |
| D2 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as | The following Facility-wide policies had been issued:<br>▪ Incident Management: Abuse, Neglect and Exploitation, revised 12/21/09;<br>▪ Managing Unusual Incident(s) Other than Abuse, Neglect or Exploitation Allegations, revised 12/21/09; | |

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| | appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require: | ▪ Completing Incident Information Reports for Discovered Injuries and Unusual Incidents, revised 10/01/08;<br>▪ Critical Incident Team, revised 8/03/09; and<br>▪ Reassigning Alleged Perpetrators, revised 12/23/09R.<br><br>Copies of these policies were reviewed during the baseline visit. There was consistency with the intent and requirements of both the Settlement Agreement and DADS policy. As relevant, specific comments regarding their adequacy are provided below. The Monitoring Team will continue to evaluate the Facility's implementation of these policies. | |
| | (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. | The LBSSLC policy was consistent with these requirements. Standardized reporting forms had been developed, and were being used at the Facility. Generally, the investigation reports reviewed documented that reporting requirements were being followed. The Facility Director and/or the Department of Family and Protective Services (DFPS) and, in certain cases, the Office of the Inspector General were notified as required in these situations by LBSSLC staff.<br><br>However, while on site, the Monitoring Team identified a couple of issues that should have been reported, but had not been. There was at least one incident involving a serious injury to an individual that was not reported. Specifically, on 3/18/10, during a site visit to 525 N. Cedar Avenue, Individual #289 was observed with a notable laceration to her forehead. When asked, staff that present stated that the injury was the result of self-injurious behavior. This incident and injury were not referenced in the minutes of the Incident Management Review Team meeting on 3/19/10.<br><br>In addition, while on site, members of the Monitoring Team identified and called the abuse hotline regarding an allegation of neglect. This incident involved Individual #128 for whom it appeared inadequate nursing assessment had resulted in a delay in care. When the individual was taken to the hospital, she was diagnosed with a urinary tract infection, an infection in her mouth, and pneumonia. Numerous staff was aware of this delay in care, but it had not been reported as an allegation of neglect. | |
| | (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, | The policy entitled "Reassigning Alleged Perpetrators" that was revised 12/23/09, specified that when "an allegation is received by LBSSLC, the AP (alleged perpetrator) will be removed immediately from any contact with person's (sic) served and administratively reassigned." Investigation reports reviewed during the baseline visit generally documented that reassignment did occur on a consistent basis. Letters to the AP instructed him/her to report for alternative duty, and the Incident and Risk Manager supervised any employee so assigned.<br><br>Two understandable exceptions to this general practice were noted in the records | |

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| | 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. | reviewed. First, in an incident involving a fall that was witnessed and reported by the individual's roommate (DFPS # 34983012), there was no staff person assigned to be present at the time of the fall, and, therefore, and no one was removed from duty. In the second instance, there was no known AP. This incident involved the discovery of bruises in which the AP was unknown. In this incident, the Emergency Room physician confirmed that the bruises were related to a past injury (LBSSLC # 10-01-130).<br><br>In the review of investigation reports, there were examples of other measures taken to protect the individual from further harm including: increased levels of supervision and the provision of in-service training to staff. These interventions were planned and implemented under the guidance of the Personal Support Team (PST.)<br><br>Unfortunately, there were a number of environmental and staffing constraints at LBSSLC, making it difficult to consistently provide a safe environment. Crowding and the clustering of individuals with high needs for support had the potential to undermine the individual safeguards implemented by the PST. In addition, while absolutely essential, the mandated reassignment of any alleged perpetrator also required flexible staffing, which at the time of the review, did not exist due to the high turnover rate and the high use of overtime. All of these factors made it difficult to ensure a stable complement of staff who were knowledgeable about the strengths and needs of each individual. To ensure consistent staffing on the residential units, the underlying structural issues leading to the unstable staffing patterns in evidence at the time of the review will need to be resolved.<br><br>Since 7/09, according to information contained in an A/N/E Employee Report dated 3/5/10, 13 employees had been dismissed as a result of the findings of investigations related to abuse, neglect or exploitation.<br><br>There was evidence of continuous review of reported incidents at the Incident Management Review Team meetings held every weekday morning, as well as at the monthly Restraint Reduction meeting, and through the Risk Management data. However, as is discussed in further detail above with regard to Section D.2.a of the SA, not all incidents and injuries were reported consistently. | |
| | (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 | All staff interviewed during the baseline review knew the procedures for reporting abuse and neglect. Some staff reported that they had used the hot line to report allegations of abuse or neglect, and had found the subsequent investigations to be thorough and responsive. However, as noted above with regard to Section D.2.a of the SA, while on site, the Monitoring Team identified one incident that should have been referred as potential neglect, but was not, despite the fact that many staff, including management staff were aware of the incident. | |

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| | completion of such training. | Competency-based training materials were reviewed. Direct support professionals interviewed informally on the residential units confirmed that they had received such training at Orientation and annually thereafter. Documentation of such training was noted in investigation reports detailing the training provided to the AP.<br><br>During upcoming monitoring visits, reviews will be conducted of training records to ensure that staff is successfully completing the competency-based training on a yearly basis. The quality of the competency-based training also will continue to be reviewed, including review of training materials, and if possible, through observation of the actual training. | |
| | (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. | All statements signed by employees attending a 3/3/10 training session on abuse and neglect were requested. Signed statements were provided expeditiously for each employee on the training roster with the exception of one form, apparently submitted inadvertently, where the name was similar to but did not match that on the training list.<br><br>Reportedly, between 6/1/09 and 3/23/10, there had been 113 employee terminations. The reasons for termination included job abandonment; probation-not suited; misconduct; resignation in lieu of firing; violation of rules; exhaustion of all leave; and unsatisfactory performance. The number of employees disciplined for the failure to report abuse or neglect was not specified. | |
| | (e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and | This was not examined fully as part of the baseline review, but will be during the next review. However, the policy on Abuse, Neglect or Exploitation stated that: "educational information was sent to each primary correspondent and LAR in March 2008 and will be sent annually thereafter. Annually, when the individual served is scheduled for their annual PST meeting, educational information will be provided to the correspondent, LAR and individual served. The QMRP conducting the meeting will annotate in the PST documentation the fact that the educational information was provided to the correspondent, LAR and individual served." | |

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| | exploitation. | | |
| | (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 LBSSLC Facility monitors tracked the presence of rights posters from 7/09 through 1/10. In 11/09, compliance was reported at 100%.<br><br>With the one exception of 515 S. Cedar Avenue, in each living unit and day program site reviewed for the baseline survey, a pictorial description of individuals' rights was posted. However, these information sheets often were partially obscured by other announcements; were placed on employee bulletin boards, not easily visible to the individuals served; or were higher than eye level. In 514 S. Cedar Avenue, the poster was placed close to the ceiling in a locked staff office.<br><br>The intent of Sections D.2.e and D.2.f of the SA would not appear to be a merely pro-forma mailing or posting of rights information. Rather, concerted efforts should be made to assist individuals in learning about their rights, and about how to exercise them. Such efforts could take many forms, including, for example, learning objectives related to the exercise of rights; regular house meetings in which individuals are not only taught about their rights, but encouraged to exercise rights such as choice making about foods or activities; posting in homes or day programs about a "right of the month" with ongoing discussion with individuals about that right and how they could exercise it. The Monitoring Team recognizes that the concept of rights can be a difficult one to understand, but there are many concrete aspects to rights such as choice-making, use of the telephone, ability to choose with whom one spends time, etc., that many individuals at LBSSLC could understand and begin to or continue to exercise. Other individuals supported by LBSSLC could understand more complex rights such as the right to vote, or the right to refuse treatment. Efforts to educate individuals about their rights should be individualized, as appropriate. | |
| | (g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement. | The policy on Abuse, Neglect or Exploitation required the Facility Director or designee to notify immediately the law enforcement agency for investigation and collection of evidence for any suspicion of criminal activity. Based on this initial review, the one death that should have been reported was, in fact, referred to law enforcement in a timely manner. Police were also informed in a timely manner when Individual #151 was found to be missing, and when Individual #137 had an injury of unknown origin. The extent of the police's involvement in the confirmed physical abuse of Individual #60 was not clear, although they were informed of the investigation. This requirement will continue to be tracked in future reviews. | |
| | (h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good | The above policy stated that: "retaliation will not be tolerated. This includes, but is not limited to, harassment, disciplinary measures, discrimination, reprimand, threat and criticism." During the baseline review, the Director of Incident and Risk Management | |

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| | faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner. | volunteered the sole reference to the possibility of retaliation for reporting abuse or neglect. He reported that one employee believed that she was being singled out for retaliation by other staff at her worksite. An in-service training session was held and all staff persons were cautioned that retaliation would not be tolerated. This was an appropriate response to the staff member's concern. | |
| | (i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation. | LBSSLC had promulgated guidelines for ensuring that significant injuries of individuals served were reported for investigation. Audits were to be done at least semi-annually. The Campus Coordinator was assigned two homes to review shift logs, and observation/progress notes weekly to ensure that all significant injuries were previously reported. The Director of Incident and Risk Management was to audit the Campus Coordinator's reports at least quarterly to determine if all injuries had been reported. His findings were to be shared with the Incident Management Review Team. The Team would then discuss any identified problems, and be responsible for retraining staff, if necessary.<br><br>As noted above with regard to Section D.2.a, the Monitoring Team identified at least one instance of an individual sustaining a serious injury, and it not being reported appropriately. | |
| 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: | DADS had issued policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury and other incidents involving individuals living at the SSLCs. This policy was entitled: Protection from Harm—Abuse, Neglect and Incident Management, Policy #002.1 dated 11/6/09. In the sections that follow, any concerns related to the DADS policy are noted as appropriate. | |
| | (a) Provide for the conduct of all such investigations. The investigations shall be | Section III.D of the above policy required that all investigators have expertise and demonstrate competence in conducting investigations. The Facility policy "Incident Management—Abuse, Neglect and Exploitation, dated 12/21/09, had the same | |

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| | conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator. | requirement. Investigators are required to complete the course Comprehensive Investigator Training (CIT 0100) within one month of employment or assignment as an investigator. Section III.E of the DADS policy required Incident Management Coordinators and Primary Investigators to complete Labor Relations Alternative's (LRA) course entitled: "Fundamentals of Investigations Training" within six months.<br><br>Reportedly, DFPS investigators had met this requirement, but documentation of their training was not available during the baseline review. Documentation was available regarding the Facility investigators, and it showed they had met the requirements.<br><br>Neither policy specified training in working with people with a developmental disability. Although not clearly stated, none of the investigators had direct line supervisory responsibility for staff working with Individuals at the Facility. During upcoming monitoring visits, training records will be requested for both DFPS and Facility investigators to determine if they have been provided with adequate training on working with people with developmental disabilities. | |
| | (b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation. | DADS Policy Number 002.1, entitled Protection from Harm – Abuse, Neglect, and Incident Management, referred at I.D to cooperation with DFPS, and Section V.A.2.d referred to cooperation with DFPS in the conduct of investigations. The Facility policy referenced at (2) and (6) the requirement that cooperation must occur with DADS and DFPS. | |
| | (c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations. | Section V.D stated that the Director or designee would immediately notify the law enforcement agency for investigation and collection of evidence for any suspicion of criminal activity. The SSLC must abide by all instructions given by the law enforcement agency. The Facility policy at (3) and (6) required such notification of and cooperation with law enforcement. | |
| | (d) Provide for the safeguarding of evidence. | The Investigator's Training Manual did not provide requirements for safeguarding of physical evidence. The Facility policy contained Guidelines for Securing Evidence, Accompanying Abuse/Neglect Victims for Examination, and Bathing Victims Prior to Examination. | |
| | (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 | Section VIII.B specified documentation requirements. Specifically, it stated that investigations must commence within twenty-four hours or sooner. Section VIII.D required the SSLC to complete an investigation report within 14 calendar days (10 calendar days after 6/1/10.) | |

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| | 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. | Concerns were raised about the volume of work assigned to the staff responsible for investigations at LBSSLC. Slippage in the completion of reports was acknowledged. Some investigation reports had been delayed up to two months, apparently due to the workload. The issuance of correspondence related to investigation findings, and the review of final reports had been affected as well.<br><br>In order to ameliorate the backlog of investigations and prevent it from increasing further, the assignment of another investigator (for a total of two investigators plus the Incident and Risk Manager), and the addition of clerical support should be considered. Reportedly, the Department of Justice previously recommended these staffing increases. | |
| | (f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the | The Comprehensive Investigator Training Slides provided direction on preparing an investigation so that it forms a clear basis for its conclusion. In addition, DADS policy in Section VIII.H detailed the information required in the preliminary investigation. Section IX.C described the content of the final Facility investigation, including the requirements stated in (f).<br><br>Overall, the investigation processes of DFPS and LBSSLC appeared to be structured effectively, and to be implemented in a consistent manner. The investigators at LBSSLC worked collaboratively with their colleagues at the Department of Family and Protective Services (DFPS).<br><br>Seventy-five investigation reports were submitted to the Monitoring Team during the baseline review. Based on the documentation examined, as required by the Settlement Agreement and by policy, DFPS investigated allegations of abuse and neglect at LBSSLC, and the Facility investigated incidents of serious injury and an allegation of sexual abuse between peers.<br><br>Thirty-eight of these reports (50%) were analyzed for compliance with Section D of the Settlement Agreement. Thirty-one (82%) were completed by DFPS, and seven (18%) were completed by the investigator at LBSSLC. Findings from the review of these thirty-eight investigations indicated:<br><br>The investigations completed by DFPS involved allegations of physical abuse (12), neglect (14), verbal abuse (4), and sexual abuse (1). All but one of the investigations completed at the Facility involved allegations of serious injury. The exception was an incident involving an allegation of sexual abuse (touching) between peers.<br><br>Eight (26%) of the DFPS investigations confirmed the allegation. In six incidents involving physical abuse (2) or neglect (4), LBSSLC staff was terminated from | |

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| | investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions. | employment at the Facility. The following describes the circumstances for the two confirmed allegations in which staff were not terminated:<br>▪ One involved a "pulled" staff person giving an individual cheerios even though there was a ground diet order. The staff had not been instructed properly, and he was given training. It was not clear if other retraining or disciplinary action was taken with regard to supervisory staff who should have ensured that the "pulled" staff member was trained, or that this was looked at from a systems perspective.<br>▪ The other involved a case of confirmed neglect. The staff member, however, was "excused" because she had been assigned too many individuals to transition from the residential unit to the day program.<br><br>Six of the seven (86%) allegations regarding serious injury investigated by the Facility were confirmed. The incident involving alleged sexual contact between peers was found to be inconclusive. The investigators did not recommend any disciplinary actions in the six confirmed cases. However, they made a number of appropriate recommendations about the care/supervision of the six individuals who experienced injuries.<br><br>Thirteen of the 31 investigations (42%) conducted by DFPS did not commence within twenty-four hours as required by the DADS policy. With the exception of one investigation in which it could not be determined, six of the Facility investigations began within twenty-four hours of the incident.<br><br>Each of the seven investigations conducted by the Facility was completed within a ten-day period. Not all of the DFPS investigations were completed in a timely manner. Six exceeded the 14-day timeframe. Eleven of their investigations were completed within ten days; the remaining thirteen investigations were completed within the 14-day time limit. One completion date could not be determined because of missing documentation. There was no evidence, in the information reviewed, that extensions were requested and approved.<br><br>The investigations, both from DFPS and LBSSLC, followed the same format. In each investigation reviewed, the incident or allegation was described; the alleged victim was named; if the alleged perpetrator was known, the name was provided; and witnesses were documented. The interviews with the alleged victim, alleged perpetrator and any witnesses were summarized. Documents were referenced and, in each case reviewed, the individual's record was reviewed, at least to a limited extent. The histories of the alleged victim and the alleged perpetrator, if known, were included in the report. The investigator's findings were summarized, but the rationale for the findings seemed abbreviated, at times. | |

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| | | Despite the standardization of the reports, it was of concern that there were relatively few investigations in which recommendations for systemic corrective actions or, more specifically, recommendations related to significant staffing issues were made for consideration by the Facility or DADS' administrations. For example:<br>▪ In the investigation of an injury to Individual #79, staff was found to have been placed in an "impossible" situation caring for several individuals, but no recommendations were made about the adequacy of staffing.<br>▪ Individual #107 was fed Cheerios cereal despite his order for a ground diet. Neglect was confirmed; the "pulled" staff was not instructed about the diet requirements for this Individual. Although in-service training was recommended, there were no recommendations about the Facility-wide reliance on "pulled" staff to compensate for staff shortages on a given shift, or the mechanisms necessary to ensure individuals' safety when pulled staff had to be used.<br>▪ There were three investigations involving the failure to provide adequate supervision. In December 2009, Individual #266 was found in a field without shoes or pants in 14-degree weather. He had feces on his hands and legs. This Individual slipped out of his residence while staff was occupied with other assignments. The supervisor was warned but no other recommendations were issued. Similarly, Individual #151 was reported missing in March 2009. His history indicated a similar incident in April 2008. In the latest incident, a contributory factor was cited as: "…shift charge assignment of duties for the staff was not sufficient." In-service training was recommended, but the larger issue of the adequacy of staffing was not addressed. Additionally, Individual # 218 left the grounds, but there were no recommendations included in the investigation report.<br><br>In the thirty-eight investigations reviewed, there were thirty individuals involved. Five individuals had more than one incident investigation, including Individual #203, Individual #132, Individual #107, and Individual #185, each of whom had two investigations; and Individual # 303 who had four incidents investigated. In the cases, such as those pertaining to Individual # 303, there must be extra vigilance by the investigators to ensure that a history of unfounded reports does not diminish the thoroughness of any future investigations. The safeguards in place to protect against this concern will be reviewed during the next monitoring visit. | |
| | (g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to | Section XII.C of the DADS policy stated that the Incident Management Coordinator was responsible to review all investigations to ensure that they were thorough and complete, and that the report was accurate, complete and coherent. Any deficiencies must be corrected promptly. | |

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| | ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. | Based on interviews and review of investigation reports, it was evident that the Facility investigator and the Director of Risk Management reviewed each investigation. A summary checklist was attached to each investigation in order to confirm that the expectations outlined above in D.3.f of the SA were met. It was also noted when the investigation report was reviewed at the Incident Management meeting, and when the Director or her designee reviewed the report. It was not clear what level of supervision was provided during the conduct of the investigation itself. | |
| | (h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident. | Section IX. A of the DADS policy stated that an Unusual Incident Report (UIR) was required for each incident and investigation. The final UIR must be in the approved State Office format reviewed and approved by the Director or their designee within five working days of the date the State Center learned of the incident. The LBSSLC policy stated at (6)2a that: "Each facility will create a summary of each incident/allegation and email the summaries no later than 9:00 am the morning of the next working day following the incident or receipt of the allegation to their assigned Operations Coordinator." | |
| | (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. | Section XIII.B of the DADS policy included this requirement. Further review will need to be conducted of this requirement during upcoming reviews. | |
| | (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. | Section VIII.L of the DADS policy states this requirement regarding the maintenance of and access to investigation records. Compliance with this requirement will be reviewed in future monitoring visits. | |
| D4 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to | Section XIII of the DADS policy stated the requirements for tracking, analysis and corrective action.<br><br>The development and initial implementation of processes to track and trend data about | |

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| | 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. | incidents and injuries was promising. Three examples of the reports used to track and trend data about injuries and incidents were examined during the baseline review:<br>▪ The ANE Report tracked incidents by individual, date, time, and location. Commentary relative to the cause of the incident was included, including any allegations of abuse, neglect or exploitation by staff.<br>▪ The incident summary report included similar information as described above.<br>▪ An injury summary report detailed the individual, the date of the injury, the nature of the injury, and the total number of injuries for each person.<br><br>However, despite this documentation, there appeared to be a failure by the Facility actually to correct the potential for harm, particularly in certain residential areas. This was particularly evident in 515 and 516 S. Cedar Avenue, where numerous individuals with challenging, complex behavior issues were residing, resulting in incidents and injuries.<br><br>In general, it appeared that sufficient focus had not been concentrated to the extent needed at the residential unit level to correct concerns identified. As was discussed with State Office staff during the review, serious potential for harm was observed during this review. The risk was known because it had been documented in various reports, but it had not been addressed adequately. The risk was found in more than one residential unit, and appeared to have resulted from a number of factors, including:<br>▪ Inappropriate groupings of individuals with very different, often unique, needs for support;<br>▪ Extremely serious staffing concerns, including the assignment of newly hired, inexperienced staff to work with individuals with complex and challenging needs for support;<br>▪ As exemplified at 527 N. Cedar Avenue, inadequate staffing levels for the number of individuals with complex needs as evidenced by six staff for 20 individuals, all of whom were totally dependent on staff for every activity of daily living;<br>▪ Reliance on overtime, and, as reported by staff, not entirely voluntary overtime, resulting in a reliance on tired staff to implement critical responsibilities;<br>▪ An annualized turnover rate of 60% among direct support professionals. Although the Facility was engaged in recruiting staff, there had been insufficient attention to date to the screening potential candidates, and retaining current staff.<br>▪ Adequate independent safeguards were not in place, for example, monitoring at the State-level. The staff who were managing the problematic programs were responsible for making decisions about change. Risk management data was not fully incorporated into the | |

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| | | decision-making process. Objectivity did not seem to be present to the extent needed to ensure the adequate protection of individuals, and future compliance with the Settlement Agreement.<br><br>It is essential to note that during the course of the review as the Monitoring Team expressed concerns to State Office staff who were onsite, they took swift action to conduct further investigation of issues raised. Since the monitoring visit of Lubbock concluded, the Monitoring Team met with State Office staff, who provided an update on actions taken to address the most serious issues identified during the review. The State reported that a number of actions have been taken, including identifying an interim Director to provide management oversight; the development and partial implementation of a plan to decrease the numbers of individuals with intense behavior issues living on 515 and 516 S. Cedar Avenue, including providing these individuals with additional personal space; and reconfiguring the staffing in these homes as well to provide support from more tenured staff to newer staff. In addition, the State described the efforts that the new administration had developed and begun to implement to increase the State Office's involvement in quality assurance/enhancement activities, as well as follow-up with regard to serious incidents and allegations. The Monitoring Team appreciates the State's immediate and thorough response to addressing the issues identified. The Monitor will continue to request regular updates on the progress that the State and Facility are making in reducing the potential risk for harm to individuals supported by LBSSLC. | |
| 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 | Criminal background checks are required for all employees and ongoing volunteers. Although the State policy on Abuse, Neglect and Exploitation does not contain information on prerequisites to allowing staff or volunteers to work directly with individuals, Section 3000 of the DADS regulations on Volunteer Programs requires criminal background checks on volunteers at section 3200.3. The DADS Operational Handbook, Revision 09-21 Effective 10/29/09, at Part E, Section 19000 requires criminal background checks on employees. The DADS criminal history rule also contains prerequisites for allowing staff of volunteers to work directly with individuals.<br><br>During upcoming reviews, samples will be drawn to ensure that such checks are being consistently completed. Such a sample will include staff as well as volunteer records. | |

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

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

1. In order to address the protection from harm issues identified during the course of the LBSSLC review, the State should continue to implement the actions it reported having begun to implement, including strengthening management oversight at the Facility; the development and implementation of a plan to decrease the numbers of individuals with intense behavior issues living on 515 and 516 S. Cedar Avenue, including providing these individuals with additional personal space; reconfiguring the staffing in these homes as well to provide support from more tenured staff to newer staff; and increasing the State Office's involvement in quality assurance/enhancement activities, as well as follow-up with regard to serious incidents and allegations.
2. There should be ongoing reminders and training for staff regarding what constitutes a reportable incident, and their responsibilities with regard to reporting.
3. Posters that explain individuals' rights should be placed in areas in the homes and day programs to which individuals have regular access. They also should be placed in areas or at a height that takes into consideration the particular needs of the individuals served in the program. For example, in a home that supports many individuals who use wheelchairs, the posters should be placed at eye-level for a person in a wheelchair.
4. Concerted efforts should be made to assist individuals in learning about their rights, and about how to exercise them. Such efforts could take many forms, including, for example, learning objectives related to the exercise of rights; regular house meetings in which individuals are not only taught about their rights, but encouraged to exercise rights such as choice making about foods or activities; posting in homes or day programs about a "right of the month" with ongoing discussion with individuals about that right and how they could exercise it. Efforts to educate individuals about their rights should be individualized, as appropriate.
5. Requirements about training of investigators should be included in the DADS policy on Abuse/Neglect/Exploitation, or if these requirements are elsewhere in state policy, reference to their location should be provided in the A/N/E policy. The DADS policy also should include requirements that the Facility Investigator be outside the direct line of supervision of the alleged perpetrator.
6. The IMRT should discuss, record the results of deliberation and take action on investigations they review that raise serious systemic issues such as inadequate staffing, repeated injuries to the same individual, etc.
7. The expectations with regard to the safeguarding of evidence should be added to the Investigator's Manual.
8. As appropriate, investigations that identify potential systemic issues should result in recommendations for systemic change, and/or further investigation by the Facility into potential systemic issues.
9. In order to ensure protection from harm, the Facility should develop a plan for reducing the numbers of individuals who live and work together, as well as identifying alternatives that allow individuals personal space. This needs to be done carefully so as to not disrupt homes on campus that serve individuals with no or few behavior issues. For example, the grouping and staffing of individuals with challenging behaviors, as documented at 515 S. Cedar Avenue, requires immediate re-examination and restructuring to prevent further injury, and disruption of active treatment.
10. Staff providing direct supports should become a more integral part of the reform effort at LBSSLC. They have many concrete suggestions for change. For example, mentoring of new employees should be strengthened. There also should be a thorough review of the support provided to direct support professionals and nursing staff. Such a review, and any resulting plan of action should be designed with the outcome of reducing

the high turnover rate.

11. In order to forestall the growth of a sizeable backlog in investigations, the assignment of another investigator (for a total of two investigators plus the Incident and Risk Manager), and the addition of clerical support should be considered.

| SECTION E: Quality Assurance | |
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| 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:<br>▪ **Review of Following Documents**:<br>o Trend Analysis Reports for 7/09 through 10/09, and 1/10 through 2/10;<br>o Incident Management: ANE and Unusual Incidents, dated 7/09;<br>o Multiple Restraint Analysis for 9/09 through 11/09, and 12/09 through 1/10;<br>o Client Injury Trending, December 2009 through February 2010;<br>o Follow-up Recommendations Guidelines, revised 12/07;<br>o Policy on Pending Recommendations Tracking List, dated 1/25/10;<br>o Centers for Medicare and Medicaid (CMS) deficiency statements for 4/30/09, 5/08/09, 6/17/09, 7/7/09, 7/30/09, 10/14/09, and 1/15/10; and<br>o Policy on Safety Committee, dated 2/2/10<br>▪ **Interviews with**:<br>o Dawn Ripley, Director of Quality Enhancement |
| | **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| | **Summary of Monitor's Assessment:** At LBSSLC, there was significant collection of data occurring. For example, a substantial amount of information regarding incidents and allegations was being collected and aggregated. Likewise, the program monitors were utilizing monitoring tools to collect data in a number of different areas. Often, though, these tools did not collect information about the quality of the protections, supports, and services provided to individuals at LBSSLC.<br><br>Even though the monitoring and data collection systems needed to be refined, at the time of the review, useful information was being collected, and distributed to decision-making staff. However, although this information was available and appeared credible, it was not consistently used to improve the quality of life, safety and protection from harm of the individuals residing at LBSSLC. It generally did not appear that this raw data was analyzed in any meaningful way, or that responses to these reports, particularly in the form of concrete actions plans, were developed, documented and implemented. In order for the Facility to have a fully functioning quality enhancement process in place, it is essential that this occur.<br><br>In addition, data collected by the Risk Manager needed to be more fully incorporated into the Quality Enhancement process. |

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| E1 | Track data with sufficient particularity to identify trends across, among, within and/or | At LBSSLC, there was significant collection of data occurring. In the documentation provided to the Monitoring Team and based on interview with the QE Director, it was clear that the four Program Monitors were regularly collecting data through the | |

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| | regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports. | implementation of multiple monitoring tools. Such tools had been developed to review, for example, recordkeeping, the Personal Support Plans, PNMPs, integration and movement of individuals to the community, nursing care, etc. It was concerning that staff reported that much of this monitoring had been placed on hold at the end of January 2010 to allow QE staff to assist the Facility to "prepare for the Monitoring Team's visit."<br><br>In other sections of this report, some of these monitoring tools are discussed in further detail, for example, in the sections of this report that address nursing care, physical and nutritional management, interdisciplinary planning, and recordkeeping. Generally, it was found that these tools collected significant amounts of data that could be helpful to the Facility in beginning to make improvements in a number of areas.<br><br>The tools varied with regard to types of information they collected. Many tools had been developed to address Settlement Agreement requirements. Some, such as the tools developed to review individual planning and most integrated setting components included a number of indicators related to the quality of the documentation. For example, in the PSP Monitoring checklist, there were questions related to whether all supports were developed to address all needs identified. However, as noted throughout these various sections of the report, although the tools collected much valuable information, some only evaluated the presence or absence of an item as opposed to the quality of a support of service being provided. To provide a couple of examples, one of the nursing monitoring tools assessed whether annual and quarterly nursing assessments had been completed. It did not assess the quality of such nursing assessments, which as this report illustrates is problematic. Likewise, the recordkeeping monitoring tool assessed whether integrated progress notes were current, not whether the integrated progress notes were adequate to ensure that treatment was adequately provided. As the monitoring process evolves, it will be essential to ensure that the quality of protections, supports and services is captured.<br><br>One of the other issues with many of the tools was that indicators were written with multiple questions within one indicator. For example, on the PSP Monitoring Checklist, one indicator included the following three questions: "Are outcomes positively stated? Are they realistic? Do they increase a skill or move the person closer to obtaining their goal?" These are all good questions. It was unclear, though, which question a monitor would be answering by checking the "yes" or "no" column for this indicator.<br><br>According to the QE Director, the information from these monitoring activities was trended and reports provided to Department heads, with the expectation that corrective action plans would be developed for indicators scored below 70 percent. Based on the documentation provided, quarterly reports included a summary of raw data for each of the indicators reviewed. At times, narrative also was provided to provide more specific | |

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| | | information about the issues identified.<br><br>In addition, data were being collected through other sources, such as the incident management database. Trend Analysis Reports had been initiated. These reports documented types of incidents; staff allegedly involved; individuals involved; location; date and time; cause of incident; and outcomes of investigations. Some examples of the types of tracking and trending that was occurring are provided below.<br><br>A Client Injury Trending Report provided the total injury counts (according to the level of seriousness from FY 07 through February 2010. There were 710 injuries reported from December 2009 through February 2010.<br>▪ Of those injuries reported, 516 were self-caused; 54 were peer-caused, and 159 were caused by others, including staff.<br>▪ Seven injuries were serious; 604 were classified non-serious; and 92 required no treatment.<br>▪ Abuse or neglect allegations were filed for 52 injuries.<br>▪ Medical care was required for 58 injuries.<br>▪ There were two fractures and three injuries requiring sutures or staples.<br>▪ The time elapsed before the injuries were assessed was also reported. Within two hours, five injuries were treated; nine were treated within eight hours; and nine were treated within twenty-fours. It took more than twenty-four hours for 11 injuries to receive medical attention.<br>▪ This report does not provide detail as to the location of the individuals who are injured.<br>▪ It appeared to be a numerical summary.<br><br>Individuals with four or more injuries are reviewed each month at the Health Status meeting. The report for the period July to December 2009 indicated the highest number of injuries in units 513, 515, and 523. The number of injuries reported was 189, 147 and 142, respectively. The most likely time for injuries is the 6-8 pm time period.<br><br>Abuse, Neglect and Exploitation allegations and Unusual Incidents were tracked monthly, and a report was issued that identified trends.<br><br>The use of multiple restraints (three or more in a thirty day period) also was tracked monthly. This report analyzed information from the restraint checklist, such as the use of less intrusive alternatives; causes of restraint; environmental factors, etc. In 1/10, this process identified discrepancies between the completed checklists and the restraints documented in the Unit meeting. These findings were reported to responsible staff for corrective actions. | |

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| 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. | For the monitoring tools and other data collected, quarterly reports summarized the data across all three months of the applicable quarter, and compared the findings with previous quarters. Quarterly reports were submitted to the Program Improvement Committee (PIC) for review and follow-up action. As is noted above with regard to Section E.1 of the SA, the QE Director reported that quarterly reports also were sent to Department heads with the expectation that action plans would be developed and implemented for any indicators falling below 70 percent. As is discussed in further detail in other sections of this report, it generally did not appear that this raw data was analyzed in any meaningful way, or that responses to these reports, particularly in the form of concrete actions plans, were developed, documented and implemented. In order for the Facility to have a fully functioning quality enhancement process in place, it is essential that this occur.<br><br>There were a couple of types of reports for which follow-up recommendations had been made. These included the trend analyses for injuries and restraints.<br><br>With regard to incident reporting Follow-up Recommendations Guidelines were revised in 12/07. Recommendations made during the course of an unusual incident investigation were tracked. All recommended actions had to be completed, and documented before the case was closed. A sample of unusual Incidents was being reviewed every quarter. The Safety Committee had been established by policy, and met monthly to review data and discuss concerns. Recommendations resulting from such activities included, for example, putting a protective coating on the floors to prevent falls, reviewing the placement of furniture in the living room areas, reducing clutter, in-servicing staff, testing for allergies to reduce scratching, monitoring lifting through random evening/weekend visits, and redesigning the open living room space.<br><br>Review and analysis of restraint data resulted in the development of an action plan that looked at each identified problem area in restraint use. The recommendations were mostly related to documentation improvement. The most concrete recommendations were in the Restraint Report for the First Quarter 2010. This report recommended training and monitoring staff in home unit with the highest use of restraints, looking at the appropriateness of the placement of individuals living in this home (#521), and evaluating the effectiveness of the positive behavior supports for the individuals with the most use of restraints. There was also a recommendation that the horizontal side-lying restraint use be reviewed during the restraint debriefings. This was the most restrictive hold because it involved placing the person on the floor with two staff holding the person down.<br><br>The following was an example of valuable data that had been collected, but did not appear to have been analyzed thoroughly, or an action plan developed to address the | |

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| | | findings. A monthly report was issued entitled "Tracking of Consumer Support Observation/Interview." This report documented findings regarding: 1) engagement; 2) the use of a respectful tone of voice by staff; 3) the choices offered to individuals; 4) whether independence was encouraged; 5) whether privacy was respected; and 6) whether personal appearance was acceptable. Information was obtained through the observation of eight individuals selected randomly. The following results were reported:<br>▪ In 12/09, the Engagement Score was 46%; the Respect Score was 91%; and the Appearance score was 100%.<br>▪ In 1/10, the Engagement Score was 48%; the Respect Score was 93%; and the Appearance Score was 100%.<br>▪ In 2/10, the Engagement Score was 47%; the Respect Score was 83%; and the Appearance score was 100%.<br><br>Further analysis of these findings should have been conducted at each residential unit in order to design and implement strategies for improvement. Use of a larger sample could provide very important information about the need to enhance active treatment (engagement).<br><br>LBSSLC had had a number of ICF/MR surveys and investigations in 2009 and early 2010. Many of these had raised issues that could aid the Facility in identifying trends and permit intervention at a systemic level. Although the Facility had put a number of plans in place to address the immediate issues raised in the reports, it did not appear that the Facility was analyzing the cumulative reports to identify trends, evaluating potential underlying causes of the issues identified, and then responding to the systemic issues raised through these reports. For example, the death of one individual that occurred, and then other investigations by ICF/MR surveyors showing various failures to provide care, should have resulted in swift systemic reform to address issues related to staffing and staff training, but they did not. | |
| E3 | Disseminate corrective action plans to all entities responsible for their implementation. | As noted above with regard to Section E.2 of the SA, quarterly reports were submitted to the PIC and Department heads for review and follow-up. However, it did not appear that corrective action plans were consistently developed, and then disseminated to others who would have responsibility for their implementation, or portions of their implementation. | |
| 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. | Again, as discussed above, action plans generally were not in place. As a result, little monitoring was occurring with regard to the implementation of such plans.<br><br>A report issued in December 2009, entitled Section D—Abuse and Neglect, indicated that the Quality Enhancement Division was monitoring Unusual Incidents on a quarterly basis. Implementation of corrective actions was determined by sampling unusual | |

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| | | incident reports and investigations, reviewing relevant files and meeting notes. However, discrepancies in documentation are noted in this report. | |
| E5 | Modify corrective action plans, as necessary, to ensure their effectiveness. | This will be reviewed during upcoming monitoring visits once corrective action plans are consistently in place. | |

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

1. Monitoring tools should be reviewed and revised, as necessary, to ensure that they are capturing consistently the quality of the protections, services and supports being provided.
2. Monitoring tools should be reviewed and revised, as necessary, to ensure that each indicator measures one specific piece of information.
3. The valuable information already being collected through monitoring, trending, and tracking, and other quality enhancement efforts needs to be used more rigorously to actually eliminate potential risk still evident for individuals served by LBSSLC. The information the QE Department gathers needs to be analyzed to identify problematic trends and/or individual issues, and action plans need to be developed and implemented to address issues identified. Such action plans should include actions, person(s) responsible, timeframes for completion, and definition of the desired outcome(s).
4. Once these action plans are developed, they need to be monitored to ensure their completion, as well as to ensure they are effective in addressing issues identified. If they are not, they should be modified appropriately.
5. Information gained through the ICF/MR regulatory process should be used not only to correct the immediate deficiency, but also to analyze potential underlying issues/causes, and to address those as well.

| SECTION F: Integrated Protections, Services, Treatments, and Supports | |
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| 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:<br>▪ **Review of Following Documents**:<br>o LSS - IDT Process – Program Development: Person Directed Planning Assessment Process, revised 4/2/09;<br>o LSS-IDT Process Program Development: Protocol for Person Directed Planning, dated 9/30/08;<br>o List of individuals by home with 2009 and 2010 PSP dates, scanned 3/23/10;<br>o Personal Support Plan Completion Tracking Tool for PSPs occurring 8/3/09 through 1/28/10;<br>o QSO Scoring Guide for Sections F and S Answer Sheet, not dated;<br>o Section F. Integrated Protections, Service, Treatments and Support monitoring template, revised 9/21/09;<br>o LSSLC Attendance Tracking for November 2009, December 2009, and January 2009;<br>o Personal Support Plan (PSP) Monitoring Checklist, revised 5/5/09;<br>o PSP Assessment Tracking Record, for PSP meetings from 5/5/09 through 1/28/10;<br>o Instructions/Guidelines for Using the Vocational Services Assessment, revised 3/10;<br>o LBSSLC Assessment of Vocational Development, dated 5/20/08;<br>o List of QMRPs with Demonstrated Competency, scanned 3/19/10;<br>o Emails and Personal Support Plan Addenda dated 1/22/10, and 2/17/10 for Individual #306 for whom the team could not reach a consensus regarding a referral for a move from one home to another on campus;<br>o Person Directed Planning Training, Lubbock State School, June 2006;<br>o Person Directed Planning, Your Role as a New Employee PowerPoint presentation, undated; and<br>o PSPs and related assessments for the following individuals: Individual #110, Individual #16, Individual #56, Individual #303, Individual #177, Individual #195, Individual #196, Individual #159, Individual #12, Individual #122, Individual #15, Individual #168, Individual #268, Individual #269, Individual #97, Individual #79, Individual #264, Individual #153, Individual #69, Individual #49, and Individual #279<br>▪ **Interviews with**:<br>o Trent Lewis, Director of Active Treatment, on 3/15/10;<br>o Marisol Gonazales, ISP Coordinator, on 3/15/10<br>o Lola Walker, QMRP Coordinator, on 3/15/10; and<br>o Thirteen (13) Qualified Mental Retardation Professionals (QMRPs), on 3/18/10<br>▪ **Observations of**:<br>o PSP meeting for Individual #309 |
| | **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |

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| | **Summary of Monitor's Assessment:** The biggest challenge for LBSSLC with regard to PSPs appeared to be with regard to ensuring that team meetings include interdisciplinary discussions that result in one comprehensive, integrated treatment plan for each individual. At LBSSLC, this appeared to be a multi-faceted problem. One issue was that assessments did not appear to be being provided to teams in a timely manner to allow incorporation into the PSPs. In addition, as is noted in other sections of this report, issues with regard to adequate assessments impact teams' ability to identify strengths as well as needs of individuals. As assessment processes improve, teams will have better tools on which to base their discussions, and the resulting integrated plans.<br><br>According to documentation provided as well as a review of requested PSPs, some individuals had not had their PSPs updated on an annual basis. In other cases, it appeared meetings had been held, but plans had not been finalized and were not ready for implementation within 30 days. These are issues that need to be addressed quickly.<br><br>One area where all plans reviewed could benefit from additional attention was with regard to "community participation." While some plans included opportunities to take trips to the community, few presented opportunities for participation in a manner that would support continuous community connections such as friendships and work opportunities. |

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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: | | |
| 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. | Based on interview, and review of LBSSLC policy and other documentation, the Qualified Mental Retardation Professional has been identified as the facilitator of the team. The LBSSLC policy entitled IDT Process – Program Development: Person Directed Planning Assessment Process defined the QMRP as: "A professional… that ensures the Individual Support Plan/Action Plans are integrated, coordinated, and monitored." | |
| 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 | LBSSLC had an attendance tracking system, and provided documentation for the months of November 2009 through January 2010. The printout provided information about attendance at PSP meetings, Personal Support Plan Addendum (PSPA) meetings and Person Focus Worksheet (PFW) meetings. There were limited categories for team members, including the person served, Legally Authorized Representative (LAR), QMRP, Residential Coordinator (RC), Registered Nurse (RN), Psychology, and two columns for "Other." For many individuals, additional team members would need to participate in | |

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| | supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs. | their team meetings. Based on this tracking form, there also did not appear to be an expectation that direct support professionals would consistently participate in meetings.<br><br>Review of the data showed that:<br>▪ The LAR frequently was not present, or their presence or absence was not recorded (i.e., a blank space on the form).<br>▪ It was unclear what designation was used to identify if the individual was present or not. Their names were consistently listed to identify who the meeting was about, however, there was no column indicating their presence or absence.<br>▪ Direct support professionals appeared to be in attendance for approximately half of the meetings.<br>▪ Disciplines that were noted to be infrequently present included vocational staff, habilitation therapy staff, physicians, and dieticians. | |
| F1c | Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs. | LBSSLC maintained a PSP assessment tracking record that documented the dates of individuals' PSPs, and assessment due dates. Dates were entered for various assessments. The tracking record submitted was for PSP dates from 5/5/09 through 1/28/10, for 168 individuals. The following shows the numbers and percentages of assessments for which dates were not entered on the assessment tracking record, including for:<br>▪ Physicals, for 148 out of 168 (87%) of individuals, no physical date was noted;<br>▪ Nursing assessments, 69 were missing, or 41%;<br>▪ Residential assessments, 110 were missing, or 65%;<br>▪ Day supports, 70 assessments were missing, or 42%;<br>▪ Psychology assessments, 37 were missing, or 22%;<br>▪ Dental assessments, 27 were missing, or 17%;<br>▪ Water Safety, 37 were missing, or 22%;<br>▪ Recreation assessments, 24 were missing, or 14%;<br>▪ Habilitation therapies and nutritional assessments each had 13 missing, or eight percent; and<br>▪ Vocational assessments, there were only two missing, or one percent.<br><br>The numbers of assessments not available for the development of PSPs is of significant concern. For some individuals, it was unclear how a team meeting could be held, and a PSP developed at all given the lack of assessments. For example:<br>▪ Individual #323's PSP was developed on 12/3/09. According to the PSP Assessment Tracking Record, the following eight assessments were not present: dental, physical, psychology, residential, habilitation therapies, nutrition, water safety, and recreation.<br>▪ Individual #155's PSP was reported to have occurred on 12/15/09. The following eight assessments were documented as being missing: nursing, dental, | |

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| | | physical, psychology, residential, habilitation therapies, day supports, and water safety.<br><br>Based on interview with staff, the use of the Personal Focus Worksheet (PFW) had been in a pilot phase at LBSSLC, and had been implemented Facility-wide for PSP meetings being held beginning on 12/1/09. This assessment was to be completed by the individual and the team 30 days prior to the PSP meeting, and was designed to determine what was most important to the person. This process also was utilized to determine if additional more individual-specific assessments needed to be completed, such as music therapy, or a new seniors program assessment.<br><br>Staff also reported that team members had attended a day and a half of training on the state-mandated Positive Assessment of Living Skills (PALS) process. This assessment was to be completed by residential staff. Other assessments that staff reported were routinely conducted and included in the planning process included: physical/medical, nursing, psychological, Occupational Therapy (OT), Physical Therapy (PT), day/vocational, nutrition, water safety, and recreation.<br><br>The Facility submitted its vocational assessment format that included a number of evaluation areas, including work tasks and skills, work attitudes, work-related behaviors, present and future employment options and work preferences, attendance, and adaptive equipment or accommodations needed. This assessment format included many essential components for evaluating an individual's current skills and work habits, as well as their stated preferences with regard to future work. The instructions for completing the assessment indicated that in order to complete the assessment, the assessor should review information about the individual, such as his or her admission packet, observe the individual performing tasks in the work center on campus, and interview the individual and those who know the individual best. These are all good tools to use in completing a vocational assessment. These basics, however, need to be expanded upon to create vocational profiles for individuals that will be helpful to teams as they plan for the vocational future of the individual.<br><br>Vocational evaluations should focus on potential work that is interesting to the individual, and on how that kind of work could be made available to the individual. The evaluation should create a vocational profile based on, for example, objective data, situational assessments, a thorough work history, and/or interest inventories. Often times, for example, an individual might not be able to state what their interests are, due to lack of exposure to different jobs available. By using situational assessments, individuals would be provided with opportunities to try out different jobs to determine if they have or could learn the necessary skills and aptitudes, and if they are interested in pursuing such work. | |

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| F1d | Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual. | There was not always a clear connection between the assessments and the PSP. For example:<br>▪ As addressed in the section of this report that addresses SA requirement F.1.c, if the assessments were not complete and available to team members at the PSP meeting, it prevented productive cross-disciplinary discussion. This is a serious concern that needs to be addressed. This was further confirmed in the review of records. For example:<br>o Individual #303's PSP, dated 1/5/10, was completed without the benefit of an updated medical/physical. The one referenced in the PSP was dated 1/4/09. No pharmacy evaluation was submitted. A Physical Therapy evaluation had not been completed since 2/06.<br>▪ The personal focus worksheet was not available in all plans reviewed, but where it was, it showed promise for shaping plans based on the interests and preferences of the individual. | |
| 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. | |
| **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: | The DADS policy for this section had not been developed at the time of this review, and so it was not reviewed. The LBSSLC policy entitled: "IDT Process – Program Development: Person Directed Planning Assessment Process" addressed mainly the logistics of the assessment process and basic planning process, and did not address all of the components of the SA. For example, no description was provided or expectations set with regard to the interdisciplinary process of plan development; there was no guidance provided regarding incorporation of individuals' preferences into the PSP; and there was no discussion of the need to integrate information related to community participation, or consider the question of most integrated setting. | |
| 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 | Lists of prioritized needs were not found in the plans reviewed. This is discussed in further detail with regard to Section S.3.a. | |

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| | 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; | Another area where all plans reviewed could have benefitted from additional attention was with regard to "community participation." While some plans included opportunities to take trips to the community, few presented opportunities for participation in a manner that would support continuous community connections such as friendships and work opportunities. If barriers for supporting individuals to participate in the community exist, then these need to be identified in individuals' plans. | |
| | 2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs; | For 11 of the 21 PSPs reviewed (52%), no measurable goals or outcomes were included in the PSPs. For these plans, no "Action Plan" section was found, which typically was where the team identified the desired outcomes, and related measurable actions steps. Ten of the 21 PSPs (48%) included some individualized and measurable goals/objectives, treatment strategies and supports. However, none of the plans reviewed included a comprehensive set of measurable goals, objectives, treatments and strategies to be employed to fully support the individual.<br><br>As is discussed in other sections of this report, nursing plans, Behavior Support Plans, and physical and nutritional support plans were not fully integrated into the PSP. They were generally stand-alone documents that may have been referenced in the PSP. Specific individualized, measurable goals and objectives were not defined in individuals' PSPs to support the implementation of these essential plans. For example, in order to provide health care supports to individuals served, direct support professionals as well as nursing staff need to provide supports to an individual. Supports such as ensuring that an individual is offered fluid throughout the day, or is repositioned every two hours should be specified in measurable ways in individuals' PSPs. Some examples of the ways in which PSPs failed to define measurable objectives include:<br>▪ Individual #303 had a goal to "loose weight over the next 12 months to achieve his desired weight range." This was not measurable, nor did it define the necessary supports that would be provided to assist him in achieving this goal.<br>▪ Individual #16 had an outcome in his 1/7/10 PSP to "have 0 episodes of constipation or impaction during the next 12 months." Although this was a measurable goal, no strategies to assist him in achieving it were noted, and the nurse was the only one responsible for assisting him in achieving it.<br>▪ Individual #240's 10/8/09 PSP included an objective that stated that he "will be assisted to find a job or volunteer (sic) in the community." This was a great goal but no strategies to assist him in achieving this were identified.<br><br>In addition, it was not always clear that the goals and objectives were the ones that were most important to the person in light of his/her preferences. It also was not clear that preferences were integrated into goals and objectives that were developed by the team. Instead, preferences tended to be addressed separately, mostly as "opportunities | |

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| | | included in activities provided within his/her Daily Schedule," or reminders to staff of interests. For example:<br>▪ One of Individual #303's stated preferences was participation in sports, such as baseball. This could have been included as a strategy to assist him in losing weight, but was not.<br><br>With regard to the requirement that PSPs identify plans to overcome barriers to living in the most integrated setting, this was not evident in any of the plans reviewed. It is discussed in further detail with regard to the Facility's compliance with Section T.1.b.1 of the Settlement Agreement. | |
| | 3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual; | As noted above, none of the plans reviewed included a comprehensive set of measurable goals, objectives, treatments and strategies to be employed to fully support the individual. | |
| | 4. Identifies the methods for implementation, time frames for completion, and the staff responsible; | For the goals and objectives identified, PSPs generally described the timeframes for completion, and the staff responsible. Methods for implementation were not always adequate as is discussed in further detail in the section of this report that addresses Section S of the Settlement Agreement. | |
| | 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 | Staff reported that some of the barriers to implementing programs in the community included: staffing resources, transportation, and financial resources for activities in the community. With regard to staffing, as is discussed in many other sections of this report, the lack of stable staffing appeared to have an impact on the Facility's ability to ensure individuals had opportunities for skill acquisition opportunities in the community. Staff reported that most of the homes had vehicles assigned to them, but these resources were not adequate given the number of individuals living in each home. Wheelchair accessible vans were noted as being a particular need. The Monitoring Team confirmed this in a visit to Home 525 that served a number of individuals who had mobility difficulties, but did not have an accessible vehicle. Staff indicated that they borrowed vehicles from other homes to try to ensure that all individuals in the home had access to the community. Finally, staff also noted financial resources as a barrier at times to including community skill acquisition goals and objectives in individuals' plans.<br><br>Not all strategies and supports were practical and functional at the Facility and in the community. Strategies, particularly behavior plans employed restraint and close supervision, which should be viewed as short-term protections, while more practical and functional options are developed and instituted. | |

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| | | This is an area that requires further review during upcoming monitoring visits. | |
| | 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. | For the goals and objectives included in PSPs, generally, the PSPs specified data to be collected and/or documentation to be maintained, and specified a frequency for data collection. It was not always clear who was responsible for reviewing the data, and what that review meant in terms of making changes when there was little or no progress. As is discussed above with regard to Section F.2.a.2, the overarching concern was that many goals and objectives were not specified in individuals' PSPs. As a result, appropriate data was not being collected to assist teams in decision-making. | |
| 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. | Based on the review of PSPs, this was an area that required substantial improvement. As is discussed in other sections of this report, the Monitoring Team found a lack of coordinated supports in a number of areas, including between dental/medical and behavior/psychology; nursing and dental; and between the disciplines responsible for the provision of physical and nutritional supports to individuals served. Review of the PSPs generally showed a multidisciplinary as opposed to interdisciplinary approach. | |
| 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. | As is discussed in further detail with regard to Section V.4 of the SA, there were problems noted with various staff having access to essential components of individuals' records. In particular, staff responsible for the implementation of action plans, and goals/objectives did not consistently have access to the "All About Me" book. | |
| 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 | Based on interview with staff and documentation review, it appeared that LBSSLC had processes in place for Personal Support Plan Addendum (PSPA) meetings, and Monthly Communication Meetings. Reportedly, PSPA meetings were held whenever there was a change in the individual's life that required a change to his/her PSP. Examples of such changes were given as a change related to the individual's health, or supervision level. At Monthly Communication Meeting, team members reportedly met to discuss programming, and the individual's status with regard to medical, behavior and therapeutic needs. At these meetings, it was expected that staff working with the individual on the various shifts would be present. | |

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| | interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate. | Based on the documents provided, it appeared that quarterly meetings were occurring regularly. For many individuals PSPAs also were documented. However, because documentation was not provided to support monthly reviews of individuals' programs, it was not clear that this was occurring consistently. Such documentation was requested for a sample of 11 individuals, but consistent monthly review documentation was not found. This is an area that requires further review during upcoming monitoring visits. | |
| 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 reviewing the Person Directed Planning Training, dated June 2006, the training materials included voluminous information regarding the planning process, including many instruction sheets, and forms. It was not clear how this information was presented to training participants, and if such presentation was meaningful, and resulted in the QMRPs and other PST members attaining the skills and competencies necessary to develop adequate integrated plans for individuals at LBSSLC.<br><br>As is discussed below with regard to Section F.2.f of the SA, QMRPs indicated a need for additional training on the PSP development process, and stated that it had been a while since they had received such training. It appeared from the documentation provided that 2006 may have been the last time formal training was provided.<br><br>The LBSSLC IDT Process Program Development: Protocol for Person Directed Planning policy identified the competency-based assessment process for QMRPs and PSTs. It indicated that QMRP competency was to be assessed using two monitoring forms that would be implemented by the PSP Coordinator or QMRP Coordinator. The two forms included the PSP meeting evaluation and PSP written document evaluation. The policy indicated that: "Competency will continue to be assessed at least quarterly until such time as the monitoring forms have indicated that the QMRP has reached the desired competency level. Upon reaching competency, one random check per year will be completed." It was not clear what the definition was of "desired competency level."<br><br>During the review, a list was requested of QMRPs who had demonstrated competency in the development of PSPs. The list provided included the names of nine QMRPs, including the QMRP Coordinator. At the time of the review, it was reported that there were 14 QMRPs, not including the QMRP Coordinator, two of whom were still in training. Based on this information, eight out of the 12 QMRPs (67%) who were past the training phase of their tenure with LBSSLC had demonstrated competence in the development of PSPs.<br><br>The PST's competency was to be measured using the PSP meeting evaluation form. Training was to be provided by the monitor immediately following the PSP meeting to the entire PST on any improvements needed. Again, competency was to be measured at | |

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| | | least quarterly until the "desired competency level" had been reached, but no definition of this term was provided.<br><br>Based on staff interview, the PSP Coordinator was responsible for training new staff on the PDP process, action plans, and their role in the development, revision, and implementation of the plans. Based on review of the Person Directed Planning, Your Role as a New Employee PowerPoint presentation, it appeared to provide valuable basic information to new staff about the concept of person-directed planning, as well of the logistics of developing action plans that incorporated an individual's preferences, strengths, and needs. It also appeared to utilize adult learning concepts.<br><br>The training included a written test that captured some of the basic elements of the training. It was unclear what the expectations were for a "passing" grade on the written test, or what other competency-based measures were used to test staff's mastery of the necessary skills and competencies. The implementation of this training will be reviewed in more detail during upcoming monitoring visits. | |
| 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. | A review of documentation showed that: a) at times individuals had not had an annual PSP review meeting; and b) when meetings were held, the completed PSPs were not filed in a timely manner in individuals' records. Specifically:<br>▪ A list of 2009 and 2010 PSP dates showed that at the time of the review, four out of 233 individuals (2%) were overdue for annual PSP meetings.<br>▪ More concerning, the Personal Support Completion Tracking tool showed that for PSP meetings held from 8/3/09 through 1/28/10, 28 out of 103 of the PSP documents (27%) had not been completed and filed in the individuals' records.<br><br>This was confirmed with the review of individual records. For example:<br>▪ Individual #264 had a plan dated 1/27/09, according to the documentation provided. At the time of the review, this meant that his plan was almost two months overdue.<br>▪ Likewise, Individual #268 had a plan dated 2/25/09, making his plan overdue at the time of the review.<br>▪ As noted with regard to Section P.2 of the SA, a review of OT/PT Update current assessments for Individual #113, Individual #162, Individual #14, and Individual #29, indicated that they had PNMPs, but these individuals did not have an updated Personal Support Plan.<br><br>Although it was not clear what the causes for this were, some of the factors that might be contributing to this were discussed by the QMRPs in a meeting with Monitoring staff. They included:<br>▪ Due to the lack of consistent direct support professionals in many of the homes | |

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| | | on campus, QMRPs reported being "pulled" frequently to provide direct supports;<br>▪ Due to vacancies or QMRPs being out on leave, remaining QMRPs frequently had to cover for their co-workers. At the time of the review, it was reported that five of the QMRPs were covering others' caseloads;<br>▪ Many of the QMRPs reported not having been fully trained on many of the processes for which they were responsible, and having to learn as they went. This likely resulted in even basic tasks taking longer than they should, thereby, impacting QMRPs' ability to complete all tasks assigned to them in a timely manner.<br>▪ QMRPs were not meeting on a regular basis to discuss and share ideas, receive updates on new forms and processes, etc.<br>▪ There appeared to be a lack of clarity of role responsibility and/or accountability for job responsibilities. For example, QMRPs reported that Residential Coordinators were supposed to write Specific Program Objectives, but often did not. QMRPs at times took over these responsibilities in an effort to complete the PSPs. However, this detracted from their ability to complete all of their own work. This was an area that reportedly the QMRP Coordinator, and PSP Trainer were in the process of addressing;<br>▪ A number of staffing changes had resulted in added responsibilities for the QMRPs, including social work activities, such as family contact, when social work positions were eliminated, and clerical duties when the clerical support that used to be available to the QMRPs became unavailable; and<br>▪ Some QMRPs reported that they "could not remember the last time" they had training on the PSP process. Others said that they had been trained approximately a year prior. They identified additional training topics that would be helpful, such as Conflict Resolution, Team Building, Dementia and Alzheimer's Disease, and Autism.<br><br>The PSP is the document that should drive the delivery of protections, supports and services. It is essential that the QMRPs who have the responsibility for PSPs' development, monitoring, and modification have the time and skills to perform these duties in a quality and timely manner. Some of the factors listed above may be detracting from their ability to do this. The Facility should investigate the causes for PSPs not being completed in a timely and complete manner, and should address the issues identified. | |
| F2g | Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and | The Facility appeared to have developed a number of different quality assurance/enhancement tools to measure compliance with this Section of the SA. For example, the following tools were provided for review: 1) QSO Scoring Guide for Sections F and S, Answer Sheet; 2) Section F. Integrated Protections Service Treatments and | |

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| | 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. | Support; and 3) Personal Support Plan (PSP) Monitoring Checklist. These checklists generally tracked the requirements of the SA. They also generally appeared to include a number of valuable indicators that would provide information about both processes and outcomes on an individual, and, at times, systemic level. Information gained from these forms generally could have been aggregated to provide a systems picture of the integrated planning process.<br><br>However, as noted in the section above that discusses quality assurance, at times, indicators were written with multiple questions within one indicator. For example, on the PSP Monitoring Checklist, one indicator included the following three questions: "Are outcomes positively stated? Are they realistic? Do they increase a skill or move the person closer to obtaining their goal?" These are all good questions. It was unclear, though, which question a monitor would be answering by checking the "yes" or "no" column for this indicator. In addition, it was not clear from the documentation provided what the expectations were with regard to the frequency of review, the sample size, the criteria used to determine acceptable levels of performance, or the follow-up activities that were expected to occur. Moreover, as is discussed with regard to Section E of the SA that addresses Quality Assurance, it was not clear that information being collected through monitoring processes was consistently being analyzed, and, as appropriate, plans being developed to address identified areas of need. | |

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

1. Once the State's policy with regard to interdisciplinary teams and integrated planning is finalized, LBSSLC should review, and revise, as appropriate, its policies on these topics.
2. The following recommendations are offered with regard to training staff on the interdisciplinary approach and individualized planning process:
    a. Training for QMRPs and PSTs at LBSSLC should be completed as soon as possible.
    b. QMRPs and/or others with responsibility for facilitating team meetings should be provided with competency-based training on group facilitation, including conflict resolution, particularly as is relates to the interdisciplinary team process. QMRPs should be surveyed to determine what other types of training they believe would be helpful.
    **c.** As teams are trained on the State's revised PSP policy and format, a focus should be on all team members' role in the interdisciplinary process, including the integration of information and development of strategies to address individuals' preferences and needs, and to identify and overcome barriers.
    d. The training curricula currently used at LBSSLC should be reviewed and enhanced to address additional areas, including but not limited to identifying priority needs of individuals served; identifying all of the protections, services and supports an individual requires; developing measurable goals and objectives; developing strategies to assist individuals in meeting their goals; and clearly defining expectations with regard to the implementation of and data collection related to action plans, Specific Program Objectives (SPOs), and Staff Service Objectives (SSOs).
3. As indicated in other sections of this report, focused efforts should be made to improve the quality and timeliness of assessments that are used in the development of individuals' PSPs.

4. Barriers to the inclusion and implementation of community-based skill acquisition programs, such as transportation, staffing, and funding, should be investigated and addressed.
5. The LBSSLC vocational assessment should be expanded upon and/or alternatives to the vocational evaluations/assessments should be identified and implemented. Vocational evaluations should focus on potential work that is interesting to the individual, and on how that kind of work could be made available to the individual. The evaluation should create a vocational profile based on, for example, objective data, situational assessments, a thorough work history, and/or interest inventories.
6. Personal Focus Worksheets should be completed on everyone before their annual PST meeting. Staff should be trained on how to discover important information about a person's interests and wishes from observation rather than only from conversation, particularly when the individual does not communicate verbally.
7. PSPs should integrate the recommendations from assessments, not just reference them, and make the health care, therapeutic, and behavior support plans a part of the PSP, rather than stand-alone documents.
8. LBSSLC policy related to competency-based training of QMRPs and PSTs should define the "desired competency" level.
9. The Facility should investigate the causes for PSPs not being completed in a timely and complete manner, and should address the issues identified.
10. With regard to monitoring activities, the Facility should:
    a. Review and revise monitoring tools, as necessary, to ensure that each indicator measures one specific piece of information;
    b. If not already done, set expectations with regard to the frequency of review, the sample size, the criteria used to determine acceptable levels of performance, and the follow-up activities that are expected to occur;
    c. 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.

| SECTION G: Integrated Clinical Services | |
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| 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:** Information gathered as a result of activities undertaken to assess clinical services discussed throughout this report was analyzed to make determinations with regard to the Facility's progress with these provisions of the Settlement Agreement. |
| | **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| | **Summary of Monitor's Assessment:** As is discussed in other sections of this report, at the time of this initial review, there were a number of gaps with regard to the integration of clinical services. |

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| G1 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need. | As is discussed in other sections of this report, at the time of this initial review, there were a number of gaps with regard to the integration of clinical services. Some of the most striking included the need for greater integration between dental/medical and behavior/psychology; nursing and dental; psychology and speech, and between the disciplines responsible for the provision of physical and nutritional supports to individuals served. These are all discussed in further detail in the sections of this report that address these various disciplines.<br><br>There were some disciplines that demonstrated strong collaboration, including between psychology and psychiatry, as well as between neurology and medical/nursing. These too are discussed in relevant sections of the report. | |
| 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. | This is an area that requires review during an upcoming monitoring visit. | |

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

1. Recommendations regarding integration of clinical services may be found in each of the respective sections of this report.
2. The Facility should continue to move forward with plans to ensure that appropriate clinicians review recommendations from non-Facility clinicians, and document whether or not such recommendations are accepted, and, if not, why not. As appropriate, recommendations should be forwarded to individuals' PSTs.

| SECTION H: Minimum Common Elements of Clinical Care | |
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| 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:** Information gathered as a result of activities undertaken to assess clinical services discussed throughout this report was analyzed to make determinations with regard to the Facility's progress with these provisions of the Settlement Agreement. |
| | **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| | **Summary of Monitor's Assessment:** According to the Facility's Plan of Improvement, the Facility is in the process of developing policies and procedures to implement these provisions of the Settlement Agreement. The target date for most of these activities is 6/26/11. As is illustrated throughout this report, different clinical disciplines were at different stages of ensuring that assessments and evaluations were completed as required or needed, treatment plans were developed and implemented, monitoring systems were in place to measure compliance with and the efficacy of treatment plans, and treatments and interventions were modified as needed. |

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| H1 | Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs. | As is illustrated throughout other sections of this report, there were issues with regard to assessments and evaluations being completed regularly, and performed in response to development or changes in an individual's status. Some examples of this included multiple assessments not being completed in time for individuals' annual PSP meetings; nursing assessments, particularly with regard to individuals who experienced acute illness, not being adequate; individuals who may benefit from communication systems not being adequately assessed; and individuals using enteral nutrition not being fully assessed annually to determine the need for ongoing tube feeding. | |
| H2 | Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and | This will be more fully assessed during the next monitoring visit. | |

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| | Related Health Problems. | | |
| H3 | Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses. | As is referenced in the section above with regard to Section H.1 of the Settlement Agreement, without timely and thorough evaluations and assessment, the planning of treatments and interventions is hindered. For example, for individuals for whom communication needs had not been properly assessed, adequate treatments and interventions were not being developed, and implemented. Likewise, because psychiatric diagnoses might not have been accurate, then proper treatment was potentially not being provided. | |
| H4 | Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner. | As is illustrated in various sections of this report, clinical indicators often were not identified. For example, nursing plans did not identify what clinical indicators were to be tracked, by whom, or when. Physical and nutritional management plans also did not identify the functional outcomes to be measured. | |
| 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. | Again, as is illustrated, for example, in the nursing and physical and nutritional support sections of this report, there were not systems in place to effectively monitor the health status of individuals. | |
| 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. | Until accurate clinical indicators are developed and monitored/measured, this will continue to be an indicator on which the Facility needs to work. | |
| 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. | According to the Facility's Plan of Improvement, such policies were anticipated to be completed beginning at the end of December 2009, with a target date of 6/26/12. This will be further assessed during upcoming visits. | |

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

1. Recommendations regarding the common elements of clinical care are included in other sections of this report.
2. The Facility should continue to develop and implement policies related to the common elements of clinical care.

| SECTION I: At-Risk Individuals | |
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| 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:<br>▪ **Review of Following Documents**:<br>o Health Risk Assessment Tool-Nursing;<br>o Braden Scale;<br>o LBSSLC Health Status List;<br>o LBSSLC individual list of emergency room visits and hospitalizations;<br>o Health Risk Assessment Rating Tools;<br>o Quarterly MD Progress Notes for Health Status Meeting (HSM);<br>o Meeting Participants and Health Status Statement forms; and<br>o Medical records for the following individuals: Individual #271, Individual #135, Individual #134, Individual #98, Individual #214, Individual #303, Individual #75, Individual #84, Individual #154, Individual #38, Individual #213, Individual #10, Individual #108, Individual #194, Individual #251, Individual #125, Individual #143, Individual #320, Individual #114, Individual #128, and Individual #263<br>▪ **Interviews with**:<br>o Don Minnis, RN, BSN, Chief Nurse Executive;<br>o Jeremy Ellis, RN, QE Nurse;<br>o Debbie M. Jones, MS, CCC-SLP, Chairperson of NMT;<br>o Occupational Therapists (all); and<br>o Speech Language Pathologists (all)<br>▪ **Observations of**:<br>o Health Status Team meeting for Home 516; and<br>o NMT Meeting, on 3/19/10 |
| | **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| | **Summary of Monitor's Assessment:** The current risk assessment tools used by LBSSLC did not provide an adequate comprehensive risk assessment for any of the areas addressed, and did not result in the appropriate identification of clinical risk indicators or risk levels for the individuals reviewed. Standardized statewide tools with established reliability and validity should be used by all the Facilities in assessing and documenting clinical indicators of risk to ensure that individuals' risk levels are appropriately identified. The current system being used does not accurately identify individuals at risk, and does not ensure that proactive interventions are timely put in place to address the specific areas of risks.<br><br>Once an appropriate risk identification system is developed and implemented, the Facility must develop and implement appropriate assessment tools to perform interdisciplinary assessments of services and |

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| | supports for at-risk individuals. Such assessments tools should also be used for reassessment in response to changes as measured by established at-risk criteria. The initial assessments and reassessments will need to occur according to the required timeframes set forth in the Settlement Agreement.<br><br>The Health Status Team (HST) meeting has potential, however, in its current form it lacked appropriate criteria and structure to assist the team in accurately determining risk levels. The team discussion at these meetings should result in identification of an associated level of intensity of clinical supports to address the risks, as well as the implementation of proactive measures aimed at preventing risks. |

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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. | At the time of this review, LBSSLC was not able to accurately identify individuals with clinical risks. The Facility was using the Health Risk Assessment Tool-Nursing as directed by the State as the tool to identify the clinical risk indicators for individuals. However, this tool was simply a questionnaire that was scored either "yes" or "no" for questions in areas regarding Cardiac, Constipation, Dehydration, Diabetes, gastrointestinal (GI) concerns, Hypothermia, Medical Concerns (other), Osteoporosis, Respiratory, Seizures, Skin Integrity, Urinary Tract Infection, and Aspiration/Choking. The questions contained on the tools had no weighted values and consequently, the tool did not provide an accurate indication of risk. The tool was not an adequate comprehensive risk assessment for any of the areas mentioned, and did not result in the appropriate identification of clinical risk indicators.<br><br>In addition, Health Status Team (HST) and Nutritional Management Team (NMT) risk levels were not congruent. A review of individuals on the Health Status Risk List, dated 3/08/10, identified only two individuals at risk of aspiration. The NMT documentation, however, identified multiple individuals as High Risk-Level 1 due to pneumonia and/or aspiration pneumonia. It was unclear why the HST had identified so few individuals as at high risk of aspiration when, for example, there were multiple individuals with concurrent hospitalizations and a diagnosis of aspiration pneumonia. The Health Status Team and the Nutritional Management Team functioned independently of each other which did not support an integrated problem-solving approach to identifying individuals with the most complex physical and nutritional support needs, and providing effective supports to minimize their identified health concerns. The HST and NMT must agree on defined standardized risk categories and assessment processes to ensure individuals at highest risk are identified.<br><br>Standardized statewide tools with established reliability and validity should be used in assessing and documenting clinical indicators of risk to ensure that individuals who have clinical risks are appropriately identified. This would be the first step in the process of developing and implementing proactive interventions to address these risks. For | |

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| | | example, the Facility was using an appropriate standardized tool, the Braden Scale, to assess skin integrity issues. The tool clearly identifies levels of risk for skin issues, so that appropriate interventions can be implemented to treat the existing issue, and prevent further worsening of the problem.<br><br>Based on observations of the Facility's Health Status Team Meeting for Home 516, during which representatives from all disciplines discussed and determined the risk rating (one to three; with one being the highest level of risk) for individuals, the lack of criteria used to assign a risk level rendered these risk determinations arbitrary at best. For a number of individuals reviewed, the team struggled to assign risk levels without guidelines to assist in the process. In addition, aside from the Health Status Team meeting more frequently for individuals determined to be at the highest risk level, there appeared to be no other clinical benefits or interventions associated with being deemed at the highest risk level. Also, there was no discussion or review of individuals assigned lower risk levels to ensure that proactive measures and interventions were in place to possibly prevent them from developing a higher risk status. Unfortunately, despite the amount of time the professionals spent in this meeting trying to determine a risk level number, clinical discussion regarding appropriate interventions to address current clinical issues and to improve outcomes did not occur in meaningful fashion.<br><br>Although the Health Status Team meeting in its current structure did not adequately identify or ensure that risk areas were being appropriately addressed, the group had potential to fulfill its mission if a risk system was developed that included appropriate criteria and structure to assist the team in accurately determining risk levels. The appropriate assignment of such risk levels should result in an associated level of intensity of clinical supports being identified to address the risks, as well as the implementation of proactive measures aimed at preventing these and other possible risks.<br><br>From review of LBSSLC's Health Status List, and the list of individuals who had been admitted to the community hospital or seen at the community emergency room (ER), several individuals who had been hospitalized had not been identified by the HST as being at risk. For example:<br>▪ Individual #114 was hospitalized twice for pneumonia, on 5/14/09 and 11/8/09, but was listed as a Level 2 - Moderate risk, on the Facility's Health Status List.<br>▪ Individual #128 was hospitalized on 11/26/09, and again on 1/22/2010 for pneumonia, and was also listed on the Facility's Health Status List as a Level 2.<br>▪ Individual # 263 was hospitalized on 12/13/09, and 1/7/2010 for pneumonia and was listed on the Facility's Health Status List as a Level 3 - Low risk. | |

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| | | Clearly, the current risk identification system was not appropriately identifying individuals at risk, or providing an objective measure of the level of that risk. Because risks were not even being properly identified, they were also not being properly addressed. | |
| I2 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk. | As noted above, the Facility's risk screening tools were inadequate in identifying individuals' clinical risks indicators. Without an adequate system to identify individuals' risk indicators, the appropriate assessments had not been completed. Once an appropriate system is developed and implemented, the Facility must develop and implement appropriate assessment tools to perform initial interdisciplinary assessments of services and supports for these individuals, and re-assessments in response to changes as measured by established at-risk criteria, according to the required timeframes set in the SA. | |
| I3 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring. | As stated previously, the Facility did not have the underlying screening and assessment processes in place that are necessary for implementation of this provision. It is concerning that staff at LBSSLC candidly agreed with the deficits of the risk system, but were implementing the system reportedly because State Office had directed the use of the system. At the time of this review, there had been no update or modification made to the Plan of Implementation addressing the risk system.<br><br>From review of the Health Risk Assessment Rating Tools, the Quarterly Medical Doctor (MD) Progress Notes for HSM (Health Status Meeting), and the Meeting Participants and Health Status Statement forms for 18 individuals from 3/18/2010, the section "Healthcare Provider's Review Statement and signature" was blank for all of the 18 individuals. In addition, there were generally no recommendations provided by the team for any of the individuals, including those who had health risk indicators assigned at the highest risk level. Consequently, there was no documentation indicating that the Health Status Team had made any recommendations as a function of the Health Status Meeting for individuals experiencing health risks. Although team members at the HSM expressed some recommendations, they were not being documented, communicated to the appropriate Personal Support Teams, or tracked to ensure that they were actually being addressed and implemented. From observation of the Health Status Team meeting and review of the documentation generated from that meeting, there was no indication that | |

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| | | the Health Status Team had any effect on clinical outcomes for individuals. | |

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

1. The State should consider identifying and implementing standardized tools to be used by all the Facilities in assessing and documenting clinical indicators of risk. These standardized tools should be selected based on their reliability and validity, as well as their ability to provide a weighted score, and meaningful clinical information to allow teams to identify objectively individuals' level of risk in the appropriate clinical areas.
2. In addition, there is a variety of information available from which to identify individuals who are potentially at risk, such as incident management data. The policies and procedures for a risk management system should draw together the various risk assessment instruments and procedures into one process that can reliably identify individuals whose health or well-being are at risk, and to address their needs.
3. The Facility should develop and implement interdisciplinary assessments of services and supports for the individuals identified as at risk, and in response to changes as measured by established at-risk criteria, according to the required timeframes set forth in the Settlement Agreement.
4. As required by the SA, for each individual assessed, the Facility should establish and implement a plan within fourteen days of the plan's finalization, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk. More immediate action should be taken when the risk to the individual warrants. Such plans should be integrated into the PSP, and should include the clinical indicators to be monitored and the frequency of monitoring.
5. The Health Status Team meeting format should be redesigned to ensure that appropriate criteria and structure are in place to assist the teams in accurately determining risk levels. The assignment of such risk levels should result in the teams identifying an associated level of intensity of clinical supports to address the risks, as well as proactive measures aimed at preventing risks.
6. The HST process must be coordinated with the Nutritional Management Team process, so that the two groups work in an integrated fashion to identify and address individuals' risk.

| **SECTION J: Psychiatric Care and Services** | |
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| 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:<br>▪ **Review of Following Documents**:<br>o Dental/Medical Sedation and Restraint, dated 11/14/10;<br>o Dental Sedation/NPO [Nothing by Mouth] for appointment, dated 03/01/08;<br>o Quality Assurance Review of Dental Services, dated 10/30/09, prepared by Jeremy Ellis, RN, BSN;<br>o Example of completed Quarterly Psychoactive Medication Review Form, dated 01/07/10;<br>o Blank copies of the following Psychiatric Forms:<br>a. Atypical Antipsychotic Monitoring;<br>b. Dyskinesia Identification System: Condensed User Scale (DISCUS);<br>c. Monitoring of Side Effects Scale (MOSES);<br>d. Personal Support Team Participants;<br>e. Psychiatric Assessment;<br>f. Psychiatric Consultation Report;<br>g. Psychiatric Summary;<br>h. Psycho-Social Modalities;<br>i. Quarterly Psycho-Active Medication Review;<br>j. Review of Reiss Screen; and<br>k. Unusual Incident Report;<br>o Positive Behavior Supports – Psychiatric Assessment, dated 09/01/08;<br>o Positive Behavior Support – Psychological Evaluations and Updates, dated 1/21/10;<br>o Positive Behavior Supports Prescribing Psychotropic Medication, dated 10/27/08;<br>o Psychiatric Clinic Procedures, not dated;<br>o Example of Dr. Weddige's schedule, week of 2/22/10 through 2/28/10;<br>o Alphabetical List of all Persons Served on Psychoactive Medications, revised 2/02/10;<br>o Job Description for Psychiatry Assistant, not dated;<br>o List of Individuals Currently Prescribed Anticholingergic Medication and Duration (most recent start date 1/22/10);<br>o List of Individuals with Probable Tardive Dyskinesis, not dated;<br>o List of Individuals with Human Rights Committee-Approved Dental/Medical Restraint/Sedation, not dated;<br>o List of Meetings/Rounds attended by the Psychiatrist, not dated;<br>o Job Description of Psychiatrist, not dated;<br>o Curriculum Vitae of Richard L. Weddige, M.D., not dated;<br>o Curriculum Vitae of Richard Orr, M.D., not dated;<br>o Texas Medical Board Certification/Physician Profile of Richard Orr, M.D., dated 2/16/10;<br>o The following statement, which was not dated: "There have been no complaints about psychiatric and medical care made by any party to facility since July 1, 2009;"<br>o List of Individuals Prescribed Benzodiazepines, scanned 2/17/10; |

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| | o List of Individuals Prescribed Intra-Class Polypharmacy, not dated;<br>o Monthly Facility Review Psychoactive Medication Polypharmacy, dated 1/26/09 (this may be an error; the date likely should be "1-26-10," as the review includes 2010 dates);<br>o Monitoring Data Submission Spreadsheet, scanned 2/22/10;<br>o A Complete Listing of all Individuals who had been Evaluated with the Reiss Screen for Maladaptive Behavior, dated 03/06/09. The list also included the date the screening was completed, as well as the staff members involved;<br>o The Monthly Facility Review of Psychoactive Medication Polypharmacy Reports covering the time period from 08/26/08 through 2/23/10;<br>o List of Victims of Peer-to-Peer Aggression with Frequency and Type of Injury from 7/09 through 2/10;<br>o List of Individuals Receiving Three or More Psychotropic Medications from 11/10/09 through 2/10/10, prepared by Tammy Marshall, Program Compliance Coordinator;<br>o Quarterly Analysis of Psychiatric Assessments and other Aspects of Psychiatric Treatment, (from 10/09 through 12/09), prepared by Tammy Marshall, Program Compliance Monitor, dated 1/14/10;<br>o Quarterly Analysis of Psychology Assessments and Support Plans (from 10/09 through 12/09), prepared by Tammy Marshall, Program Compliance Monitor, dated 1/11/10;<br>o Quarterly Analysis of Behavioral Medical and Dental Restraints (First Quarter Fiscal Year 2010), prepared by Tammy Marshall, Program Compliance Monitor, dated 2/04/10;<br>o A table entitled, "Comparative on Polypharmacy," which provided frequencies for the following time points: 6/05, 9/08, 9/09, and 3/10 for the following:<br>a. Individuals on one psychotropic medication;<br>b. Individuals on two psychotropic medication;<br>c. Individuals on three psychotropic medication;<br>d. Individuals on four psychotropic medication;<br>e. Individuals on five psychotropic medication;<br>f. Individuals on six psychotropic medication;<br>g. Individuals on two antipsychotic medications;<br>h. Individuals on two or more mood stabilizers;<br>i. Individuals on two antidepressants;<br>j. Individuals receiving benzodiazepines;<br>k. Individuals on conventional antipsychotics;<br>l. Individuals on Mellaril; and<br>m. Individuals on Atarax;<br>o The medical records of the following individuals who receive psychotropic medication were reviewed on site: Individual #264, Individual #322, Individual #134, Individual #132, Individual #60, Individual #206, Individual #26, Individual #220, Individual #51, Individual #137, Individual #82, Individual #159, Individual #155, Individual #233, Individual #34, and Individual #116.<br>o Based on the initial on-site reviews, a number of individual records were selected for which relevant sections of their records were requested for off-site review. The list of individuals |

for further review was derived from lists of individuals who were either receiving multiple psychotropic medications, had high frequencies of restraint, and/or had high levels of aggression and/or self-injurious behavior (SIB). The following 24 (20% of individuals receiving psychotropic medication) were selected for a more detailed off-site review: Individual #26, Individual #239, Individual #107, Individual #266, Individual #322, Individual #159, Individual #82, Individual #137, Individual #113, Individual #245, Individual #233, Individual #220, Individual #50, Individual #33, Individual #82, Individual #34, Individual #60, Individual #111, Individual #106, Individual #288, Individual #242, Individual #116, Individual #58, and Individual #310.

- **Interviews with**:
  - Richard Weddige, M.D., Staff Psychiatrist, on 3/16/10;
  - Dr. James Forbes, Director of Behavioral Services, on 3/17/10;
  - During a 3/18/10 tour of the residential units, Psychology staff members from the following units:
    a. 528 N. Cedar: Teresa Balawejder, Behavior Analyst
    b. 518 S. Cedar: Philip Kite, Psychologist
    c. 515 South Cedar: Carolyn Milton, Behavior Analyst; and
  - Attendance at the Psychiatric Clinic on 3/17/10 (see below)
- **Observations of**:
  - During a tour of the residential living units at the LBSSLC, which was facilitated by Ms. Marilyn Foster, the reviewer observed the following individuals who were identified as receiving psychotropic medication in the 02-02-10 document entitled, "Alphabetical List of all Persons Serviced on Psychoactive Medications:" Individual #251, Individual #304, Individual #167, Individual #45, Individual #68, Individual #160, Individual #280, Individual #66, Individual #277, Individual #70, Individual #146, Individual #183, Individual #113, Individual #58, Individual #26, Individual #318, Individual #206, Individual #126, Individual #184, Individual #310, Individual #8, Individual #11, Individual #197, Individual #268, Individual #233, Individual #322, Individual #35, Individual #315, Individual #230, Individual #114, Individual #137, Individual #109, Individual #118, Individual #259, Individual #147, Individual #111, Individual #257, Individual #116, Individual #193, Individual #309, Individual #161, Individual #174, Individual #306, Individual #239, Individual #107, Individual #284, Individual #255, Individual #65, Individual #165, and Individual #276.
  - Six individuals also were observed in the context of the 3/17/10 Neurology Clinic. The following individuals had both a seizure disorder and a psychiatric disorder: Individual #243, Individual #73, Individual #240, Individual #314, Individual #190, Individual #299.
  - Psychiatric Clinic Assessment for Individual #134.

**Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports.

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| | **Summary of Monitor's Assessment:** The Psychiatry Department at the LBSSLC had a strong foundation. The Staff Psychiatrist, was certified by the American Board of Psychiatry and Medicine, and had a long career in academic psychiatry at the Texas Tech University Health Sciences Center, Department of Psychiatry. He had worked full-time at the LBSSLC for nine years.<br><br>The Staff Psychiatrist was optimistic that the Facility would be able to hire another full-time psychiatrist who had extensive experience in the Texas mental health system. Two full-time psychiatrists should be adequate, as the 2/2/10 listing of individuals receiving psychoactive medication indicated that there were 120 individuals receiving psychoactive medication at that time.<br><br>There was monitoring for psychoactive medication side effects, with regular administration of the MOSES, DISCUSS, laboratory testing, for metabolic side effects of the second generation, antipsychotic agents (SGAs), regular assessment of medication blood levels, and electro-cardiograms when indicated. The communication between the Departments of Psychiatry, Medicine, Psychology, and Neurology was impressive. The Staff Psychiatrist's assessment and ongoing consultation notes were detailed and met established clinical criteria. He also had the capability of consulting on individuals daily, or two-to-three times a week, if they were experiencing a psychiatric deterioration. There also was documentation indicating that he had, on occasion, sought second opinions from other psychiatrists in the community.<br><br>The Facility had made consistent significant progress in reducing polypharmacy with psychoactive medication since 2005, although there continued to be a number of individuals who were receiving multiple psychoactive agents.<br><br>The areas that required improvement were related to the following issues: The diagnosis of either Intermittent Explosive Disorder or Impulse Control Disorder was utilized for 30% of the individuals receiving psychotropic medication, and the diagnosis of Stereotypic Movement Disorder with SIB was the psychiatric diagnosis for 15 individuals (12.5%). These diagnoses were problematic because they did not provide a great deal of etiological specificity, which could be utilized to justify the administration or selection of specific psychotropic medication. The behavior profiles that corresponded to these diagnoses could often be present on a learned or environmental basis.<br><br>As is detailed in the sections of this report that address Sections J.9 and J.13 of the SA, there were concerns about the classification of specific behaviors as being both symptoms of a psychiatric disorder, and being present on a learned or operant basis. Other concerns were related to the degree to which the efficacy of the psychoactive medication had not been empirically established, and the narrative sections of psychiatric reports related to weighing the risks and benefits of psychoactive medication being extremely general in nature, often using terminology that was nearly identical in many of the records. An additional concern was the ongoing use of restraint, and relatively high levels of peer-to-peer aggression at LBSSLC, which would suggest that the psychoactive medications prescribed for those individuals with a psychiatric disorder were ineffective, that individuals' Behavior Support Plans were ineffective, and/or there were not enough trained staff members to implement them. |

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| J1 | Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals. | Dr. Richard Weddige, the Staff Psychiatrist, was Board Certified in Psychiatry by the American Board of Psychiatry and Neurology. He served on the Faculty of Texas Tech University Health Sciences Center School of Medicine, Department of Psychiatry, full-time for 27 years. He retired in 2001. Following his retirement from the Faculty, he began consulting to the Lubbock State Supported Living Center on a part-time basis, and had been full-time at the Facility for the last nine years. There was also currently a locum tenens psychiatrist, Dr. Richard Orr, who was at the LBSSLC on a three-month contract. Review of Dr. Orr's Curriculum Vitae indicated that he was not certified by the American Board of Psychiatry and Neurology.<br><br>The Staff Psychiatrist estimated that over the past two years, they had had a locum tenens psychiatrist on site for a total of nine months (approximately). He did not assign the locum tenens psychiatrist a specific caseload, but instead assigned specific tasks, such as emergency consults and annual assessments. Thus, the Staff Psychiatrist remained involved with all of the cases, both when a locum tenens psychiatrist was present, as well as when they did not have one on campus.<br><br>During a 3/16/10 interview with the Staff Psychiatrist, he also indicated that he was fairly confident that LBSSLC would be able to hire another full-time psychiatrist who had several years experience in the mental health hospital system in Texas. At the time of the review, the current number of individuals receiving psychotropic medication at the LBSSLC was approximately 120. Thus, the caseload for each would be 60, which should be manageable. | |
| 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. | During a 3/16/10 interview with the Staff Psychiatrist, he indicated that every 30 days, he prepared a Psychiatric Review of every individual receiving psychotropic medication. The sources for these reviews were the Monthly Data Sheets, his Consultation Notes, and his personal notes on each individual. These Psychiatric Reviews were produced monthly by dictation, which was then transcribed. He had also compiled a three-by-five-inch note card for each individual, which contained the most salient information. These were updated whenever changes occur.<br><br>The Staff Psychiatrist also prepared Quarterly Psychiatric Review Notes on every individual receiving psychotropic medication. These were prepared to coincide with the individual's 90-day Quarterly Health Status Committee Meeting, which were conducted in the dining room of the individual's residence. During the month in which an individual's 90-day review was completed, a monthly review was not done for that individual. He also manually completed the Quarterly Worksheet of relevant lab values for each individual undergoing these reviews. (The format of these meetings is discussed | |

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| | | in detail in the Medical Review section of this report.)<br><br>An Annual Psychiatric Assessment also was prepared every year for all individuals at LBSSLC receiving psychotropic medication. These Annual Assessments were held in the Clinic Building, and also were attended by the Nurse Case Manager, the QRMP, the Residential Coordinator, the Psychologist assigned to the individual, and representatives of the Direct Support Professionals.<br><br>The Staff Psychiatrist indicated that he received several phone calls a week, and performed STAT (immediately or without delay) assessments of individuals having difficulties, either in the residence or in the Clinic Building. He generated a separate note for each of these encounters. The Staff Psychiatrist saw individuals who were in crisis on a daily basis, or two-to-three times per week. The documentation of these more urgent consults consisted of a handwritten note in the individual's record, which was followed by a dictated note.<br><br>There were occasions when an individual required psychiatric hospitalization, due to the danger they presented to self or others. These admissions were usually to the Big Springs State Hospital, or the Crisis Stabilization Unit at Sunrise Canyon.<br><br>There was evidence of the Annual, Quarterly, and Monthly Notes in all of the records reviewed of individuals who were receiving psychotropic medications. These were located in the Psychiatry Section of the Medical Record. There also were notes related to STAT or urgent visits in a number of individual records. These usually appeared in the Integrated Progress Notes section of the Medical Record, and there also at time was a subsequent entry in the Psychiatry section of the record. | |
| 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. | A major component of this requirement relates to the non-specific use of psychotropic medication to manage disruptive behaviors in the absence of an active Behavior Support Plan, or as punishment. All of the records reviewed indicated that individuals receiving psychotropic medication did have active Behavior Support Plans. The quality of such BSPs is discussed in further detail in the section of this report that addresses Section K of the SA.<br><br>The use of psychotropic medication as punishment is more difficult to discern than may initially be apparent. No instances were witnessed or revealed through record review of the obvious use of psychotropic medication as a punishment. For example, to the extent that an intramuscular (IM) injection of psychotropic medication is administered to an individual after a physical assault on a peer or staff member, without a clear indication that another assault is likely to occur in the next several minutes to a few hours, the IM injection could be considered to be a reactive application of an aversive stimuli. No | |

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| | | examples of this were found. The records reviewed indicated that the Staff Psychiatrist usually responded to an acute exacerbation of aggressive behavior, SIB, or extreme agitation with either an oral STAT medication or a sublingual medication, such as Zydis. These appeared to be appropriate uses of medication to address the immediate needs of the individual, and would not be considered punishment.<br><br>With regard to psychotropic medications not being used in the absence of a psychiatric or neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis, this is discussed in further detail below with regard to Section J.6 of the SA. | |
| 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. | It appeared that for some individuals the LBSSLC interdisciplinary teams had implemented strategies to replace the routine use of pre-sedation medication prior to dental procedures with psychological strategies to desensitize the individual to the procedure. There were some discrepancies between information provided during interviews with staff, and Facility quality assurance data.<br><br>On 3/18/10, during an interview with the Director of Dental Services at the LBSSLC, he estimated that currently approximately 75% of the individuals that were seen in the Dental Clinic had a desensitization program in place; 50% received a pharmacological pre-visit dose of medication [usually Ativan two milligrams (mg)] to accomplish the visit; and 25% were able to participate in the dental procedures without any behavior or pharmacological supports. The total of the percentages exceeds 100%, as many of those with desensitization programs still required the assistance of a pre-appointment dose of Ativan. The desensitization plan was individualized. However, the usual outline for these plans consisted of the following steps:<br>1. The individual visited the Dental Office until they felt comfortable with coming to the office.<br>2. The next step involved entering into the Dental Exam Room until it no longer produced anxiety.<br>3. Once the individual was comfortable the Exam Room, they were asked to sit in the dental examination chair.<br>4. After the individual was comfortable in the dental chair, the next step was to have the dental hygienist stand over them.<br>5. The final steps in the process involved the dentist also standing over the individual in the chair, and then beginning to gently probe into their mouth.<br><br>The Director of Dental Services indicated that after he became the Facility dentist, he organized a major remodeling of the Dental Clinic, to make it seem less intimidating. This remodeling included a lighted, overhead, translucent painting of a relaxing outdoor scene, which was strategically placed over the dental chair in an effort to distract and | |

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| | | comfort the individual. The Director of Dental Services did not use mechanical restraints.<br><br>The Quality Assurance Review of Dental Services, dated 10/30/09, reviewed a random sample of five individuals for evidence of desensitization plans in the PSP and noted: "Desensitization plans for the three individuals identified are either non-existent or do not have specific goals listed to show progress or when to discontinue the plan," and arrived at a compliance rate of 40%. Thus, there was a discrepancy between this report and the estimate of the Director of Dental Services.<br><br>LBSSLC utilized the services of a dental anesthetist to complete the necessary procedures for those individuals for whom the desensitization program and/or the usual pre-medication was ineffective. This process was reviewed with the Director of Dental Services in some detail, as in some states/jurisdictions, this degree of anesthesia would not be administered at the Facility, but would instead be performed in a hospital setting, with an anesthesiologist present. The following provides additional information about this process.<br><br>The Director of Dental Services began by noting that the dentist who performed the anesthesia had an additional two years of Residency Training devoted to this activity. The dental anesthetist would usually begin with a combination of inhaled Nitrous Oxide and Sevoflurane to relax the individual before administering the intravenous (IV) medication, which usually consisted of a combination of Ketamine, Versed, and Propoful. The clinical selection criteria were that the individual not be over 63 years of age, and not have any significant respiratory disease. The dentist administering the anesthesia performed his own physical exam first. Throughout the procedure the individual's oxygen saturation was monitored, as were the blood pressure and pulse. A three-lead EKG was also in place for continuous monitoring, and the individual was intubated through the nose. The dentist who administered anesthesia came to LBSSLC two to three times per month for a full day. Five procedures usually were completed in one day, with an average duration of one and one-half to two hours. The maximum length of time was three hours. The dentist administering the anesthesia attended only to the anesthesia, while the Director of Dental Services completed the dental work. They had been using this system for the last two years. When asked about the threshold for aborting a procedure, the Director of Dental Services indicated that he is conservative, and will stop the procedure if he is concerned about it. Specifically, he described a recent attempt to use anesthesia on Individual #239, which was aborted when he began to cough during the inhalation phase. That individual later went on to develop pneumonia. However, Director of Dental Services did not believe this was because of the aborted dental procedure, but rather that the individual could not tolerate the anesthesia, as he was already developing pneumonia. There was oxygen available in the Dental Suite, and the Director of Dental Services was able to turn it on. | |

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| | | In completing additional research regarding generally accepted standards, the reviewer learned that this practice is recognized, but in most states, there is not a separate license apart from the general license to practice dentistry. The comfort level regarding the utilization of anesthesia outside of a hospital, with an anesthesiologist present, varies depending on the individual dentist. The primary concerns being the underlying health of the individual and the duration of the procedure. No compelling evidence was identified that would indicate that the procedure, as it is administered at the LBSSLC, violates any accepted standard of care. It is recommended, though, that the Facility dentist continue to monitor the clinical outcomes with particular attention paid to those individuals for whom the procedure is aborted due to a deterioration of their clinical status, as well as individuals who develop pneumonia within two weeks of the procedure. | |
| J5 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement. | As indicated above with regard to Section J.1 of the SA, at the time of the review, LBSSLC employed one full-time Psychiatrist, and had another full-time Psychiatrist present who was on a three-month locum tenens assignment.<br><br>During a 3/16/10 interview with the Staff Psychiatrist, he estimated that, over the past two years, they had used approximately nine months of locum tenens psychiatry services. There were approximately 120 individuals receiving psychotropic medication according to the 2/2/10 list of such individuals. The Staff Psychiatrist did not assign a caseload to the locum tenens psychiatrist, but rather assigned certain specific functions. The Staff Psychiatrist also indicated that he and the administration were reasonably confident that they would be able to hire another experienced psychiatrist who was familiar with the Texas mental health system. The acquisition of this psychiatrist would result in caseloads of approximately 60 individuals for each psychiatrist, which would be a manageable number of individuals to follow. | |
| J6 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B. | At the time of the review, LBSSLC relied upon the Staff Psychiatrist's psychiatric assessment, diagnosis, and case formulation, although he also appeared to consult with Psychology staff. Review of his individual psychiatric assessments indicated that the initial assessments were thorough and contained all of the sections that would usually be contained in an initial note, including: recent history, past history, family history, medical history/status, substance abuse history, developmental and social histories, mental status examinations, psychiatric diagnosis with formulation, and a Treatment Plan related to the diagnosis. This was consistent with Appendix B of the SA.<br><br>The Staff Psychiatrist had access to community psychiatrists from whom he could obtain a second opinion. There was documentation indicating that he had obtained a second opinion for Individual #288, and Individual #26. | |

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| | | On 3/17/10, the reviewer observed a Psychiatric Consultation in the Clinic Building concerning Individual #134. The meeting had been scheduled secondary to two recent episodes of aggression. He had been admitted to LBSSLC approximately thirty days prior to the review. The Behavior Analyst, as well as the Residential Coordinator, the RN Case Manager, the QRMP, and direct support professionals were in attendance.<br><br>There was an extensive review of the recent, past, and developmental history, as well as his medical history and current status. The psychotropic medications that he had been prescribed prior to his admission, which were continued after his admission, were as follows: Seroquel 50mg BID (twice a day); Zoloft 100mg QAM (every morning); Trazodone 100mg TID (three times a day); and Depakote 500mg TID. His residence prior to admission also had a PRN (as needed) Order for Zyprexa. His history also included a psychiatric hospitalization one month prior. There was a discussion of his relationship with his family, as well as his interpersonal relationships on the Unit. The Staff Psychiatrist's interview with the individual was both empathic and thorough.<br><br>After the interview, Individual #134 returned to his Unit, and the Staff Psychiatrist continued to discuss the issues with the staff. Although the consultation was precipitated by recent episodes of aggression, the Staff Psychiatrist noted that he seemed lethargic and staff had commented on this as well. He also questioned whether he was psychotic, and outlined a plan to taper the Seroquel and then, pending the results of that, begin to taper the Trazodone. | |
| 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 | The Reiss Screen was designed to identify individuals for whom a formal psychiatric assessment should be considered, based on the results. It was not intended to replace a formal psychiatric assessment. During an interview with the Staff Psychiatrist, he indicated that the Reiss Screen had been used at LBSSLC to identify individuals who had not had a psychiatric assessment, but might benefit from such an assessment. When asked about his thoughts concerning the reliability of the Reiss Screen based on this experience, his response was that it seemed to have a good reliability as a screening instrument.<br><br>He also noted that the administration of the Reiss Screen had identified individuals who then underwent a psychiatric assessment. Thus, it would not appear in the records of individuals who already had a psychiatric assessment, or were admitted with an established psychiatric diagnosis. Because the method used by the reviewer to select individual records for review primarily focused on those individuals receiving psychotropic medication, and/or whose names appeared on other lists, such as utilization of physical or chemical restraint, it was unlikely that individuals selected would have a Reiss Screen, unless the screening process led to a subsequent psychiatric | |

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| | diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner. | assessment and the utilization of psychotropic medication. During future reviews, a sample of records will be selected of individuals for whom a Reiss Screen has been conducted.<br><br>As noted in the list of documents reviewed, comprehensive documentation was submitted with regard to the administration of the Reiss Screen, and the staff members involved with this process. This documentation showed ongoing administration of this screening instrument. Specifically, the spreadsheet dated 3/6/09, entitled, "Reiss Screen for Maladaptive Behaviors" listed 110 individuals who had been administered the Reiss Screen from 3/7/08 through 6/10/09. Given that there are approximately 120 individuals receiving psychotropic medication, this would indicate that virtually the entire population of LBSSLC had had either a psychiatric assessment, or has been administered the Reiss Screen. The Reiss Screen was noted in the records of the following individuals who were not receiving psychotropic medication: Individual #132, Individual #155, and Individual #135. | |
| 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. | Based on interview and observation there appeared to be a close working relationship between the Psychiatry and Psychology Departments. The Staff Psychiatrist relied on the Psychology Staff for both data that relates to the behaviors that are thought to be responsive to psychotropic medication, as well as the impact of environmental and interpersonal factors that may be effecting the individual's behavioral presentation.<br><br>The interactions between the Staff Psychiatrist, and the Behavior Analyst at the Psychiatry Clinic on 3/17/10, and the Health-Risk Status Meeting at 516 S. Cedar on 3/18/10, indicated that he both sought and respected her opinion. Specifically, he was interested in her assessments of the individuals' clinical status, as well as environmental and behavioral contributions to the individuals' overt maladaptive behavior. During this initial review, there was not the opportunity to observe the Staff Psychiatrist's interactions with other members of the Psychology staff, but these initial impressions were very positive. Additional information related to the impact that this collaboration has had on the treatment provided to individuals is discussed in further detail below with regard to Section J9 of the SA. | |
| 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 | This provision relates to the clinical evidence of the collaboration between Psychiatry and Psychology. To determine the Facility's status with regard to this requirement, the Psychiatry section of the individual records included in the sample were examined, as well as the Human Rights Review section, and the sections related to the provision of behavior services, such as the positive behavior support plan (PBSP), and the functional analysis. Specifically, the review was designed to ascertain the degree to which a given monitored behavior was identified as both a learned behavior subject to behavioral change, and a target behavior to determine the efficacy of psychotropic medication. The | |

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| | and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible. | rationale for this assessment is that if the identified behavior is a symptom of an established Axis I psychiatric disorder, it would most likely not be amenable to behavior change techniques. Conversely, those behaviors that are identified in the functional analysis as being present on an operant basis would be inappropriate targets for psychotropic medication. The existence of the same behavior in both categories should prompt a discussion as to the rationale for its appearance in both categories. Based on detailed review of the sample of records, there was co-existence of the same behavior in both categories in 16 (66%) of the 24 records. The records that did <u>not</u> have the co-existence of the same behavior in both categories were as follows: Individual #26, Individual #113, Individual #159, Individual #233, Individual #54, Individual #242, Individual #50, and Individual #82.<br><br>A statistical analysis was not performed related to the individual factors that characterize the individuals for whom behaviors were designated as both target behaviors of psychotropic medication, and also were identified in the functional analysis as being present on a behavioral-operant basis. However, gross inspection of the data suggested that this overlap was more apt to occur in individuals who were functioning in the Severe to Profound Range of intellectual disability, and also had a diagnosis of an Autism Spectrum Disorder, such as Pervasive Developmental Disorder. Those individuals for whom this overlap in the categorization of their overt behaviors did not occur were much more likely to function in the Mild-to-Borderline Range of intellectual disability, and to have a discreet Axis I psychiatric disorder (such as Schizophrenia or Bipolar Disorder), and there were clear examples of recorded behaviors related to the underlying psychiatric disorder, as illustrated by the three examples (in italics) below.<br><br>The following excerpt from the "HRC Review of BSP," dated 2/11/09, pertains to Individual #159:<br><br>"*PSYCHIATRIC MEDICATION:*<br><br><u>Psychoactive Medication(s)</u>*: Clozaril (currently being tapered with intent to discontinue), Desyrel, Zyprexa, and Lamictal*<br><br><u>Diagnosis and Symptoms</u>*: [Individual #159] has Axis I diagnosis of Posttraumatic Stress Disorder and Axis II diagnoses of Mild Mental Retardation and Borderline Personality Disorder, Symptoms of these disorders include flashbacks & nightmares related to traumatic events, not being able to control her behavior when experiencing emotions such as anger, fear, or frustration and exhibited as hitting, kicking, biting herself or other, scratching herself or others, head-banging, and displaying disproportional anger for the situation.* | |

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| | | *Target Variable(s) or Marker(s) Being Tracked for Each Medication: Desyrel is used to help decrease bouts of insomnia related to her diagnosis of Posttraumatic Stress Disorder (PTSD). Zyprexa is an antipsychotic to help with her impulsivity as displayed by aggression, SIB, and Instigating Conflict. Lamictal is an anticonvulsant/mood stabilizer to help with her impulsivity as displayed by aggression, SIB, and Instigating Conflict.*"<br><br>The following excerpt from the "Positive Behavior Support Plan," dated 3/15/10, pertains to Individual #113:<br><br>"*Relationship of Plan and Fundamental Outcomes: The fundamental outcomes for [Individual #113] are to be free of Bipolar I symptoms and to increase his independence by learning to perform necessary living skills. This plan supports the medications Lithium and Zyprexa to alleviate/reduce the symptoms of Mania and Depression and incorporates training techniques that have been demonstrated to be effective by the science of behavior analysis. These techniques will be utilized to teach him new behavior chains and to supplement existing behavior chains. Through this acquisition training he will become more independent of staff assistance and thereby will exist in a less restrictive environment.*"<br><br>In summary, there is a need to identify how the behaviors that are identified as symptoms of the diagnosed psychiatric disorder derive from that diagnosis. This is often already clear for individuals who have a Bipolar Disorder or Psychotic Disorder, but it is less clear for individuals with severe intellectual deficits and Autism Spectrum Disorders. This need not be an overly burdensome process, as once the connection is established and documented, it can simply be carried forward in the record, unless there is a new development. It is likely that for many of these individuals, the clinicians already have developed a hypothesis about this connection, but this has not been documented.<br><br>To the extent that a given behavior is described as being both a symptom of a psychiatric disorder and being present on a learned or behaviorally determined basis, there should be a discussion documented that explains the rationale for the dual classification. For example, there might be a distinction between aggression, which appears to relate to a hallucinatory perception, as opposed to aggression that occurs in demand situations. | |
| 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 | Risk-benefit analysis as it relates to the use of psychotropic medication in individuals with developmental disabilities involves a number of inter-related steps. The first of these steps is to assess the *severity* of the behavioral symptoms of the psychiatric disorder in terms of physical harm to the individual or others, and/or the psychological suffering of the individual if the manifestations of the psychiatric illness are untreated. Second, this risk of physical harm is then weighed against the side effect profile of the proposed psychotropic medication. This discussion should include not only the potential | |

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| | 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. | side effects, but also the probability of the occurrence of those side effects. The third element in this assessment relates to the likelihood that the proposed medication will be effective in diminishing the physical harm produced by the behavioral symptoms of the psychiatric disorder that the medication is intended to address.<br><br>In simpler terms, the clinical maxims "The cure should not be worse than the disease," and "First of all, do no harm" describe the purpose of risk-benefit analysis as it relates to the use of psychotropic medication for individuals with intellectual disabilities. In the LBSSLC records reviewed, the risk-benefit considerations with regard to the use of psychotropic medication primarily appeared in the Human Rights section of the record. The risks of the psychotropic medications were usually put forth in very general terms, and the benefits were described as decreasing the maladaptive behaviors, as illustrated in the following representative example from the "HRC Review of BSP," dated 02/04/09, which pertained to Individual #111:<br><br>"*RISK VS. RISK ANALYSIS*<br><br>*The risks and benefits of the procedures of this plan have been analyzed by the Personal Support Team in order that this approach has the highest potential for improving quality of life while minimizing risks to the greatest extent possible.*<br><br>*Potential Risks/Discomfort: The behavioral procedures included in this plan do not pose any significant risk to [Individual #111] and do not restrict his rights. Possible side effects of Seroquel (quetiapine) include dizziness, headache, prolonged drowsiness, low white blood count (causing high risk for infections), weight gain, or Tardive Dyskinesia caused by long-term use of antipsychotic medication. Repetitive and involuntary movements characterize Tardive Dyskinesia (i.e., grimacing, tongue protrusion, lip smacking puckering and rapid eye blinking, rapid movements of the arms, legs and trunk may occur).*<br><br>*Benefits: Benefits of this Plan are reflected in the Relationship of Plan and Fundamental Objectives section.*<br><br>*Risks of Not Providing this Treatment: Failure to provide this treatment could result in continued and increased SIB. Choosing not to use Seroquel could result in increased symptoms of Stereotypic Movement Disorder with SIB, resulting in decreased quality of life for [Individual #111]. Failure to provide treatment would result in him experiencing continued difficulty in benefiting from vocational, training, and leisure activities.*<br><br>*Determination by Personal Support Team: The possible risks of not providing the treatment outweigh the potential risks associated with the interventions incorporated in this plan. Should conditions change and the converse occurs, the Personal Support Team* | |

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| | | *will meet and develop alternative strategies.*"<br><br>This terminology, or terminology that was very similar, occurred in all of the records reviewed. No discussion was found of the probability that the medication would be effective in reducing the frequency and intensity of the identified target behaviors, although the terminology cited above would suggest that the medication would be virtually 100 percent effective.<br><br>An example of a risk-benefit analysis that provided somewhat more specific information was contained in the following excerpt that was taken from the "HRC Review of BSP," dated 08-19-09, for Individual #137.<br><br>"*RISK VS. RISK ANALYSIS*<br><br>*<u>Risks/Discomfort</u>: [Individual #137] may experience some distress when encouraged to move away from peers. No other risks or discomforts are believed to result from the behavioral procedures of the plan. [Individual #137] may experience the following side effects: Seroquel – dizziness, headache, prolonged drowsiness, low white blood count (causing high risk for infections), and weight gain. Tegretol – drowsiness, dizziness, dry mouth, nausea, vomiting, diarrhea, decreased appetite, excessive sweating, high blood pressure, and blurred vision.*<br><br>*<u>Benefits</u>: These procedures will promote the safety of [Individual #137] and others. The use of Seroquel and Tegretol is believed to have resulted in decreases in the intensity and frequency of aggression without any identified side effects. The use of these procedures should allow greater participation in training and leisure activities. These procedures should enhance [Individual #137's] quality of life.*<br><br>*<u>Risks of Not Providing this Treatment</u>: Lack of treatment could result in increased aggression, agitated behavior, and crying. Failure to provide treatment could result in [Individual #137] experiencing increased discomfort as the symptoms of his Bipolar Disorder NOS worsen.*<br><br>*<u>Determination by Personal Support Team</u>: The possible risks of not providing the treatment outweigh the potential risks associated with the interventions incorporated in this plan. Should conditions change and the converse occur, the Personal Support Team will meet and develop alternative strategies.*" | |
| J11 | Commencing within six months of the Effective Date hereof and with full implementation within one | This provision relates to the degree of inter-class and intra-class polypharmacy, as well as the attempts to reduce polypharmacy. | |

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| | 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. | During an interview with the Staff Psychiatrist, he provided a record that illustrated the yearly reductions in the rates of polypharamcy, dating back to 2005. The data clearly showed a consistent, marked reduction in the rates of polypharmacy. Review of individuals' records also showed evidence of the monthly polypharmacy reviews. Despite this ongoing effort to decrease the use of multiple psychoactive medications, there were still several individuals who continued to receive three or more medications.<br><br>In Section J.13 below, issues are addressed that directly contribute to polypharmacy with psychotropic medication. Specifically, the recommendations with regard to the importance of documenting the efficacy of each individual medication with pre and post-behavioral data should make it much easier to identify those medications that an individual is receiving which can be targeted for tapering strategies based on the lack of empirical proof of their value. This process also will ensure that if an individual is receiving more than one psychotropic agent that the use of each agent has been validated. | |
| 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. | The records reviewed indicated that the Monitoring of Side Effects Scale (MOSES) and Dyskinesia Identification System: Condensed User Scale (DISCUS) was being performed for 100% of the sample for at least the last two years. The interval between the documentation of administration of these instruments in the 24 records reviewed ranged from three to six months. There were some longer gaps between the documentation of administration of the instruments. However, in those cases, there was a discrepancy between the date listed for the last exam on a current evaluation, and the date of the most proximal evaluation form in the record. Thus, it is conceivable that the records were missing some documents, which would explain the appearance of longer gaps in administration.<br><br>The Staff Psychiatrist indicated that nursing staff perform the MOSES, and the Psychiatric Assistant performs the DISCUS. Initially, there was concern that the Psychiatric Assistant did not have the clinical experience to perform these evaluations. However, the Staff Psychiatrist indicated that the Psychiatric Assistant had undergone an accepted training program to administer the DISCUS, and had in his possession a certificate from that program. | |
| 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 | This provision of the Settlement Agreement addresses three extremely important points. The first of these is the validity of the psychiatric diagnosis, as it relates to the identified behaviors that are thought to derive from that diagnosis. The second point is the degree to which the prescribed medications are appropriate for that diagnosis. The third issue is the degree to which the medication can be empirically demonstrated to be effective in decreasing the frequency and intensity of the behavioral symptoms of the disorder. In order to assess the Facility's status with this provision, a tripartite analysis was | |

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| | treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly. | completed of the 24 records for which a detailed review was completed off site. In order to accomplish the first of these three analyses, the psychiatric diagnoses for the individual were noted along with the behaviors attributed to that diagnosis. For this initial review, efforts were made to determine if it was possible to establish some linkage between the individuals' behavioral profile, and the psychiatric diagnosis. This was possible in all of the 24 records reviewed. However, in future reviews, there will be more scrutiny related to the assessment of the degree to which the psychiatric diagnoses of record conform with the criteria outlined in the *DSM-IV-TR* guidelines, or the diagnostic criteria put forward in the *DM-ID Diagnostic Manual for Psychiatric Diagnoses*, developed by the National Association of Dual Diagnosis in conjunction with the American Psychiatric Association.<br><br>There were two psychiatric diagnoses that appeared frequently, and could be problematic. These are Impulsive Control Disorder/Intermittent Explosive Disorder, and Stereotypic Movement Disorder with SIB.<br><br>According to the spreadsheet dated 2/2/10, which listed medication and psychiatric diagnosis, at that time there were 120 individuals receiving psychoactive medications. The psychiatric diagnosis for 36 (30%) of these individuals was either Impulse Control Disorder or Intermittent Explosive Disorder. A further 15 (12.5%) had a psychiatric diagnosis of Stereotypic Movement Disorder with SIB. Although these diagnoses may fit the behavioral profile of the individual, they do not convey any etiological specificity that could aid in the selection of appropriate psychotropic medication. For example, the SIB could be present purely on the basis of communication and escape behavior, and the impulsive-aggressive behavior could be secondary to demand situations or the denial of a request.<br><br>The Facility should investigate these trends related to the high percentages of individuals who have psychiatric diagnosis of Intermittent Explosive Disorder or Impulse Control Disorder, as well as Stereotypic Movement Disorder with SIB. To the extent that these diagnoses are maintained, the psychiatrist working with the psychologist should develop a reasonable hypothesis that explains the rationale for these behaviors to be considered the product of a psychiatric disorder, as opposed to a behavioral disorder, or if the behavioral profile is a manifestation of both factors to describe how they interact. This process would then, naturally, lead to a discussion of the hypothesis supporting the use of the psychoactive medication(s).<br><br>The second analysis involved comparing the list of prescribed psychotropic medication to the psychiatric diagnosis of record. Any reasonable hypothesis or explanation was considered to be acceptable (e.g., the use of Naltrexone for a diagnosis of Stereotypic Movement Disorder with SIB). It was determined that either the psychoactive | |

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| | | medication profile was appropriate for the diagnosis of record, and/or there was a reasonable neuropharmacological rationale for their use in 14 of the 24 records reviewed (58%). The individuals for whom an adequate justification of the rationale for their use could not be found were as follows: Individual #34, Individual #26, Individual #239, Individual #60, Individual #111, Individual #266, Individual #106, Individual #288, Individual #322, and Individual #107.<br><br>The final analysis related to the section of this provision related to the determination that the prescribed psychoactive medications have been effective in decreasing the frequency, and/or intensity of the behavioral symptoms, which are described as being related to the primary psychiatric diagnosis. This analysis was accomplished by examining the longitudinal behavioral data that appeared in the Psychological section of the records. This was compromised somewhat by the routine purging of records so data for only the last few years was available, resulting in baseline data for a medication that was begun five or more years ago not being available. To compensate for this lack of historical empirical data, there tended to need to be some reliance on the Staff Psychiatrist's assertions in the record that the longstanding psychotropic medication had been effective in decreasing the frequency and intensity of the monitored behaviors. Empirical evidence showed that the prescribed psychotropic medication was effective in diminishing the identified behavioral symptoms of the psychiatric disorder in 10 of the 24 records reviewed (41.6%). Those individuals for whom there was sufficient evidence to suggest that the medications were effective were as follows: Individual #82, Individual #310, Individual #33, Individual #50, Individual #51, Individual #220, Individual #233, Individual #245, Individual #113, and Individual #137.<br><br>The Facility needs to empirically justify the utility of each psychoactive medication by comparing the pre-medication baseline frequency data with three to six months of the most recent corresponding data. This analysis should also take into account the inherent variations in the monthly frequencies of the monitored behaviors (i.e., if the intrinsic variation in the monthly frequencies is in the range of 600% to 800%, how does one distinguish between random variation and actual improvement?) This process will be facilitated by the fact that the Staff Psychiatrist and the clinical teams at LBSSLC tended to only introduce one medication at a time, which is a good clinical practice. This also makes it much easier to determine the efficacy of different medications, as they are introduced.<br><br>Behavior data that is collected by the Psychology Department on an ongoing basis will need to be used by Psychiatry to make such determinations. As is recommended below, a system should be developed that will identify how the behaviors that are identified as symptoms of the diagnosed psychiatric disorder derive from that diagnosis. If this recommendation is implemented, it will become clear which of the target behaviors are | |

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| | | linked to the psychiatric disorder. A general length of time that it takes to titrate a medication to adequate dosages, as well as the time required for the medication to exert its therapeutic effects, are generally known. Thus, one has only to compare the related frequency data for the three-to-six months after the medication is at therapeutic levels, to the corresponding data for the three-to-six months of baseline pre-medication data, to establish an empirical basis from which to conclude that the medication has or has not been effective, while also taking into account the problem of the inherent monthly variation, as discussed above. Consideration can also be given to those situations where there has only been a modest change in frequency, but the intensity has dramatically decreased. Once this has been established, a mechanism should be developed to carry the documentation forward, so that it is not lost when the records are purged, | |
| J14 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks. | LBSSLC had a large number of individuals who appeared to not be competent to make an informed decision relating to the inherent risks and benefits of the proposed psychotropic medication, and who did not have a Legally Authorized Representative (LAR). For these individuals, the Director made the decision regarding psychotropic medication use, and who signed the necessary consent form. The documentation available in the records would suggest that the Director was signing off on the necessary documentation. However, what was not clear was the process that the Director used to weigh the risks versus benefits of the proposed treatment. During future reviews, additional information will be reviewed related to the information that is provided to the Director to assist her in making such decisions, including information related to how clinicians have come to the decision to use medication to treat the individual, any discussion of least restrictive alternative, and any guidance the Director has received in reaching her decision.<br><br>In the 24 records reviewed, the attempts were made to determine if the individual had a LAR. Such documentation was identified in 10 of the 24 (41.6%) individual records reviewed. It was not clear if this was a documentation issue, or if this was an accurate representation of the number of individuals who did not have guardians. Also, some individuals were admitted as minors, and it was not clear if guardianship was pursued when they became adults. The individuals for whom there was a concrete statement that a LAR was in place were as follows: Individual #34, Individual #60, Individual #111, Individual #106, Individual #288, Individual #242, Individual #116, Individual #51, Individual #310, and Individual #52. | |
| J15 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the | On 3/17/10, the reviewer attended the Neurology Clinic. The Staff Psychiatrist, the Medical Director, a Primary Care Physician, and a Physician's Assistant also attended this clinic. | |

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| | 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. | A nurse from their Residential Unit accompanied the individuals reviewed, and presented the relevant history. Individuals' clinical files were also available to the neurologist. A total of 10 individuals were reviewed. Those individuals who had both a psychiatric and neurological diagnosis were: Individual #243, Individual #73, Individual #240, Individual #314, Individual #190, and Individual #299.<br><br>Those individuals that did not have a co morbid psychiatric diagnosis were: Individual #203, Individual #120, Individual #182, Individual #313, and Individual #316.<br><br>After his evaluation, the neurologist discussed his findings with the Staff Psychiatrist, the Medical Director, and the other physicians. He also dictated his Progress Note during the session, which provided an immediate summary of his thoughts.<br><br>The thoroughness of these reviews was impressive, as was the direct discussion between the neurologist, psychiatrist, and primary care providers (PCPs), as well as the information that was provided by the unit nurses. Throughout the review of individual records, documentation was found of the interactions between neurology, medicine, and psychiatry. | |

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

1. The Facility should move forward with plans to hire an additional psychiatrist with the requisite qualifications.
2. With regard to the use of anesthesia to assist in the completion of some dental procedures at the Facility, it is recommended that the Facility dentist continue to monitor the clinical outcomes with particular attention paid to those individuals for whom the procedure is aborted due to a deterioration of their clinical status, as well as individuals who develop pneumonia within two weeks of the procedure.
3. A system should be developed that will identify how the behaviors that are identified as symptoms of the diagnosed psychiatric disorder derive from that diagnosis.
4. To the extent that a given behavior is described as being both a symptom of a psychiatric disorder and being present on a learned or behaviorally determined basis, there should be a discussion documented that explains the rationale for the dual classification.
5. Personal Support Teams, particularly psychology and psychiatry staff, need to be trained on conducting thorough risk-benefit analyses of the use of psychotropic medication. These analyses should involve a three-pronged approach, including: a) assessment of the *severity* of the behavioral symptoms of the psychiatric disorder in terms of physical harm to the individual or others, and/or the psychological suffering of the individual if the manifestations of the psychiatric illness are untreated; b) weighing the risk of physical harm against the side effect profile of the proposed psychotropic medication; and c) assessment of the likelihood that the proposed medication will be effective in diminishing the physical harm produced by the behavioral symptoms of the psychiatric disorder that the medication is intended to address.
6. The Facility should ensure that side effect monitoring occurs for each individual receiving psychotropic medications on at least a quarterly basis, as required by the SA.
7. The Facility should investigate the trend identified related to the high percentage of individuals (30%) who have a psychiatric diagnosis of Intermittent Explosive Disorder or Impulse Control Disorder. To the extent that these diagnoses are maintained, the psychiatrist working with the psychologist should develop a reasonable hypothesis that explains the rationale for these behaviors to be considered the product of a

psychiatric disorder, as opposed to a behavioral disorder, or if the behavioral profile is a manifestation of both factors to describe how they interact. This process would then, naturally, lead to a discussion of the hypothesis supporting the use of the psychoactive medication(s). The same recommendation would apply to the individuals who have a psychiatric diagnosis of a Stereotypic Movement Disorder with SIB.

8. Attempts should be made to empirically justify the utility of each psychoactive medication by comparing the pre-medication baseline frequency data with three to six months of the most recent corresponding data. This analysis should also take into account the inherent variations in the monthly frequencies of the monitored behaviors. Behavior data that is collected by the Psychology Department on an ongoing basis needs to be used to accomplish this. If Recommendation #3 above is implemented, it will become clear which of the targeted behaviors are linked to the psychiatric disorder. Once this has been established, a mechanism should be developed to carry the documentation forward, so that it is not lost when the records are purged
9. For those individuals who are receiving multiple psychoactive medications, it would be useful to provide the rationale for each medication.

| SECTION K: Psychological Care and Services | |
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| 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:<br>▪ **Review of Following Documents**:<br>o Tracking grid of psychological services, for Positive Behavior Support Plans (PBSPs);<br>o Tracking grid of psychological services, for Safety Plans;<br>o Tracking grid of psychological services, for functional assessments, Behavior Support Committee (BSC) and Human Rights Committee (HRC) approval, list updated as of 3/16/10;<br>o Vitae of Jim Forbes, M.Ed., BCBA, Director of Behavioral Services;<br>o Summary document of title, position, and credentials (or development of credentials) of Behavioral Services Staff, as of 2/10/10;<br>o "Plan to Demonstrate Competence of Psychologists - Updated 8/6/09"<br>o Packet of information including copies of diplomas, educational, training and/or conference certificate of attendance, online quiz summaries, and Behavior Analyst Certification Board certificates and field and practicum experience supervision forms for behavioral services staff;<br>o Summary document of budgeted positions, staff, contractors, unfilled positions, current FTE, current staff-to-individual ratio, and current census as of 2/15/10;<br>o "Positive Behavior Support Plan Self-Monitoring Guide & Quality Assessment Rating Scale;"<br>o "Psychological Assistant Responsibilities (2/24/10);"<br>o Behavioral Services Meeting Notes Summary Document from 6/08 through 12/09, and meeting minutes from Behavioral Services Meeting on 12/16/09, 1/12/10, and 2/3/10;<br>o Weekly Behavior Support Peer Review Committee Meeting Notes from 8/6/09 through 1/29/10;<br>o Human Rights Committee (HRC) meeting minutes from 9/2/09 through 3/3/10;<br>o LBSSLC – Positive Behavior Support - Psychological Evaluations and Updates, dated 1/21/10(R);<br>o LBSSLC – Positive Behavior Support - Positive Behavior Support Practices dated 01/21/10 (R);<br>o LBSSLC – Positive Behavior Support - Prevention and Treatment of PICA dated 11/25/09;<br>o Listing of Recipients of Individual Psychotherapy by Outside Counselor;<br>o Requesting Counseling Protocol – Guide for PST Members, dated 2/24/09;<br>o PBSP Assessment-Guided Staff Training rubric, dated 7/8/09;<br>o PBSP Observation-Guided Staff Training rubric, dated 7/8/09;<br>o Positive Behavior Support Plans (PBSPs) for: Individual #276, Individual #213, Individual #77, Individual #107, Individual #126, Individual # 82, Individual #218, Individual #23, Individual #264, Individual #237, Individual #94, Individual #232, Individual #60, |

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| | Individual #125, Individual #106, Individual #288, Individual #134, Individual #202, Individual #240, Individual #33, Individual #4, and, Individual #286;<br>o Safety Plans for: Individual #213, Individual #82, Individual #94, Individual #298, Individual #288, and Individual #33;<br>o Psychological Assessments, including Inventory for Client and Agency Planning (ICAP) Evaluations when available for: Individual #264, Individual #276, Individual #213, Individual #77, Individual #107, Individual #126, Individual #218, Individual #237, Individual #94, Individual #60, Individual #125, Individual #106, Individual #135, Individual #288, Individual #33, Individual #286, Individual #202, and Individual #23;<br>o Structural and Functional Assessment Reports for: Individual #264, Individual #276, Individual #213, Individual #77, Individual #107, Individual #286, Individual #126, Individual #82, Individual #218, Individual #23, Individual #237, Individual #94, Individual #232, Individual #60, Individual #125, Individual #106, Individual #288, Individual #202, Individual #240, and Individual #33;<br>o Functional Analysis Summary Reports for: Individual #317, Individual #4, and Individual #274;<br>o REISS Screening Reports for: Individual #317, Individual #120, and Individual #168;<br>o Integrated and Safety Plan Progress Note, when applicable, for: Individual #264, Individual #276, Individual #213, Individual #107, Individual #126, Individual #82, Individual #232, Individual #125, Individual #298, Individual #288, Individual #202, Individual #33, and Individual #286;<br>o Training Documentation &/or Competency Assessments, when available, for: Individual #264, Individual #276, Individual #213, Individual #107, Individual #126, Individual #82, Individual #218, Individual #23, Individual #94, Individual #232, Individual #125, Individual #298, Individual #134, Individual #202, Individual #33, and Individual #2;<br>o Case notes from New Hope Christian Counseling Center, including for: Individual #106; Individual #197; and Individual #121<br>▪ **Interviews and Meetings with the following**:<br>o Jim Forbes, Director of Behavioral Services, on 3/15/10 and 3/18/10;<br>o Trent Lewis, Marisol Gonazales, and Lola Walker, on 3/15/10;<br>o Psychology Assistants, including Adam Crawford, Nicole Johnson, Amber Flores, Cheryl Gambles, and R. Jamie Trevino, on 3/17/10;<br>o Speech-Language Pathologists, on 3/17/10;<br>o Associate Psychologists, including Teresa Balawejder, Beckie Robbins, Christina Sosa, Lamecca Abduljaami, Phillip Kite, Krista Leubner, Carolyn Milton, Joanna Mollica, and Ron Flint, on 3/17/10;<br>o Thirteen QMRPs and Active Treatment Coordinators, on 3/18/10;<br>o Residence Coordinators, including Rodshadi Moore, Renate Ruiz, Felicia Cooper, Tiffany Lattimore, Danette Mitchell, Pat Moore, Ladonna Pendgraft, Stefani Williams, Rachel Anderson, Jessica Alcorta, Earnice Coppage, Courtney Ashton, and Tajuana Mam, on 3/19/10 |

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| | ▪ **Observations Conducted**:<br>o Psychiatric clinic meeting for Individual #166 and Individual #218, on 3/16/10, with Dr. Richard Orr, and attended by several clinical, nursing, and direct care staff;<br>o Restraint Reduction Committee, on 3/18/10;<br>o Behavior Support Committee (BSC) Peer Review Meeting, on 3/18/10;<br>o Annual Personal Support Plan (PSP) meeting for Individual #301, on 3/16/10;<br>o Human Rights Committee (HRC) Meeting on 3/17/10;<br>o Onsite direct observation, including interaction with direct care staff and other professionals, occurred throughout the morning, day and/or early evening hours at the following residential and day programming sites:<br>▪ 526 N. Cedar Avenue (Tulip), on 3/15/10;<br>▪ 504 E. Mesquite Drive (Quail), on 3/16/10;<br>▪ 514 S. Cedar Avenue (Birch), on 3/16/10;<br>▪ 516 S. Cedar Avenue (Fir), on 3/16/10;<br>▪ 517 S. Cedar Avenue (Maple), on 3/16/10;<br>▪ 518 S. Cedar Avenue (Oak), on 3/16/10;<br>▪ 519 S. Cedar Avenue (Pine), on 3/16/10;<br>▪ 515 S. Cedar Avenue (Elm), on 3/17/10;<br>▪ 536 Magnolia Drive (EIWS; 'Big Workshop'), on 3/17/10;<br>▪ 531 Chestnut (Hearts and Hands) – brief visit with staff, on 3/17/10;<br>▪ 521 N. Cedar Avenue (Canna), on 3/17/10;<br>▪ 525 N. Cedar Avenue (Rose), on 3/17/10;<br>▪ 528 N. Cedar Avenue (Zinnia), on 3/18/10; and<br>▪ Day program at 540 Lark Street (residential services building), on 3/19/10 |
| | **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| | **Summary of Monitor's Assessment:** Two of the current psychology staff, specifically, the Director and Assistant Director, were Board Certified Behavior Analysts (BCBAs). Many of the Associate Psychologists were completing the necessary courses and receiving the required supervision to apply to take the BCBA exam. In addition, with recent changes to the tuition reimbursement process, it was likely that additional psychology staff members would pursue BCBA coursework and supervision.<br><br>Observations and discussion with psychological staff reflected a rigorous internal peer review system. The process included an initial review by a single more experienced Associated Psychologist, and once feedback was provided and revisions, if necessary, were completed sufficiently, a broader review by the PST, and then the Behavior Support Committee (BSC), including the Director of Behavioral Services. The committee reviewed Structural and Functional Behavioral Assessments (SFBAs), Positive Behavior Support Plans (PBSPs), and Safety Plans. External peer review, however, was not occurring at the time of the review.<br><br>According to direct observation and staff verbal reports, data was not always collected in a timely fashion (i.e., immediately), and it was often not recorded as prescribed. When asked to identify factors contributing to inconsistent data collection, staff reported a lack of appropriate staffing ratios, use of |

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| | untrained relief or pulled staff, recent moves of individuals in residential locations, and the lack of accountability for staff members who did not collect data as trained. One reason that seemed consistent involved the multiple methods used to collect data and how these varied systems may increase staff confusion or error.<br><br>Generally, individuals receiving behavioral services had a Structural and Functional Behavioral Assessment written, updated or reviewed within the last year. These assessments were quite comprehensive, and primarily adhered to a standard format. The assessment methodology or processes that were the basis of these reports are widely accepted, and viewed as standard practice within the field of ABA. Overall, it appeared that these reports produced substantial information relevant to providing effective behavioral supports.<br><br>The identification of functional equivalent replacement behaviors, however, was less consistently reported in the sampled SFBAs. This appeared somewhat problematic as, in a few cases, the replacement behavior described in PBSPs did not appear to be functionally equivalent to the identified undesirable behavior in the SFBA.<br><br>In general, the PBSPs were very comprehensive, detailed and demonstrated consideration of the individual's strengths, needs and preferences. Areas where the PBSPs excelled included the rationale, including references of evidenced-based practices; operational definitions of target behaviors; descriptions of potential functions of behavior; identification of reinforcers; both preventative (antecedent) and reactive (consequence) strategies; description of data collection procedures; and expected treatment outcomes, especially for targets for decrease. Overall, the plans reflected thoughtful interventions that appeared to be based on empirically supported treatments as well as results of current structural and functional assessments.<br><br>Areas where the PBSPs were somewhat limited or insufficient included descriptions of previously attempted interventions and outcomes, baseline data for replacement behaviors, and, at times, treatment objectives for replacement behaviors. In general, reviewed plans seldom identified more than one replacement behavior, and compared to behaviors targeted for decrease, operational definitions for replacement behaviors appeared to be less objective, precise, and, perhaps, more difficult to accurately and reliably measure. The strategies outlined to teach desired replacement behaviors also seemed less detailed and rigorous compared to antecedent or consequence-based procedures for target behaviors.<br><br>At the time of the review, numerous issues negatively impacted the adequate training of direct support professionals on the implementation of PBSPs. One of the most challenging was the instability of staff in the programs due to high rates of turnover, and staff being "pulled" from one program to another. The training provided was not competency-based. This lack of adequate training, particularly with regard to the PBSPs for individuals with the most challenging behaviors, had the potential to place them as well as staff at risk. |

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| K1 | Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint. | The psychology staff appeared to be a group of dedicated, hardworking, and thoughtful professionals committed to improving the lives of the individuals they serve at Lubbock State Supported Living Center. All of the staff members, including the Director and Assistant Director of Behavioral Services as well as the Associate Psychologists, had obtained at least a Master's degree. These degrees were in areas such as education, counseling, behavioral sciences, experimental, and school psychology. Two of the current psychology staff, specifically, the Director and Assistant Director, were Board Certified Behavior Analysts (BCBAs). Approximately half of the psychologists within the department, including the Assistant Director, were relatively new to LBSSLC (i.e., employed there approximately two years or less).<br><br>Six of the eight Associate Psychologists were pursuing BCBA credentialing through completion of online coursework through the University of North Texas, as well as receipt of necessary supervision from the Director and Assistant Director of Behavioral Services. In fact, most had completed at least 50 percent of the required coursework. It appeared that there was significant administrative support for the pursuit of graduate coursework and the BCBA. Indeed, a formal written plan was in place, and was being actively implemented in an attempt to recruit, train, and/or maintain BCBA-level professionals. Recently, the Associate Psychologists were informed that they would no longer need to pay 'out of pocket' for these courses, and then be reimbursed after completion of the course. This change will likely reduce the financial barriers for the two remaining Associate Psychologists who were interested, but who could not afford, to complete the BCBA coursework.<br><br>Many of the Associate Psychologists had obtained supplemental training in ABA through conference attendance, instruction through trainings sponsored by Behavior Intervention Specialists, and/or participation in the ABA self-study program. These opportunities were valuable, because many Associate Psychologists appeared to have limited educational backgrounds in ABA.<br><br>In addition to the Associate Psychologists, there were five Psychological Assistants. These professionals voiced strong interest in pursuing additional training, including advanced competencies in applied behavior analysis. Some reported a need for a more structured initial training as well as opportunities for ongoing training.<br><br>Although only two members of the current psychology staff are board certified, many of the Associate Psychologists were completing the necessary courses and receiving the required supervision to apply to take the BCBA exam. In addition, with recent changes to the tuition reimbursement process, it was likely that additional psychology staff members would pursue BCBA coursework and supervision. | |

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| | | A natural consequence of obtaining an advanced certification such as the Board Certified Assistant Behavior Analyst (BCABA) or BCBA is an expectation for additional compensation. Indeed, professionals with these credentials are in great demand. Consideration should be given to increasing, or ensuring salary ranges commensurate with levels of experience for professional staff who receive either the BCBA or BCABA certification. The ability to offer increasing range of salary will likely assist with the ongoing recruitment and retention of professional staff. | |
| K2 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility. | The Facility employed Jim Forbes, M.Ed., BCBA, as Director of Behavioral Services. His Master's degree was in School Psychology and, more recently, he had obtained further graduate training in Applied Behavior Analysis through the University of North Texas. Subsequently, he obtained board certification as a Behavior Analyst.<br><br>The Director of Behavioral Services had been employed in his current position for seven years, and had extensive experience (31 years) supporting individuals with intellectual, mental, and physical disabilities. He had taken the lead in the development of statewide policies and procedures for behavioral assessment, positive behavior support, and limiting the use of restraint.<br><br>Interviews and discussions with psychology staff, including Associate Psychologists and Psychological Assistants, as well as professionals within other disciplines (e.g., nursing, habilitation, etc.), and direct support professionals consistently produced very positive reviews and comments regarding the Director of Behavioral Services' skills, interpersonal style, and dedication. Staff reported that he was fair, readily asked for input, was easy to talk to, provided good feedback, and demonstrated good follow through. It was clear that the staff at LBSSLC had very high regard for him, and believed that his leadership and commitment were central to the Facility's future success.<br><br>A common theme voiced in discussions across multiple meetings with different disciplines centered on how the current administrative structure limited the ability of disciplines (or positions) to frequently interact and ensure consistency of supports and services. That is, many professionals (QMRPs, Residence Coordinators, etc.), in addition to psychology staff, reported that the unit based system appeared to limit their effectiveness in a number of important ways. Indeed, with the current structure, the Director of Behavioral Services did not have direct administrative supervisory responsibility over the Associate Psychologists. This appeared to limit the effectiveness of behavioral services. That is, psychological staff clearly indicated that their administrative supervisor did not fully understand the nature of psychological services, and that their ability to adequately perform their responsibilities was directly impaired by the substantial amount of time they were "pulled out" to assist with staffing within the programs. This suggested a greater emphasis, at times, to assist with providing staffing | |

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| | | coverage and not on the development, teaching and monitoring of behavior support and safety plans. In addition, supervisors with limited knowledge of the potential of ABA and corresponding behavioral services may not fully utilize their expertise. Another indication of this was that under the current management structure, behavioral services staff did not appear to be fully integrated within day services.<br><br>The Director of Behavioral Services, however, did have both administrative and professional (clinical) supervisory responsibility over the Psychological Assistants. Consideration should be given to re-structuring the administrative structure from a unit-based model to a department or discipline-based model to allow the Director of Behavioral Services to directly supervise all staff within behavioral services. This change would facilitate more consistent adherence to clinical responsibilities of behavioral services staff. | |
| K3 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs. | Observations and discussion with psychological staff reflected a rigorous internal peer review system. The process included an initial review by a single more experienced Associate Psychologist (Level V), and once feedback was provided and revisions, if necessary, were sufficiently completed, a broader review by the PST, and then the Behavior Support Peer Review Committee, including the Director of Behavioral Services, were completed. The committee currently reviews Structural and Functional Behavioral Assessments, Positive Behavior Support Plans, and Safety Plans.<br><br>Direct observation of one of the meetings by a member of the Monitoring Team reflected the active participation of committee members and the utilization of data-based decision making. Review of sampled meeting minutes from the BSC peer review suggested that the committee met weekly, and was comprised of a diverse group of professionals, for example, speech-language pathologists, occupational therapists, medical staff (MD or RN), and Quality Enhancement staff. However, it did not appear that the committee included many of the staff ultimately responsible for the plan's implementation. For example, it did not appear that Psychological Assistants or Residence Coordinators were in regular attendance.<br><br>Although Psychologists Assistants did not typically attend BSC meeting, it was noted that all behavioral services staff had the opportunity to meet at least monthly as part of the Behavioral Services meeting.<br><br>Review of Behavioral Services grids indicated that Structural and Functional Assessments, as well as BSC and Human Rights Committee (HRC) approval, and consents of PBSPs and safety plans were tracked to ensure timely annual review. According to these grids, there were assessments and PBSPs that were "out of date," because the annual date of approval had expired. More specifically, according to provided behavioral | |

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| | | services tracking log, dated 3/16/10, 26 (20%) functional assessments, 15 (12%) BSC approvals, 13 (10%) HRC approvals, and six (4%) consents were identified as out-of-date.<br><br>An additional review process included the LBSSLC Human Rights Committee. A review of the provided HRC meeting minutes indicated that the group met weekly, and was composed of LBSSLC staff (i.e., QMRPs, psychologists, QE staff, Ombudsman, RN, etc.), as well as other individuals external from the Facility (e.g., parents, and community volunteers/representatives). In addition, there was representation by an individual served occasionally reflected in the minutes. However, despite the fact that multiple community volunteers and/or parents attended HRC meetings, the majority of HRC members at each meeting appeared to be employed by LBSSLC.<br><br>Currently, there was no completely external peer review process. However, the Director of Behavioral Services was negotiating with a professor from Texas Tech University, with expertise in Special Education and Applied Behavior Analysis, to provide regular external peer review of behavioral programming. This appeared to be a very positive solution to providing consistent independent review of behavioral services. It also might secondarily offer a source for continual recruitment and retention of professional staff. That is, with a successful partnership with Texas Tech, graduate students could complete practicum/supervisory requirements at LBSSLC with the potential of obtaining part- or full-time positions after graduation and/or certification. | |
| 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 | As the collectors and recorders of the raw data, direct support professionals play a key role in the implementation and accuracy of the data collection system. A number of residential direct support professionals, when asked about particular individuals, were able to describe what target behaviors were being monitored, and how and where to record data. However, other direct support professionals, when asked similar questions, were reluctant to answer or provided incorrect or incomplete responses. A handful of staff indicated a need to review an individual's record to ensure a correct answer.<br><br>Review of a 24 sampled PBSPs indicated that 100 percent of the plans prescribed the collection of data on target behaviors (behaviors for decrease), replacement behaviors (behaviors for increase), and, at times, behaviors for monitoring (behaviors reflective of underlying psychiatric diagnosis). These 24 plans reflected a sampling of 19 percent of the total PBSPs in place at the time of the review, according to behavioral services tracking grid, dated 3/16/10.<br><br>Review of six sampled Safety Plans for Crisis Intervention indicated that 100 percent prescribed the collection of data on the use of restraints. Data displayed in these plans included the frequency, duration, and injuries related to each restraint utilized per | |

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| | revised promptly if target behaviors do not improve or have substantially changed. | month. These six plans reflected a sampling of 86 percent of the total Safety Plans in place at the time of the review, according to tracking grid dated 2/10/10.<br><br>Data related to PBSPs appeared to be collected in a variety of ways, and differed across residential programs. More specifically, data on target, replacement or other behaviors were recorded on data cards, on an Antecedent-Behavior-Consequence (ABC) behavior record, and/or in observation notes. Methods of data collection appeared to vary as well, and were noted to include frequency, partial interval, and duration data. This information was sometimes recorded in the "all about me" book, or within the Home Shift Log. Verbal reports suggested that, at times, staff did not have access to the "all about me" book and, therefore, data was not collected as it was intended to be. Direct observation confirmed this, because these books appeared to be readily available in some settings, but not in others.<br><br>Verbal reports from psychology staff reflected a strong desire to improve the data collection systems within each of their respective programs. Indeed, interviews with staff included descriptions of various attempts to redesign data systems that were more efficient and effective. It was evident that staff viewed data collection as, at times, less than optimal. Direct observation and comments from professional staff indicated that data was not always collected in a timely fashion (i.e., immediately), or not collected as written. When asked to identify factors contributing to inconsistent data collection, staff reported a lack of appropriate staffing ratios, use of untrained relief or pulled staff, recent moves of individuals in residential locations, and the lack of accountability for staff members who did not collect data as trained. One reason that seemed consistent involved the multiple methods used to collect data, and how these varied systems may increase staff confusion or error.<br><br>At the time of the review, inter-observer agreement (IOA) data was not collected. Behavioral services staff, including the Director of Behavioral Services, acknowledged that the confidence they had in the accuracy of their data, and their ability to make data-based decisions was substantially limited by the lack of IOA data collection.<br><br>According to staff reports as well as review of sampled documentation, PBSP data was typically collected and summarized on a monthly basis. Psychological Assistants might have assisted with data collection. The Associate Psychologists completed the monthly PBSP data summary, called the Integrated Progress Note, however. In general, this report included baseline and monthly data for each specific target behavior (behaviors for decrease) displayed in tables and line graphs, as well as dosages of psychoactive medications displayed in bar graphs. A range of data, usually 12 months, was usually displayed. These formats allowed individual analysis of each target behaviors, comparison to other targets, and relationships to changes in dosages of medication. | |

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| | | Data on replacement behaviors, however, was less consistently reported in these monthly documents. For example, in many of the sampled reports, data on replacement behaviors was not included, or some monthly replacement data was missing. For example, the Integrated Progress Notes of Individual #126, Individual #94, Individual #286, and Individual #60 did not include complete data on replacement behaviors. In addition, baseline data for replacement behaviors was typically not reported in any of these documents.<br><br>Tables and/or graphs displaying target behaviors, replacement behaviors, and/or medication dosages were noted within 100 percent of the sampled PBSPs, Psychological Assessments and/or Structural and Functional Assessment reports that were reviewed. In rare cases, behaviors targeted for monitoring (e.g., "depression") were operationally defined in PBSPs, for example, for Individual #125 and Individual #218. However, of these two examples, data was only formally collected and graphed for one individual, Individual #125. In general, it was consistently found across 100 percent of sampled PBSPs that only data on a single replacement behavior was included in a table and/or graph, despite cases where multiple replacement behaviors were indentified in the PBSPs. This was the case, for example, for Individual #82, Individual #94, and Individual #276. In these cases, it was unclear if only one replacement behavior was graphed, or if the data was collapsed across replacements. | |
| 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. | According to verbal reports of behavioral services staff as well as review of Facility policy, every individual at LBSSLC was required to have a current psychological evaluation. Review of requested documentation indicated that, 18 out of 21 sampled individuals had a Psychological Assessment completed within the last year. Documents requested for three individuals, however, did not include a Psychological Assessment, specifically Individual #82, Individual #134 and Individual #232. Documents for Individual #82, however, included a recently completed ICAP, suggesting that a psychological assessment may have been completed, but just not provided.<br><br>Review of the 18 available Psychological Assessments indicated that 16 reported scores from previous standardized intellectual testing. Two exceptions included one for Individual #264 for whom previous testing attempts were 'unsuccessful,' and for Individual #77 whose profound deficits in adaptive functioning did not support more formal intelligence testing.<br><br>It appeared that all of the sampled Psychological Assessments included scores from the Inventory for Client Agency Planning completed within at least the last 3 years. In some cases, scores from other adaptive behavior assessments (e.g., Vineland Adaptive Behavior Scales, American Association of Mental Deficiency Adaptive Behavior Scales, and The Adaptive Behavior Scale, Residential and Community-2) were included as well. | |

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| | | In addition to the annual Psychological Assessment, individuals who received behavioral and psychopharmacological interventions were supposed to have a Structural and Functional Assessment. Review of the sampled records indicated that all individuals, with one exception (discussed below), receiving behavioral services (i.e., had a PBSP) had a SFBA written, updated or reviewed within the last year. These assessments were quite comprehensive, and primarily adhered to a standard format. The assessment methodology or processes that were the basis of these reports are widely accepted and viewed as standard practice within the field of ABA, including structured interview formats (e.g., Functional Assessment Interview Form, The Problem Centered Interview), rating scales [e.g., Motivation Assessment Scale (MAS), Functional Analysis Screening Tool (FAST)], event recording and permanent product review (e.g., ABC behavior recording, scatter plot, etc.), and direct observation.<br><br>These reports described variables, such as setting events, antecedents, and consequences that were relevant to the target behaviors, as well as to identifying their underlying function(s). In addition, preferences and/or reinforcers were typically highlighted, and data were often displayed of target behaviors, replacement behaviors (in some cases), and medication dosages, either in tables and/or graphs. Overall, it appeared that these reports produced substantial information relevant to providing effective behavioral supports.<br><br>Although all of the sampled SFBAs provided detailed and comprehensive assessment data, as well as identified potential function(s) associated with targeted behaviors, many did not specifically identify and recommend specific functionally equivalent replacement behaviors. For example, although a primary function was identified (e.g., escape), the SFBA report recommendations were relatively vague for Individual #213. The recommendation of similarly non-specific replacement behaviors was found for Individual #240, Individual #77, Individual #286, and Individual #82.<br><br>When replacement behaviors were identified, typically only a single replacement was recommended even though, at times, multiple functions were discovered. For example, although two functions of aggression and self-injurious behavior were identified, specifically escape and access to tangibles, for Individual #125, only one potential replacement behavior, specifically money management, was recommended. The targeting of a single replacement behavior when multiple controlling functions of challenging behavior are identified is likely to limit the effectiveness of interventions. For example:<br>▪ Although opportunities for sensory activities appeared to be linked to an identified automatic function, the way in which these activities were offered to Individual #23 was likely counter-therapeutic considering the second identified function of attention. | |

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| | | Overall, PBSPs appeared to include interventions that were linked to completed functional assessment and reported within SFBAs. In addition, sampled plans included at least one replacement behavior that appeared functionally equivalent.<br><br>As previously presented, a consistent trend observed across sampled PBSPs reflected the identification, training and formal tracking of only one replacement behavior. Even in cases where two replacement behaviors were identified and/or defined, replacement behavior data was only represented through a single row or data path within a table or on a graph.<br><br>For some individuals with more challenging behaviors or whose initial functional assessments were somewhat inconclusive, an additional more rigorous assessment, a Functional Analysis (FA), had been completed. Three FAs had been completed within the last year, and the resulting reports were requested and reviewed. In general, the FAs utilized procedures and methodologies generally accepted within ABA. These assessments appeared to provide additional information potentially beneficial to confirming hypotheses about functions of targeted behavior, and developing effective interventions. Indeed, information obtained from the FAs was integrated into behavioral programming, for example, for Individual #4.<br><br>It is important to note that because FAs are likely to place individuals in situations that increase the probability of target behaviors, albeit for short durations, it is important to pursue consent and appropriate oversight when these are conducted. It is unclear, at this time, if individual's guardians provided prior consent and whether or not HRC and/or BSC provided oversight.<br><br>Additional screenings for psychopathology, behavioral and emotional issues, in addition to the above assessments, were completed using the Reiss Screen for Maladaptive Behavior. At the time, these screenings targeted individuals who were not receiving psychiatric services. Three randomly sampled Reiss Screens, completed on Individual #120, Individual #168, and Individual #313, were reviewed. These assessments were completed in April and October of 2008, and January 2009, respectively, and were reviewed by their teams. According to discussions with psychology staff, these assessments were completed as part of a system-wide supplemental screening process. It is currently unclear if a similar system-wide screening, for individuals not receiving psychoactive medications or followed by psychiatry services, will be repeated in the future.<br><br>A review of documentation for sampled individuals, specifically those without SFBAs, suggested that for at least Individual #135, given the frequency and severity of his | |

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| | | challenging pica behavior, an SFBA should have been developed. According to the Psychological Assessment, this individual demonstrated repeated pica behavior over the course of a year and, following attempts to prevent the behavior (i.e., purchase of a small safe to store his coins), continued to demonstrate this life threatening behavior. Although it appeared that these incidents occurred prior to the implementation of the LBSSLC Behavior Support Plan - Policy on Prevention and Treatment of Pica (dated 11/25/09), it seemed reasonable to expect that a more rigorous evaluation would have been completed in an attempt to more fully understand the nature of the pica, as well as potentially inform behavioral services staff in the development of assessment-linked interventions. Indeed, the policy at the time of the review prescribed, at the very least, the completion of a SFBA with the potential of subsequent development and implementation of a PBSB. The PSP, dated 9/10/09, highlighted the challenge of his PICA behavior, including "other steps" (although, not specifically described) that had been taken to limit his access to coins, and how this restriction limited his potential integration into the community. In fact, it appeared that a referral for alternative placement was not made subsequent to the team's judgment that a community placement could not provide the level of support necessary to keep him safe. It is unclear, however, what supports, specifically aimed at the prevention of pica, were being provided. That is, it did not appear that he was on an enhanced level of supervision, and although there was a goal in his PSP to remain free of ingested items (action plan #2, outcome I), it was unclear if there was prescribed programming in place to prevent or reduce the probability of pica. It seemed likely that more formalized assessment and subsequent intervention would have reduced the probability of his engaging in pica. Full interdisciplinary team collaboration also would have served to ensure that his behavioral needs were incorporated throughout his plan. For example, the psychological assessment reported that steps had been taken to limit his access to coins, yet he had a money management SPO that encouraged their use. | |
| 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. | Review of the requested documentation indicated that most of the sampled individuals had a Psychological Assessments completed or updated within the last year. Three Psychological Assessments, however, were not included in the received documentation (see Individual #82, #134, & #232). It appears likely that, for at least one of the Individual (# 82), a Psychological Assessments was completed (i.e., a recent ICAP was included, date appeared on behavioral services tracking grid).<br><br>As previously described, Psychological Assessments included data derived from ICAPs that had been completed within the last three years (i.e., concurrent with LBSSLC policy). In addition, data on target behaviors, replacement behaviors, and/or dosages of psychoactive medications were typically included in the Psychological Assessment and/or Structural and Functional Assessments. | |

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| | | In addition, review of documentation suggested a very high percentage of completion of SFBAs for almost all of the sampled individuals. However, there were several missing requested documents, including the SFBA, for Individual #134. In general, data submitted within SFBA reports included information from indirect and direct assessment methods that were conducted within the last year as well as from prior assessments. This process allows estimation of current functioning as well as comparisons across time, which assists in monitoring of changes in functioning. | |
| K7 | Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures. | Of the sampled Psychological Assessments available for review, all 18 appeared to have been updated within the last year. A similarly high rate of annual completion was observed across sampled SFBAs. More specifically, of the 20 Psychological Assessments reviewed, only one SFBA was not updated within the last 12 months, for Individual #107.<br><br>As previously reported, information on the behavioral services grid highlighting dates of all functional assessments, BSC approvals, HRC approvals, and expiration of consents indicated that 26 (20%), 15 (12%), 13 (10%) and 6 (4%), respectively, were out of date as of 3/16/10. It appeared, then, that although the sampled documentation reflected relatively good adherence to annual revisions of SFBAs, a review of the dates tracked by behavioral services suggested that 20 percent of all SFBAs were out of date.<br><br>Documentation was requested and reviewed on the two individuals most recently admitted to LBSSLC. This included information regarding Individual #134 and Individual #240.<br>▪ Individual #134 arrived in early 2010. As previously presented, the Psychological Assessment and SFBA were unavailable for Individual #134. Missing information, specifically the date of the functional assessment, from the behavioral services grid suggested that this assessment was not completed. Review of available sampled documentation, however, did reflect timely submission of an 'interim' PBSP that was developed, reviewed by both the BSC and HRC, and implemented, including initial staff training, within three calendar days of his arrival.<br>▪ Individual #240 arrived in late 2009. The psychological assessment was not available for review. Requested documentation that was available for review indicated that a Structural and Functional Assessment was completed within 41 calendar days of admission. According to the PSP, dated 10/8/09, and available HRC documentation, it appeared that an interim PBSP was implemented upon arrival, and was in place while the SFA was completed. A new PBSP with an implementation date of 11/30/09, appeared to have been implemented once the SFA was completed, appropriate reviews, including BSC and HRC, were conducted, and residential staff were trained. | |
| K8 | By six weeks of the assessment | At the time of the review, LBSSLC contracted with a community agency to provide | |

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| | 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. | counseling services to individuals supported by the Facility. According to provided documentation, 14 individuals attended individual psychotherapy sessions through this provider in the month of December. The average attendance rate for this month was less than 50 percent.<br><br>The following individuals included in the sample received psychotherapy during this time period: Individual #34, Individual #237, Individual #94, Individual #50, Individual #125, and Individual #106. Review of available documentation these six individuals was examined for integration of counseling objectives across assessments or interventions. In general, counseling services were not typically identified within psychological assessments or consistently documented in PSPs. When information was described, it typically was descriptive in nature and not offered as a measurable goal or objective.<br><br>Although the community counseling agency provided documentation, including brief comments on individual progress, it was not sufficient to determine if psychotherapy services reflected evidenced-based practice. In addition, services appeared to be goal directed, however, some of the goals were not measureable or objective. For example, the therapy goals for Individual #121 included "increase in self-esteem" or "build a level of trust and understanding …".<br><br>Individual #82 participated in counseling services this past December. Although it was unclear if the SFBA recommended counseling supports, information outlined in the SFBA and PBSP provided a rationale for offering psychotherapy. Indeed, within the last year, this individual experienced a failed community placement, and was admitted to inpatient psychiatric services. Subsequently, the provision of counseling services would be considered acceptable and standard practice. Available documentation, however, did not appear to reflect the integration of these services within behavioral or PSP objectives or programming.<br><br>In addition to the counseling services, several other types of therapeutic services were observed and described by staff, and within SFBAs and PBSPs. These therapies included Sensory Diets, and access to multi-sensory rooms where individuals are offered opportunities to experience different sensory stimulation across various modalities. These rooms were available in some residential programs as well as day programming areas and, in general, appeared to be utilized for primarily leisure activities and relaxation. There were some individuals that received these therapies as part of behavioral programming. This was outlined, for example, in the SFBA and PBSP for Individual #202. However, verbal reports also indicated that many individuals might utilize these rooms independent of behavioral programming and/or structured interventions (e.g., SPOs). | |
| K9 | By six weeks from the date of the | Of the sampled documentation, 21 PBSPs were reviewed to assess compliance with this | |

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| | 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. | outcome. In general, the PBSPs were very comprehensive, detailed and demonstrated consideration of the individual's strengths, needs and preferences. Areas where the PBSPs excelled included the rationale, including references of evidenced-based practices; operational definitions of target behaviors; descriptions of potential functions of behavior; identification of reinforcers; both preventative (antecedent) and reactive (consequence) strategies; description of data collection procedures; and expected treatment outcomes, especially for targets for decrease. Overall, the plans reflected thoughtful interventions that appeared to be based on empirically supported treatments as well as results of current structural and functional assessments.<br><br>Areas where the PBSPs were somewhat limited or insufficient included descriptions of previously attempted interventions and outcomes, baseline data for replacement behaviors, and, at times, treatment objectives for replacement behaviors. In general, reviewed plans seldom identified more than one replacement behavior, and compared to behaviors targeted for decrease, operational definitions for replacement behaviors appeared to be less objective, precise, and, perhaps, more difficult to accurately and reliably measure. The strategies outlined to teach desired replacement behaviors also seemed less detailed and rigorous compared to antecedent or consequence-based procedures for target behaviors.<br><br>In an attempt to standardize PBSPs, a rubric entitled the "Positive Behavior Support Plan Self-Monitoring Guide and Quality Assessment Rating Scale" was created by the Director of Behavioral Services, and utilized by psychology staff and BSC members to ensure consistency and quality. This appeared to be a useful form that would assist authors and reviewers of plans in developing and critiquing behavioral programming. Verbal reports from psychological staff members and review of sampled documentation suggested that this rubric was utilized briefly within the last year. However, it was unclear whether or not associate psychologists and BSC members were still using it.<br><br>One challenge in determining whether or not PBSPs had received appropriate oversight and/or consent prior to implementation was the lack of signatures on the documents themselves. That is, within the current system, cover/signature sheets were utilized by HRC and BSC, as well as for obtaining guardian or individual consent. Therefore, several documents needed to be obtained to ensure that consents and/or necessary approvals had not expired. Review of sample of records, where relevant documentation was available, revealed that approvals and consents were completed prior to implementation of the PBSP. One document, however, was missing an implementation date, thereby limiting the review, specifically for Individual #213. As previously presented, the behavioral services tracking grid identified a number of approvals and/or consents that were expired or labeled "out of date." | |

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| 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. | A number of issues related to the reliability and validity of data are discussed above with regard to Section K4 of the SA. As is discussed there, at the time of the review, inter-observer agreement (IOA) data was not collected. Psychology staff, including the Director of Behavioral Services, acknowledged the value and importance of collecting this data, and voiced a willingness to pursue consultation leading to the development and implementation of a system-wide technology capable of collecting sufficient reliability data.<br><br>Data collected on target behaviors, replacement behaviors and, in rare cases, targets for monitoring (for an example, for Individual #125), were typically displayed in tables and/or graphs. These data displays were often, but not always, included within annual revisions of PBSPs, psychology assessments, and SFBAs. At times, graphs included within these documents were difficult to view given their reduced size, for example, in the PBSP of Individual #33.<br><br>In addition, data on restraint use (frequency and duration) was also displayed in Safety Plans.<br><br>The most useful display of data was found within Integrated Progress Notes, as well as Safety Plan Progress Notes. These monthly summaries included tables and graphs that permitted ongoing monitoring of target and replacement behaviors, medication dosages as well as restraints. Graphs were generally easy-to-read and understand with clear values on vertical and horizontal axis, and obvious data paths and legends. In addition, the vertical positioning of multiple graphs often allowed easy examination and comparison of changes in behavioral data concurrent with changes in medication regimen. However, at times, given some of the data collection systems in place, it was unclear if the vertical axis represented frequency, percentage of intervals, or both, for example the graphs for Individual #2 and Individual #60.<br><br>Onsite chart review of a few sampled individuals indicated that the Integrated Progress Notes were completed, as expected, on a monthly basis. | |
| K11 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff. | Verbal reports from direct support professionals, as well as direct observations during program visits produced mixed results when assessing staff knowledge of PBSPs. During some interactions, staff members were able to provide accurate information regarding a particular individual's target behaviors and/or associated behavioral strategies. In other interactions, however, staff members were unsure of specific target or replacement behaviors, where to record data, and/or how to respond when targets were observed.<br><br>In addition, during a few visits, direct support professionals were observed providing inadequate levels of supervision (i.e., according to present staff, the individual was on | |

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| | | "enhanced") and, therefore, staff were not able to successfully monitor, redirect and record potentially unsafe behaviors (e.g., Individuals #174 and #202).<br><br>In general, PBSPs appeared to be rather lengthy (e.g., an estimated average was approximately five pages, without the Staff Instruction section). Subsequently, the length may impair the usefulness of the document. However, the last few pages of PBSPs, labeled "staff instructions," contained a structured and condensed version of the overall plan that highlighted the function of challenging behaviors, fundamental outcomes of the plan, antecedent strategies for prevention of each target behavior, consequence strategies for each target behavior, information on psychoactive medications and documentation. These pages, typically between two to four pages long, appeared helpful to psychology staff during staff training, as well as beneficial to direct support professionals looking for a quick reference or a document that was more manageable. In addition, psychology staff reported an active attempt, when revising PBSPs, to include more simple language and avoid previously used technological jargon. | |
| K12 | Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans. | It appeared that the behavioral services department had applied significant effort in developing and implementing methods and procedures to improve the effectiveness of staff training. In general, training of staff usually involved in-service trainings in large group settings at shift changes, or in smaller groups (one-to-one to one-to-three) for staff who missed the initial meeting or when training new employees, relief or pulled staff. Discussions with Associate Psychologists and Psychological Assistants suggested that these trainings typically included didactic instruction and, to a lesser extent, modeling and role-playing. In addition, because psychology offices were within the residences, psychologists or assistants were frequently available throughout the week to conduct on-the-spot, in vivo training. In addition, following staff trainings, each staff member was given a written quiz, entitled the Competency Assessment, to assess his/her knowledge of behavioral programming.<br><br>The use of written quizzes like the Competency Assessments to assess knowledge change can be useful in monitoring the effectiveness of training as well as identifying those staff in need of additional training. However, it appeared that the current procedures did not allow the utilization of these assessments to their full potential. That is, there were some reported concerns that the written assessment might not have been fully understood by staff due the terms included, as well as due to limited language proficiency of staff; that the staff completed these at home, often days after the training; and that staff "cheat" when filling out the assessments, as demonstrated by the fact that many would have the same incorrect answers. In addition, it was unclear how quickly these assessments were scored, whether or not there was an identified criterion of acceptable performance, and what the contingencies were for staff who performed poorly on one or more assessments. Lastly, it was unclear if these assessments were utilized with direct | |

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| | | support professionals who primarily worked at the day programs.<br><br>In addition, to competency assessments, two other rubrics had been designed to facilitate staff training and treatment integrity of PBSPs. The PBSP Assessment-Guided Staff Training form was developed to assist with measurement and improvement of staff competency, and involved asking direct care staff to show or report information relevant to the PBSP. The PBSP Observation-Guided Staff Training rubric was designed to measure and increase treatment integrity of PBSPs, and involved observing direct care staff and recording whether or not they implemented strategies, including data collection, as written. Data associated with the use of these assessments was not available for review. At the time of the review, it was unclear who was responsible for completing these assessments, and how often they were required to occur.<br><br>The methods and procedures currently in place appeared to provide good groundwork for the development of more effective staff training and improved staff performance. There were several limiting factors, however, that undermined the potential effectiveness of these training methods.<br><br>One of these limitations involved the amount of time allocated to training new staff. Staff's verbal reports during meetings and interviews suggested that new staff members were typically provided two or less days of onsite training. One of these days appeared to primarily involve meeting with an Associate Psychologist or Psychologist Assistant in an office reviewing plans. Given that some residential and day programs had a significant number of individuals with PBSPs (i.e., in some cases well over a dozen), it seemed improbable that staff would learn, and retain a substantial amount of meaningful information for the majority of individuals within each program.<br><br>Second, it was unclear if attendance at trainings was mandatory, and if there were any contingencies in place for direct support professionals that miss staff trainings. Some staff reports clearly suggested that direct support professionals were not held accountable for missing necessary trainings.<br><br>Third, it appeared that due to the significant and ongoing staffing vacancies at LBSSLC, many direct care staff were working in programs without sufficient training. During several residential visits, several staff members reported that they had not received training on the PBSPs relative to the individuals living at the residence. It seemed that these direct support professionals were "pulled" to work in a setting where they had no direct training. Reports from Residential Coordinators indicated that they shared responsibility for staffing coverage; however, it was unclear if a system was in place across residences or units to ensure that only those direct support professionals, especially relief and pulled staff, who had received adequate training were assigned to | |

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| | | work with those individuals. Particularly for individuals with significant behavioral issues, this lack of training on the implementation of PBSPs and Safety Plans had the potential to place both the individuals and staff at risk.<br><br>Fourth, in vivo training may be limited as demands on available trainers, including Psychological Assistants and Associate Psychologists, increased over time. The more that these professionals were "pulled" to cover openings in direct support coverage or other responsibilities, the less available they were to provide the most essential form of training, including observing, modeling, and providing feedback, where and when it was really needed. It appeared that there were rubrics designed to facilitate onsite competency-based training, including in vivo observation, corrective feedback and praise for accurate knowledge and implementation of PBSPs. As presented earlier, it was unclear how these forms were being used. Future visits will focus on the use of these forms, as well as their effectiveness in improving staff performance.<br><br>The limited integration or collaboration of behavioral services staff within onsite and community-based day programming and employment services also likely impaired the success of individuals served at LBSSLC. More specifically, staff reports consistently indicated that behavioral concerns, including job refusal, limited individuals' attendance and participation at campus-based day and vocational services, and limited their involvement in employment in community settings. At the time of the review, it appeared that Associate Psychologists and Psychological Assistants did not regularly consult with job coaches who were providing assistance and support to individuals in the community, and had very limited interaction, until just recently, with workshop managers and trainers. | |
| 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 onsite visit, there were nine Associate Psychologists (including the Assistant Director of Behavioral Services), in addition to the Director of Behavioral Services employed within the Behavioral Services department. All of the Associate Psychologists, the Assistant Director, and the Director of Behavioral Services had obtained at least a Master's degree. Only two of the nine psychologists were BCBA certified, and met the requirements in Section K.1 of the SA. The ratio of BCBA certified psychologists to individuals was 2:233, or 1:117, which did not meet the requirement of 1:30. As noted above, a number of psychology staff were in the process of becoming BCBA certified.<br><br>According to reports, there were still two positions with Behavioral Services that were open, including one Associate Psychologist position, and Psychologist. In addition, one contract position was likely to be utilized to support an "external" psychologist to conduct independent peer review. | |

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| | | In addition to these staff, five Psychological Assistants were currently employed within the behavioral services department. These staff supported the nine Master's level psychologists.<br><br>Verbal reports during meetings with psychology staff indicated an individual caseload ranging from approximately 16 to 38 as well as 35 to 95 for Associate Psychologists and Psychological Assistants, respectively. Across the Associate Psychologists and Assistant Director of Behavioral Services, an approximate range of three to 28, with an average of 14, PSPBs per caseload, was reported. | |

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

1. The Facility should continue to support BCBA certification for all behavioral services staff by providing tuition reimbursement and necessary supervision. This should include obtaining additional supervisory support, if interest continued to increase.
2. In order to assist with recruitment and retention, consideration should be given to reviewing salary ranges of behavioral services professionals to ensure that salaries are commensurate with levels of experience, as well as advanced certification (i.e., BCBA or BCABA).
3. With the current administrative structure, the Director of Behavioral Services does not have supervisory responsibility over the Facility's Associate Psychologists limiting his ability, for example, to reduce the amount of time they are "pulled" from their primary duties to cover non-clinical responsibilities. In assessing this, it is recommended that the Facility consider whether or not the current line of supervision is adequate to address the psychology/behavioral needs of the individuals served by the Facility.
4. When possible, Psychological Assistants should be included in internal BSC peer review meetings, and external conferences training opportunities. This might also include opportunities to pursue the BCABA, as well as BCBA.
5. The Facility should follow through on the plans to develop a supplemental external peer review committee comprised of professionals not employed by LBSSLC. Membership of this committee should include professionals who are board certified in behavior analysis. This committee would potentially meet less often than the BSC, but would likely offer alternative perspectives, evaluations, and feedback on perhaps more restrictive or intrusive behavioral programming.
6. Membership of the current human rights committee should be revised to include a majority of members that are not employees of LBSSLC.
7. The monitoring of and follow-up on the behavioral services tracking grid should be improved to ensure closer adherence to completion of necessary consents and approvals prior to their expiration.
8. Data collection systems should be improved, including examining methods to simplify data collection, facilitate more timely data collection to ensure that data are reliable and valid. Measures should reflect the frequency, duration, and/or intensity of problem behavior and its corresponding replacement behavior. Staff must understand the operational definitions of all targeted behaviors, must be able to identify the presence and absence of the same, and must collect measures that provide an accurate reflection of the frequency and severity of the problem.
9. Inter-observer agreement should be assessed regularly, but no less than once each month.
10. Facility staff should collect, summarize and graph data on at least a monthly basis, or more frequently, if necessary. This should include the identification, collection, summary and display of all target, monitoring, and replacement behaviors.
11. Greater emphasis should be placed on the identification, training, and monitoring of one or more functionally equivalent replacement behaviors in PBSPs. At upcoming annual PSP meetings or sooner, Associate Psychologists are encouraged to review previously completed SFBAs and examine whether or not the identified replacement behaviors are likely to be functionally equivalent (i.e., have the potential to serve

the same function) to the targeted behaviors they are intended to replace, and whether or not additional replacement behaviors are needed.

12. At risk individuals should be identified and receive appropriate psychological services. For example, Individual #135 should be fully assessed, and appropriate behavioral supports developed and implemented to address his at-risk behaviors.
13. Clear behavioral objectives should be identified whenever a person receives therapy or support services in addition to their Behavior Support Plan, and these should be integrated with the individual's PSP. Objective measures of anticipated behavior change should be collected with accompanying data analysis to determine the effectiveness or lack thereof of the recommended practice.
14. Similar to behavioral programming, data should be collected on the use of any intervention (e.g., Sensory Diet) conceptualized, described or utilized as therapeutic or therapy. This data should include goals with measureable objectives and treatment expectations. This would allow teams to determine if the therapies are effective or not and ensure the more efficient utilization of limited resources.
15. Consideration should be given to consistently utilizing the PBSP rubric entitled the Positive Behavior Support Plan Self-Monitoring Guide and Quality Assessment Rating Scale to assist in ensuring that all of the necessary elements of PBSPs are present.
16. Consider examining the way in which the competency assessments are completed, scored and utilized.
17. A system needs to be developed, if not already in place, to monitor the utilization of PBSP Assessment-Guided and Observation-Guided Staff Training rubrics as well as determine the effectiveness of their use.
18. A system needs to be developed to ensure adequate oversight and appropriate assignment of staff to ensure that staff are adequately trained to support the individuals to whom they are assigned to work.
19. The initial training in Positive Behavior Support that is provided to staff should be greatly expanded. A more in-depth review of all of the following areas should be provided: possible functions of problem behavior, identification and teaching of replacement behavior, identification and application of reinforcement, antecedent strategies, and interventions that can be applied contingent upon the target behavior.
20. Training on individual Behavior Support Plans should occur across all shifts as these plans are developed and revised. A policy that describes competency-based training for all staff implementing Behavior Support Plans should be put into practice as soon as possible. This policy should include competency-based assessment that goes beyond a written test, and involves staff actually demonstrating competence in the implementation of PBSPs. Time should be arranged for adequate initial training for staff on all plans, with follow up conducted on-the-job.
21. Additional needed areas of training should be identified, developed and implemented. This may include training on the development, implementation and monitoring of skill acquisition programs (including chaining, task analysis, etc.); assessment methods for measuring IOA and treatment integrity; and/or a review of empirically validated treatments for individuals with Autism. Attendance and participation by selected staff should be required and monitored.
22. Behavioral services staff should be more fully integrated within day vocational/employment or habilitation services.

| SECTION L: Medical Care | |
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| | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o Administration of Oral Medications procedures, dated 2/9/10;<br>o Pharmacy and Therapeutics Committee procedures, dated 2/16/10;<br>o Communication between Pharmacy, Medical, and Nursing regarding medication, dated 11/19/09;<br>o Lost-Found Medications, dated 3/4/03;<br>o Medication Adjustment, dated 3/4/03;<br>o Medications that leave LBSSLC, dated 3/4/03;<br>o Pharmacy Services, dated 3/4/03;<br>o Physicians' Orders related to Pharmacy, dated 3/4/02;<br>o Polypharmacy Definition, Non-psychotropic Medications, dated 9/1/08;<br>o Quarterly Drug Regimen Review, dated 11/19/09;<br>o Use of Standing Physicians' Orders, dated 1/13/07;<br>o Adverse Drug Reaction, dated 3/4/03;<br>o Automatic Stop Order of Medication, dated 3/4/03;<br>o Controlled Medications, dated 4/13/09;<br>o Monthly Unit Form Checklist (for medication administration), not dated;<br>o Medication Errors and Reporting, dated 5/15/09;<br>o Attendance Roster Form for Pharmacy and Therapeutics Committee Meetings, not dated;<br>o Pharmacy Services and Safe Medication Practices, dated 11/19/09;<br>o Pick-up and Delivery of Medications for Individuals who live at the LBSSLC, dated 3/4/03;<br>o Polypharmacy Definition – Psychotropic Medications, dated 9/1/08;<br>o Receipt of Pharmaceuticals, dated 3/6/03;<br>o Enteral Medication Administration Times, not dated;<br>o LBSSLC Medication Administration Observation Checklist/Medication Room Survey/Equipment Cleanliness/Medication Room Cart Security, dated 12/09;<br>o Medication Administration Times, not dated;<br>o Administration of Oral Medication, dated 2/9/10;<br>o Medication Administration via Nasogastric Tube, Gastrostomy Tube (G-Tube) or Jejunostomy Tube (J-Tube), dated 9/17/09;<br>o At-Risk Individuals – Health Status Team Meeting, not dated;<br>o List of Individuals Receiving Anticonvulsant and Osteoporosis/Osteopenia Medications, scanned 2/17/10;<br>o List of Individuals Receiving Anticonvulsant and Osteoporosis/Osteopenia Medications With Diagnosis as to Type of Seizure, scanned 02/19/10;<br>o Convulsive Seizure Management Policy, dated 2/9/09;<br>o Medical Review System, dated 4/13/09;<br>o Health Status Meeting Schedule 2009-2010, scanned 3/22/10; |

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| | o Attendance Roster, Pharmacy and Therapeutics Meeting, dated 3/16/10;<br>o Examples of Hospital Rounds Report, prepared by facility nurse/hospital liaison, 10/13/09 through 01/25/10;<br>o List of Individuals with Code Blue on campus from 3/09 through 3/10, and related follow-up Unit Investigation Reviews;<br>o Policy on Life-Sustaining Treatment, dated 8/7/09;<br>o Policy on Use of Standing Physician's Orders, dated 1/13/07;<br>o Management of Acute illnesses and Injuries, dated 1/21/10;<br>o Example of Root Cause Analysis Report Form, scanned 3/27/10;<br>o Orthoprofile Report from 7/09 through 2/28/10, listing diagnosis of orthopedic injuries and treatment;<br>o List of Individuals with "Serious Injuries" from 7/1/09 through 2/28/10;<br>o Discharge Summaries for Individuals Discharged from UMC Health System, Lubbock, Texas, returning to LBSSLC from 2009-2010;<br>o Medical Health Status List for 233 Individuals, dated 3/8/10;<br>o Master List of Individuals with Protective and Adaptive Equipment for 1/10;<br>o Daily Clinic Report for 3/16/10;<br>o Morning Report Summary for 3/17/10 (8:15 a.m.) Clinical Meeting;<br>o Emergency Room Referral Monitoring from 3/09 through 3/10;<br>o Department of Health and Human Services, Center for Medicare and Medicaid Services, Review of LBSSLC, dated 4/30/09;<br>o List of Persons Receiving Enteral Feedings as of 3/12/10;<br>o Choking Incident Data, regarding Individual #23;<br>o Listing of Individuals Diagnosed with Pneumonia, 2009-2010;<br>o Supporting Documents distributed at 3/16/10 Pharmacy and Therapeutics Committee Meeting;<br>o Drug Interaction Alerts from 12/1/09 through 2/28/10, dated 3/10/10;<br>o Pica Incident Reports, 2009;<br>o List of Pica Incidents by Individuals, 7/09 through 2/10;<br>o Unit Staffing Reports for 2/18/10;<br>o Dental X-Ray Checklist, not dated;<br>o Report of Medical Standards of Care, Quality Assurance Review of five randomly-selected individuals, performed by Jeremy Ellis, RN, BSN, dated 9/30/09;<br>o Report of Quality Assurance Review of five randomly-selected "at risk" individuals, performed by Jeremy Ellis, RN, BSN, dated 9/29/09;<br>o Dental Services, Timely and Adequate Services, Quality Assurance Review of five randomly-selected individuals, prepared by Jeremy Ellis, RN, BSN, dated 10/30/09;<br>o Do-Not-Resuscitate documentation and status monitoring for 11/09 through 2/25/10, prepared by Marilyn Foster, Program Compliance Monitor;<br>o Review of documentation organized by Don Minnis, Chief Nurse Executive (CNE), related to serious medication administration error that occurred on 2/10;<br>o State Supported Living Center Plan of Improvement, State Office Responsible Person: |

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| | Coordinator of Medical Services, not dated;<br>o The medical records of the following individuals were reviewed <u>on site</u>: Individual #292, Individual #285, Individual #6, Individual #239, Individual #286, Individual #303, Individual #161, Individual #254, Individual #301, Individual #42, Individual #256, Individual #286, and Individual #39.<br>o The medical records of the following individuals were reviewed <u>off-site</u>: Individual #301, Individual #41, Individual #135, Individual #78, Individual #182, Individual #21, Individual # 128, Individual #261, Individual #132, Individual #185, Individual #23, and Individual #245.<br>▪ **Interviews with**:<br>o Billy Bob Beck, D.Ph., Pharmacist, on 3/16/10;<br>o Anita Blackburn, Certified Pharmacy Technician, on 3/16/10;<br>o Edward Salas, Certified Pharmacy Technician, on 3/16/10;<br>o Glen Shipley, M.D., Medical Director, on 3/17/10 and 3/18/10;<br>o Don Minnis, Chief Executive Nursing Officer, on 3/17/10 and 3/18/10;<br>o Dr. Russell Reddell, Director of Dental Services, on 3/18/10;<br>o Nursing staff, direct support professionals, and unit managers at the following homes 504 West Cedar, 504 East Mesquite, 504 West Mesquite, 528 North Cedar, 527 N. Cedar, 526 N. Cedar, 518 S. Cedar, and 517 S. Cedar Avenue<br>▪ **Observations of**:<br>o Pharmacy and Therapeutics Committee Meeting, on 3/16/10;<br>o Morning Meeting of the Medical Staff, on 3/17/10;<br>o Neurology Clinic with Dr. Daniel Hurst, on 3/17/10;<br>o Health Risk Assessment Meeting, held this week at the 516 S. Cedar Unit, on 3/18/10;<br>o During a tour of the residential living units at the LBSSLC the following individuals were observed: Individual #215, Individual #301, Individual #136, Individual #293, Individual #29, Individual #261, Individual #176, Individual #196, Individual #138, Individual #78, Individual #195, Individual #181, Individual #185, Individual #323, Individual #37, Individual #191, Individual #21, Individual #211, Individual #104, Individual #226, Individual #217, Individual #258, Individual #324, Individual #89, Individual #281, Individual #7, Individual #72, Individual #62, Individual #139, Individual #17, Individual #122, Individual #228, Individual #245, Individual #97, Individual #290, Individual #52, Individual #208, Individual #296, Individual #199, Individual #275, Individual #192, Individual #76, Individual #205, Individual #282, Individual #311, Individual #12, Individual #128, Individual #252, Individual #48, Individual #47, Individual #164, Individual #172, Individual #272, Individual #95, Individual #132, Individual #260, Individual #229, Individual #204, Individual #253, Individual #270, Individual #168, Individual #265, Individual #198, Individual #269, and Individual #19; and<br>o Five individuals who had a seizure disorder in the context of the 3/17/10 Neurology Clinic, including: Individual #203, Individual #120, Individual #182, Individual #313, and Individual #316 |

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| | **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| | **Summary of Monitor's Assessment:** The medical staff at LBSSLC was composed of the Medical Director, two full-time primary care physicians, and a licensed Physician Assistant. The caseload for each primary care provider (PCP) was approximately 70 individuals, which was a reasonable number. The caseloads were distributed by residential unit, so that each provider was responsible for specific units.<br><br>There were a number of sub-specialty clinics held at LBSSLC throughout the month. The most frequent sub-specialty clinics were held for Neurology, due to the number of individuals with seizure disorders. The Neurology Clinic was impressive with regard to the thoroughness of the reviews, and the interaction between the neurologist, medical practitioners, psychiatrist, and the nurses who presented the cases.<br><br>The Medical Department had identified providers in the community who were available to see LBSSLC individuals for those specialties that do not have on-site clinics.<br><br>Based on the records reviewed, it appeared that individuals were receiving routine preventative procedures, such as mammograms, PAP smears, colonoscopies, bone density testing, electrocardiograms, monitoring for blood levels of medications, when necessary, and routine laboratory testing. The "Annual Physical Examination and Medical Summary" provided a comprehensive summary of current and past medical problems. The "Nursing Care Summary" was primarily a series of checklists, which was less useful.<br><br>One of the primary concerns about the medical care at LBSSLC was related to the critical shortage of nurses, which had contributed to a number of systemic problems, including significant medication errors. Another area of concern related to the basic provision of care, which primarily derives from the historical Sick Call format used in large facilities. This system relies heavily on direct support professionals to identify changes in the clinical status of an individual, and then to initiate the referral process by contacting a nurse, usually a Licensed Vocational Nurse (LVN).<br><br>During a tour of the facility, staff were asked about the frequency with which the physicians visit the units, and there did not appear to be a definable pattern with the exception of the 504 East Mesquite and 504 West Mesquite units, where the individuals who require the most intensive medical care reside. Staff reported that one of the physicians visited those units on a daily basis. On the other residential units, though, this system relied upon staff members who have either limited or no formal medical training to initiate the referral to the PCP. This can lead to delays in the identification and treatment of new onset illness, as well as the deterioration of a chronic condition. The lack of a routine presence on the units by the PCPs also, to a certain extent, insulated them from the direct observation of environmental problems on the residential units.<br><br>The "Medication Utilization Evaluation" (MUE) that was reviewed in the 03/16/10 Pharmacy and Therapeutics Committee was somewhat superficial, as was the review of the individuals who had experienced dehydration in the preceding quarter. The current medical risk assessment system involved |

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| | rating the risk level for 19 health status concerns on a three-point scale. However, in actuality, the determination of the risk levels was extremely subjective.<br><br>The Medical Quality Assurance Department represented an area of strength for the LBSSLC. Their ongoing reviews of the issued identified in this section of the Settlement Agreement will be crucial in bringing the Facility into compliance. |

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| L1 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. | During an interview with the Medical Director and the Chief Nurse Executive (CNE), the nursing shortage at the LBSSLC and its impact on the provision of adequate healthcare supports was discussed. With 50 out of 105 nursing positions currently vacant, there was a heavy reliance on agency nurses. Using agency nurses has led to a number of negative outcomes, including, for example, high rates of medication errors. The CNE was well aware of this problem, and had developed a plan to fill these positions. The plan was awaiting approval by the Central DADS Office. This is discussed further in the section below that addresses Section M of the SA. It is essential, however, that nursing staff be stabilized as soon as possible in order to ensure that individuals receive consistent, safe, and adequate healthcare supports.<br><br>There was also a discussion of the emergency drills. Risk Management oversees these drills, which the physicians do not attend, but should. There are six Automated External Defibrillators (AEDs) on campus.<br><br>With regard to physician staffing, the Medical Director was employed on a full-time basis, as were the other two staff physicians. The LBSSLC also employed a full-time Physician's Assistant. The Primary Care Physicians and the Physician Assistant's caseloads were allocated by the Residential Units (i.e., each PCP was assigned certain residential units for which they were responsible). The psychiatrist and dentist both reported to the Medical Director.<br><br>The Medical Director indicated that the caseload for each practitioner was in the range of 70 individuals. He supervised the PA, who was a licensed, practicing physician in Poland before she immigrated to the United States, and completed a Physician Assistant Training Program.<br><br>The After-Hours, On-Call coverage (5:00 p.m. to 8:00 a.m.) was provided by a weekly rotation of the LBSSLC physicians via telephone. The Medical Director indicated that the number of calls ranged from zero to five per week, and could usually be handled over the phone, unless a physician needed to come to the Facility to pronounce a death. The On-Call Physician made on-site rounds on weekends and holidays, which was facilitated by | |

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| | | the RN Supervisor. During these weekend rounds, the individuals were usually seen on their Living Unit.<br><br>The Medical Director was also responsible for the Laboratory, Pharmacy, and X-ray Departments. At the time of the review, there were two vacant X-ray Technician positions. The X-ray Technicians were also responsible for phlebotomy services. The Facility was using a contract service to perform the X-ray Technician's services until the positions were filled.<br><br>The delivery system of medical care at the LBSSLC was essentially a modification of the Sick Call System, which historically had been utilized in the military and large facilities. During visits to all of the residences on campus, inquiries as to how an individual was identified as a candidate to be seen at the Clinic by a PCP were consistently responded to with the answer that the process usually began with a direct support professional identifying an individual as showing signs of a new physical illness, or a change in their ongoing physical status. This information was then conveyed to the LVN or RN on the Unit, who then decided if the individual should be seen in the Clinic. The process could also be instigated by the observations of the LVN or nurse on the Unit. However, the continual reliance on agency nurses decreased the likelihood that the nurse on duty on a particular Unit would have long-term knowledge of the individual's usual clinical presentation. Reportedly, the individual identified as needing to be seen in the Clinic would usually be seen on the day of the referral, or the following day. The only units that the physicians/PA visited on a regular daily basis were 504 East Mesquite and 504 West Mesquite, where the most individuals with the most medical complexities reside. According to staff, the physician assigned to these homes visited them on a daily basis.<br><br>There continued to be relatively high rates of aspiration pneumonia, frequent utilization of emergency care in local hospitals and medical hospitalization at local hospitals as well. It would be useful to investigate if daily or every other day PCP rounds on the living units would increase the timely diagnosis of evolving illnesses and, thus, decrease the rates of Emergency Room visits and medical hospitalizations. A greater presence on the living units would also increase the PCP's direct observational experience regarding medication administration, and other important procedures on the residential units.<br><br>The Medical Director's description of how individuals were identified to be seen in the Clinic was consistent with the system that was described to the reviewer on the tour of the residences. Specifically, he noted that the identification process usually began with the Unit staff bringing the individual to the attention of the LVN, who would then contact the RN Supervisor. The practitioners began seeing patients in the Clinic around 9:00 a.m., and were available to see new referrals throughout the day. | |

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| | | The PCPs also were going to the residential units to see individuals, depending on the circumstances, for example, after a fall or a seizure. The Facility also employed a full-time hospital liaison nurse, who was responsible for coordinating the care of the LBSSLC residents who were medically hospitalized at external hospitals or a rehabilitation facility. The Medical Director indicated that the range of residents hospitalized at external facilities ranged from zero to 15 at any time, with the typical average being two to three individuals. Several of the clinical notes, which were prepared by the nurse liaison, were reviewed. The thoroughness of the documentation was impressive.<br><br>On 03/17/10, the reviewer attended the 8:15 morning Clinical Meeting, which was chaired by the Medical Director. The PCPs, and the psychiatrists attended the meeting. Nursing staff facilitated the meeting, and the information they provided was augmented with written materials. During the meeting clinical issues that occurred overnight were reviewed, as well as a review of the prior day's clinical visits and those scheduled for that day. The meeting was well organized and informative.<br><br>The frequency of on-site sub-specialty consultations was reviewed. The most frequent on-site consultation occurred for Neurology (one neurologist two times per month; and the other one time per month). On-site consultation was available at least on a monthly basis for Ophthalmology; Endocrinology Urology; Ear, Nose and Throat; Gynecology; and Podiatry. The Facility also had identified a Cardiologist and Pulmonologist, who would consult on LBSSLC individuals in their community offices.<br><br>Review of individual records found evidence of routine medical diagnostic testing in the form of mammograms, PAP Smears, colonoscopies, testing for bone density, blood levels of anticonvulsant medications, electrocardiograms, prostate-specific examinations, lipids, thyroid status, and general, routine laboratory testing.<br><br>The Annual Medical Summary and Physical Examination was an especially useful document, as it provided in one document a chronology of significant medical events going back for several years. The records of 10 individuals were randomly selected for off-site review to ascertain if the Annual Medical Summary and Physical Examination had been updated during the past year. This document had been completed in the records of the following individuals: Individual #30, Individual #41, Individual #135, Individual #78, and Individual #52, Individual #21, Individual #128, and Individual #261. A recently updated copy could not be located in the records of the following two individuals: Individual #132 (most recent completed 05/16/08), and Individual #185 (most recent completed 04/15/08). Thus, the rate for completing these on an annual basis was 80%, based on this limited sample.<br><br>The 3/1/10 list of individuals receiving enteral feeding indicated that there were 49 | |

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| | | individuals receiving some type of enteral feeding (intermittent, continuous, bolus/gravity, or just for medications and fluids.) Comparison of this list to the individuals who appeared on the "2009 Pneumonia" list as well as the corresponding list for January 2010 indicated that from November 2009 through January 2010, 11 of the 14 individuals (78.6%) who developed pneumonia or aspiration pneumonia were receiving some form of enteral feeding. Another perspective on this data was that 11 of the 49 individuals (22.4%) who receive enteral feeding developed pneumonia or aspiration pneumonia during this three-month period. The individuals who receive enteral feeding are, of course, at high risk for aspiration and/or choking, and that was likely part of the rationale in most cases for the decision to pursue enteral feeding. However, this incidence of the continued development of pneumonia/aspiration pneumonia while on enteral feeding warrants further investigation.<br><br>Another medical issue that can have fatal consequences is pica. The list of individuals who had pica indicated that from 07/09 through 02/10, seven individuals were identified as having engaged in pica behavior, five of whom had one incidence of pica during this time period, and two of whom had two. A particularly disturbing incident is described in the following excerpt from the 10/12/09 Incident Report concerning Individual #23 who did not appear to receive timely medical attention after three reported choking incidents, due, in part, it appeared to staff's reticence that "pica" was part of his expected repertoire of behavior:<br><br>"*[A staff member] provided a witness statement that states:*<br><br>*At 8:30 pm, I, [staff member], brought* [Individual #23] *to the kitchen to eat dinner. After he had eaten dinner, he got up with me and started walking to the door; I had my hands on his shoulder. While walking to the door, he was taking off his clothing protector and when he got it just above his eyes, he reached over and grabbed* [another individual's] *whole rib sandwich and put it in his mouth all in one single motion and began chewing and started swallowing the sandwich. When he started swallowing he made a sound as if he was choking but I was hesitant to start the Heimlich maneuver, because he was still chewing the food. After he made the third choking noise he fell to the kitchen floor and wouldn't get up when I tried to get him up but he laid there, so I sat him up, knelt down behind him and initiated the Heimlich maneuver. After I gave him the first thrust he appeared to cough it back up, but started chewing and swallowed it again, and it appeared yet again that he was choking as he was making the same sounds as before. So I gave him the second thrust and he coughed it back up again, but he started back to chewing and swallowed then made that choking sound, so I gave him the third thrust and he coughed it back up a third time and started back to chewing and swallowing. I then attempted to do the bite release technique because I figured that was the only way to prevent him from choking any further. While I was doing that he was continually chewing his food and swallowing it. When I did get his* | |

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| | | *mouth open he had finished the sandwich. Afterward he refused to leave the kitchen so we gave him another plate of food. Keep in mind that* [Individual #23] *is PICA and he stays hungry. After he ate that plate he attempted to grab* [another individual's] *plate of food but was unsuccessful. After we went to the dayroom it was time for his medication, so he saw the nurse. After his meds I went to Bernice's office and spoke with Janna on the phone to clarify the incident to her.*"<br><br>The following excerpt from the medical record of Individual #245 illustrated the chronicity of the pica behavior in some individuals that led to, in this case, exposure to multiple abdominal x-rays:<br><br>"***INTEGRATED PROGRESS NOTES*** *– Date/Time: 01/15/09 – 3:02 PM*<br>*SUBJECTIVE:* [Individual #245] *had an abdominal x-ray done to evaluate for a possible ingested plastic foreign body. No metallic foreign bodies were seen; however, the exam is limited for evaluation of plastic foreign body. He does seem to be asymptomatic at this time.*<br>*PLAN: No action taken*<br><br>*[Signature of Physician]*<br>*Staff Physician*<br><br>***INTEGRATED PROGRESS NOTES*** *– Date/Time: 02/05/09 – 10:20 AM*<br><br>*SUBJECTIVE:* [Individual #245] *was seen at the clinic for monthly PICA check and an abdominal x-ray was done and this showed a hair clip at the rectal area. He also had a foreign body that looks like a small pebble measuring about 1 cm. along the left colon.*<br><br>*PLAN:*<br>1. *He is currently on a routine level of supervision, the QMRP and dorm nurse was notified of the findings.*<br>2. *I will request for a Fleet's enema today and repeat an abdominal x-ray tomorrow.*<br>3. *Hopefully, he will pass the foreign body.*<br><br>*[Signature of Physician]*<br>*Staff Physician*<br><br>***INTEGRATED PROGRESS NOTE*** *– Date/Time: 02/06/69 – 9:50 AM*<br><br>*SUBJECTIVE/OBJECTIVE:* [Individual #245] *is here for follow-up on a foreign body in his rectum (hairpin in colon). He is doing well. He was put on an enhanced level of supervision yesterday. A repeat abdominal x-ray was done to follow-up on the foreign body, and it* | |

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| | | *showed that the hairpin is not present any more, but he had more pebbles noted, about 7 to 8 on both sides of the colon.*<br><br>*PLAN: AOD, QMRP, nurse, and campus coordinator were all notified and it was agreed he be put on a 1:1 level of supervision. A KUB of the abdomen will be done on Monday, 02/09/09.*<br><br>*[Signature of Physician]*<br>*Staff Physician*<br><br>***INTEGRATED PROGRESS NOTE** – Date/Time: 02/09/09 – 9:20 AM*<br><br>*SUBJECTIVE:* [Individual #245] *is here for follow-up of pica. He is currently on an enhanced level of supervision. A repeat x-ray of the abdomen was done and most of pebbles described before were gone, and he just has 1 more small pebble in the left side of the colon.*<br><br>*OBJECTIVE: He is awake, alert, and not in distress. Abdomen is soft and nontender.*<br><br>*ASSESSMENT: Ingested foreign body in colon.*<br><br>*PLAN: Enhanced level of supervision.*<br><br>*[Signature of Physician]*<br>*Staff Physician*<br><br>***INTEGRATED PROGRESS NOTE** – Date/Time: 02/09/09 – 9:20 AM*<br><br>*SUBJECTIVE:* [Individual #245] *is here for follow-up of pica. He is currently on an enhanced level of supervision. A repeat x-ray of the abdomen was done and most of pebbles described before were gone, and he just has 1 more small pebble in the left side of the colon.*<br><br>*OBJECTIVE: He is awake, alert, and not in distress. Abdomen is soft and nontender.*<br><br>*ASSESSMENT: Ingested foreign body in colon.*<br><br>*PLAN: Enhanced level of supervision.*<br><br>*[Signature of Physician]*<br>*Staff Physician* | |

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| | | ***INTEGRATED PROGRESS NOTES*** *– Date/Time: 02/13/09 – 1440 hours*<br><br>*SUBJECTIVE/OBJECTIVE: Review of KUB x-rays from 02/05/09, 02/06/09, and 02/09/09. 02/05/09 x-ray shows bobby pin within the mid to lower central pelvis, either in terminal ileum or rectum.*<br><br>*KUB of 02/06/09 shows radiopaque bodies in the ascending colon and rectal pouch. Previously seen bobby pin is not present.*<br><br>*Kub of 02/09/09 shows single round dense body in the proximal portion of the descending colon. No other radioplaque bodies are seen.*<br><br>*PLAN: Repeat x-ray on 02/18/09.*<br><br>*[Signature of Medical Director]*<br>*Medical Director*<br><br>***INTEGRATED PROGRESS NOTES*** *– Date/Time: 02/17/09 – 10:55 hours*<br><br>*SUBJECTIVE/OBJECTIVE:* [Individual #245] *has been x-rayed because of the foreign bodies. At one time there was a bobby-pin and then several radiopaque bodies. The bobby-pin has passed and so has many of the other bodies. The last x-ray on 02/09/09 stated there was a single rounded dense body in the proximal portion of the descending colon.*<br><br>*PLAN: Repeat a KUB on 02/18/09.*<br><br>*[Signature of Medical Director]*<br>*Medical Director*"<br><br>This discussion of pica had been included in this section on medical care because it represents a serious, potentially fatal issue, and it is essential that the Medical Department assume a significant leadership position in developing the Facility's preventative strategies, both on an individual and a facility-wide basis. The examples cited above would indicate that, even with enhanced or one-on-one supervision, individuals with pica behavior were still able to ingest substances that could lead to a fatal episode of choking or bowel obstruction.<br><br>The LBSSLC relied heavily on their Health Risk Assessment Rating Tool as a mechanism to reduce the exposure of individuals to undue medical/physical risk. This tool listed the following 19 items on a three-point scale: High Level=1, Medium Level=2, and Low Level=3: | |

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| | | ▪ Aspiration;<br>▪ Choking;<br>▪ Weight;<br>▪ Cardiac;<br>▪ Constipation;<br>▪ Dehydration;<br>▪ Diabetes;<br>▪ Hypothermia;<br>▪ GI Concerns;<br>▪ Medical Concerns;<br>▪ Osteoporosis;<br>▪ Seizures;<br>▪ Skin Integrity;<br>▪ UTIs;<br>▪ Polypharmacy;<br>▪ Challenging Behavior;<br>▪ Injury; and<br>▪ Respiratory.<br><br>The reviewer attended a portion of the Health Risk Safety Meeting on 516 South Cedar, which took place on 03/18/10. This meeting, which was led by Medical Director was also attended by the heads of various clinical disciplines. The head of each discipline would discuss the individual's health risk status during the prior quarter. The current risk assessment for the related risk areas would then be examined to determine if it was still appropriate. In those cases where there had been a change in an individual's clinical status, the risk level would then be increased or decreased accordingly. The major concern about this process was that the actual final rating of the risk (on the three-point scale) appeared to be subjective in nature.<br><br>The QE Nurse had completed a review of the implementation of the current Health Status Risk Assessment Rating Tool. Reports were available for his review of a random sample of the medical records for five individuals in November 2009, entitled "At-Risk Individuals." There was also an identical review for an additional five randomly selected individuals for December 2009. Thus, the total sample size he analyzed included 10 individuals. Combining the information from the two reviews produced the following results for the questions investigated:<br>1. Does the Health Status Team conduct regular risk screens (risk assessment tools)? Results: The QE review of these 10 records found a compliance rate of 50% (November 20%; December 80%).<br>2. Does risk screening adequately identify those whose health status and well-being is at risk? Results: The QE review of these 10 records found a compliance | |

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| | | rate of 10% (November 20%; December 0%).<br>3. Does the PST meet within five days of the individual being identified as being "at risk?" Results: 0% for both months.<br>4. Does the Daily Providers Meeting address changes to the individual's risk status as needed? Results: 80% for the composite sample (November 60%; December 100%).<br>5. Does the PST implement a plan within 14 days (sooner if the risk warrants a more immediate action)? Results: 0% for both months.<br>6. Do the plans include clinical indicators to be monitored and the frequency of monitoring? Results: 0% for both months.<br><br>The December 2009 Summary of the review provided the following observations and valuable recommendations:<br><br>"*Question #1: missing weight assessment tool from HSM packet in chart.*<br><br>*#2: The health risk rating tools are not being completed; only some medium and high risks are being addressed at the HSM. Even if the individual is a low risk in the applicable category, it MUST be addressed by the Physician at the HSM. It would be improper for anyone to assume that an unmarked category is a "low risk" – only the physician has the authority to make that designation. Each category of risk must be discussed and addressed at each HSM for each individual.*<br><br>*#3: PSTs are not meeting within 5 days of risks being identified. Risks are identified at each HSM. Recommendation: PSTs need to start planning on meeting within 5 days (calendar days) of each HSM in order to discuss recommendations from the HSM and the identified risks for each individual. A PSPA should accompany each meeting for each individual.*<br><br>*#5 & #6: PSTs are not implementing plans within 14 days due to the fact that they are not meeting within 5 days of identifying risks.*<br><br>*Note: when a high risk is identified the PST is obligated to meet every 30 days until the specified issue is resolved or the risk is down-graded. Meetings should be scheduled in advance (at the time of the initial meeting) in order to avoid the lapse.*<br><br>*The overall compliance score of 30% marks an 11% increase in compliance as compared to last month.*"<br><br>The QE Nurse had also been tracking the progress of the LBSSLC Medical Department in complying with the Standard of Care section of this provision. In November and | |

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| | | December of 2009, he reviewed the medical records of 10 randomly selected individuals (five each month). A summary of his results for each of the areas is as follows:<br>1. The Health Status Team identified potential risks for the individual. Results: 10% compliance (November 0%; December 20%).<br>2. Was an Annual Medical Assessment completed within the last 12 months? Results 90% (November 100%; December 80%).<br>3. Does the Preventative Care Flow reflect that the appropriate preventive care has been delivered and reviewed? Results: 10% (November 0%; December 20%).<br>4. Are diagnostic reports (labs and x-rays) reviewed, signed, and dated; and appropriate follow-up orders and documentation, if needed? Results: 90% (November 80%; December 100%).<br>5. Is the appropriate integration of services apparent by communication/documentation within the integrated Progress Notes? Results: 30% (November 20%; December 40%).<br>6. Are individuals with acute health issues provided care in an appropriate setting to meet their needs (emergency care)? Results: 100% (November 100%; December 100%).<br><br>As the Observational Summary and Recommendations section from the December 2009 report stated: "*Risks are not being identified appropriately. The risk rating tool should reflect the risk assessments. Completing the risk rating tool in full would more adequately show that there was discussion involved with each rating."* | |
| L2 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement. | The LBSSLC maintained an extensive roster of sub-specialty clinicians, who provided clinical consultation both at the Facility and in the community. It appeared that the Facility clinicians readily sought outside sub-specialty consultations. This was a reasonable position, given the complexity of the individuals who reside there. These consultants provided an external view of the provision of medical services at the LBSSLC. However, this view was limited to the scope of the outside physician's sub-specialty.<br><br>No documentation was found of regular formal reviews of the day-to-day provision of medical care by external physicians, as described in this provision.<br><br>The Quality Assurance Review dated 04/06/09, prepared by the QE Nurse addressed the Facility's progress with regard to this provision. The section related to the Non-Facility Physician Review noted: "The last annual Non-Facility Physician Review was conducted in December 2008. We will need to have an annual review conducted by December 2009 in order to remain in compliance. The review must address all components of this monitoring tool as a minimum requirement." Documentation that this has been carried out was not found during this review. Further follow-up will occur during upcoming monitoring visits. | |

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| L3 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved. | On 03/16/10, the reviewer attended the Pharmacy and Therapeutics Committee Meeting. This meeting appeared to provide the forum for the review of a number of issues related to the ongoing improvement of clinical services at the LBSSLC. The Chief Nursing Executive Officer reviewed the proposed plan to transform RN Nursing Blocks into LVN blocks (as these are easier to fill in the Lubbock area) to enhance recruitment of nurses, fill the large number of available empty blocks, and decrease the reliance on agency nurses, which has contributed to a number of system problems.<br><br>There was also a review of the Medication Administration Variances for the last quarter. There were two in December, four in January, and one in February. Three of the four individuals in January involved medication administration errors that involved another individual's medication instead of their own. All three were sent to the hospital; one of these was quite serious, in that the individual's blood pressure dropped precipitously, and the individual stopped breathing in the ambulance on the way to the hospital, requiring intubation. Fortunately, the individual did eventually recover. The nurse involved was terminated, and the incident was reported to the Board of Nursing, as the nurse did not immediately respond to the individual. It was a direct support professional that summoned assistance. The administration of another individual's medication to the wrong individual is one of the more serious types of medication errors. The fact that there were three of these in one month, despite the presence of the individual's picture on the Medication Card, illustrates the vulnerability produced by the reliance on external agency nurses to compensate for the shortage of full-time nurses. However, it was noted during the meeting that the incidence of medication variances was lower than it was a year ago.<br><br>The Staff Psychiatrist reviewed the ongoing attempts to reduce the polypharmacy with regard to psychotropic medications.<br><br>There was also a discussion of the development of a new "Re-admission packet," which streamlined the physician's approval of medical orders after an individual returns to LBSSLC from an external hospital.<br><br>The Medical Director noted that a new Pharm. D. had been hired, but had not yet begun to work.<br><br>He also reviewed the data with regard to the number of individuals diagnosed with dehydration (seven last quarter, and six during the present quarter). This quarterly review of the number of individuals who developed dehydration was only minimally useful. The summary did not provide enough additional clinical detail about the individuals to develop prospective plans to minimize the frequency with which individuals become dehydrated in the future. For example, when the Medical Director | |

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| | | was asked how many of these individuals received nutrition via feeding tubes, he was not able to provide an answer. In order to be of use in preventing future occurrences of dehydration, the review would need to include information, such as the demographic data, living unit, feeding status, and co-morbid medical/psychiatric conditions.<br><br>There was a review of the use of the anticonvulsant, Keppra. The review was relatively superficial. It only included ten individuals, and focused primarily on the dosages utilized, as compared to the usual dosage range for Keppra. In a Facility the size of the LBSSLC, it should be possible to sample the utilization of a medication, such as Keppra, for the entire population. A Medication Utilization Evaluation (MUE) should investigate not only dosages utilized, but also adverse events (10%-13% of individuals receiving Keppra will exhibit behavioral/psychiatric disinhibition or activation); and the number of individuals for whom the medication was discontinued due to lack of efficacy. This type of internal facility-based data can then be compared to larger, published databases. It was not clear during this review how seriously the Medical Department considered the results of these reviews in terms of requiring a written response.<br><br>On a positive note, a number of the Quality Assurance Reports related to the provision of medical care that were prepared by the QE nurse were reviewed. They were generally thorough, and provided valuable insight into areas requiring attention, as well as recommendations that should be considered. Some of these reviews have been quoted elsewhere in this report. Future monitoring reviews will evaluate the degree to which the findings of the Quality Assurance Analyses and reviews impact the provision of medical care at LBSSLC. | |
| L4 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. | The QE Nurse performed a Quality Assurance Review related to compliance with this provision. In November and December, the reviews noted a need to improve on the development of policies and procedures related to the provision of medical care.<br><br>The LBSSLC Medical department had made progress in meeting the requirements of this provision. As noted in the review of documents section above, there were a number of policies that related directly to the recommendations derived from the Health Care Guidelines. However it was not clear how closely these policies adhered to day-to-day clinical practice, although the review of records did indicate that routine preventive screening lab tests and procedures were being carried out on a regular basis. The next monitoring review will include a statistical assessment related to the implementation of the policies that have been developed to address the requirements of this provision. In addition to a review of the related policies, this review will be based on a random sample of individual medical records. | |

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

1. It would be useful to investigate if daily or every other day PCP rounds on the living units would increase the timely diagnosis of evolving illnesses and, thus, decrease the rates of Emergency Room visits and medical hospitalizations. A greater presence on the living units would also increase the PCP's direct observational experience regarding medication administration, and other important procedures on the residential units.
2. Physicians should be involved in Code Blue and other emergency drills.
3. The Medical Department, working in conjunction with the other disciplines, should develop more objective mechanisms for "at risk" ratings, so that it will be clear to everyone exactly what constitutes a rating of "1" or "2" or "3."
4. The internal Quality Assurance Departmental review related to the administration of the "Health Risk Assessment Rating Tool" also raised concerns about the utilization of the current system, and these issues also should be addressed.
5. The Medication Utilization Evaluations (MUE) should be modified to provide a more in-depth analysis of the use of specific medications. Drug-specific MUEs for a facility the size of LBSSLC would usually analyze data for the entire population receiving that medication, and the outcomes (positive response, no response, or adverse response). A form should be added to the MUE requiring a written response, and plan of action from the Medical Department that addresses any problems identified.
6. It is essential that as potentially problematic trends are identified, thorough analyses are completed, action plans to address contributing factors are developed and implemented, and the efficacy of such plans monitored so that plans can be modified if they are not having the desired effect. Further analysis and written action plans should be developed to address a number of potentially problematic trends identified during the course of this review, including:
    a. The number of individuals who developed dehydration as presented at Pharmacy and Therapeutics Committee Meeting of 03/16/10;
    b. The frequency of pneumonia/aspiration pneumonia in individuals who are receiving enteral feeding is relatively high. This observation should be further investigated by the Medical and Quality Assurance Departments, in an attempt to ascertain if there are systemic issues which contribute to this, which should then be addressed;
    c. The medical department should be involved in the developing a comprehensive plan to ensure the safety of individuals who have repeated occurrences of pica, placing them at risk for choking or other medical complications;
    d. The medical department should be included in efforts to address medication variance trends;
    e. The LBSSLC internal Quality Assurance Department has been monitoring the progress of the Medical Department in complying with the provisions set forth in the Settlement Agreement, related to the Health Care Guidelines. These Quality Assurance studies indicate substantial deficits that need to be addressed.
7. The Quality Assurance Department at the LBSLC has performed many important internal reviews related to compliance with the medical sections of the Settlement Agreement. This ongoing internal process will be crucial in bringing the Medical Department in compliance with the provisions of the Settlement Agreement, and their work should continue to be fully supported.
8. A mechanism should be developed to ensure that external physician reviews are performed as required by the SA.

| SECTION M: Nursing Care | |
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| 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:<br>▪ **Review of Following Documents**:<br>o QE Nursing tools and data;<br>o The medical records for the following individuals: Individual #56, Individual #127, Individual #254, Individual #269, Individual #118, Individual #185, Individual # 168, Individual # 192, Individual # 253, Individual #41, Individual #65, Individual #10, Individual #171, Individual #311, Individual #250, Individual #19, Individual #132, Individual #317, Individual #86, Individual #90, Individual #223, Individual #82, Individual #180, Individual #8, Individual #240, Individual #193, Individual #149, Individual #290, Individual #218, Individual #107, Individual #251, Individual #303, Individual #51, Individual #264, Individual #213, Individual #184, Individual #306, Individual #309, Individual #109, Individual #75, Individual #277, Individual #243, Individual #140, Individual #232, Individual #125, Individual #298, Individual #4, Individual #54, Individual # 106, Individual #143, Individual #76, Individual #16, Individual #182, Individual #314, Individual #62, Individual #74, Individual #283, Individual #237, Individual #292, Individual #54, and Individual #233, Individual #161, Individual #301, Individual #113, Individual #17, Individual #43, Individual #56, Individual #229, Individual #164, Individual #15, Individual #237, Individual #2, Individual #38, Individual #168, Individual #298, Individual #306, Individual #99, Individual #112, Individual #312, Individual #116, Individual #180, Individual #114, Individual #192, Individual #75, Individual #189, Individual #16, Individual #276, Individual #212, and Individual #55;<br>o LBSSLC policy regarding Role of Hospital Liaison/Discharge Planner;<br>o LBSSLC's Infection Control Policies;<br>o Infection Control data and graphs;<br>o LBSSLC's Infection Control surveillance data;<br>o Infection Control Surveillance Rounds data;<br>o LBSSLC Standard Precautions Monitoring Tool data;<br>o Monthly Infection Totals by Unit and associated graphs;<br>o QE Infection Control data;<br>o Pharmacy and Therapeutic Committee minutes, dated 1/28/10;<br>o Infection Control Committee Meeting minutes dated 7/15/09, 8/20/09, 9/17/09, 10/22/09, 11/30/09, 12/31/09, 1/22/10, and 2/25/10;<br>o Infection Control Monitoring Tool and data from 9/09 through 12/09;<br>o Human Immunodeficiency Virus (HIV) Prevention, Testing, and Treatment policy;<br>o Infection Control course description for new employee orientation;<br>o QE Medication Administration Observations data;<br>o LBSSLC's Nursing Policies/Procedures, and Protocols;<br>o Nursing Orientation outline and materials;<br>o Instruction for completion of Mental Retardation (MR) Nursing Assessment Tool; |

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| | ○ LBSSLC's Nursing Table of Organization;<br>○ QE Medication Administration Surveillance data for August through December 2009;<br>○ QE Nursing Assessments data for November and December 2009;<br>○ LBSSLC Medication Administration Observation Checklist form;<br>○ LBSSLC's Emergency Drill schedule and data;<br>○ Protocol for Emergency Equipment Inventory;<br>○ Unusual Incident Investigations for actual medical emergencies;<br>○ LBSSLC policy on Life Threatening Emergency Drills-Competency Training and Development;<br>○ Life Threatening Emergency drills from 3/09 to 2/2010; and<br>○ Administrative Review Team Minutes, dated 7/2/09, 9/17/09, and 1/26/2010<br>▪ **Interviews with**:<br>○ Don Minnis, RN, BSN, Chief Nurse Executive;<br>○ Jeremy Ellis, RN, QE Nurse;<br>○ Michelle McElroy, RN, Infection Control;<br>○ Sylvia Hernandez, LPN, Scheduler/Infection Control Support; and<br>○ Glen Shipley, M.D., Medical Director<br>▪ **Observations of**:<br>○ Medication Administration in Quail and Sparrow; and<br>○ Demonstration of the emergency equipment in Quail, Sparrow, and Canna |
| | **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| | **Summary of Monitor's Assessment:** LBSSLC had 105 positions allotted for the Nursing Department, and at the time of the review had 50 vacancies. Of the 50 vacancies, 30 were for Registered Nurses (RNs) and 20 were for Licensed Vocational Nurses (LVNs). In order to meet minimum staffing ratios, the Facility was using the services of seven agencies. The Facility had struggled for a number of years to fill its existing nursing positions. The lack of consistent nursing staff was having a negative impact on the continuity of care, and appeared to be one of the causes for negative outcomes experienced by individuals served by the Facility, such as increased medication errors. This issue needs to be addressed to facilitate the provision of clinical care and positive outcomes for the individuals being served by the Facility.<br><br>LBSSLC needs to develop and implement a number of Nursing and Infection Control monitoring instruments that will accurately reflect the quality of nursing care and practices being provided, and to ensure timely identification of problematic trends and implementation of timely plans of correction. In addition, these data generated by the Nursing monitoring tools need to be integrated into the Facility's Quality Management and Risk Management systems.<br><br>Although the QE tools lacked items to monitor quality, the summaries noted on the audit forms themselves indicated that problematic issues were being identified. Very specific information was contained on the audit tools regarding the problems found and the methodology used by the QE Nurse was clearly |

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| | documented. However, no plans of correction were found addressing the problematic issues found.<br><br>There were a number of significant problematic issues found regarding complete and adequate nursing assessments related to symptoms for acute changes in status. In addition, there were problems noted regarding the lack of adequate documentation of assessments prior to the transfer of an individual to the off-site medical center as well as upon return to the Facility.<br><br>The Nursing Care Plans at LBSSLC generally did not include appropriate and measurable objectives. As these are improved, it will be necessary for nursing quarterly assessments to include a discussion of the progress an individual is making or not making, interventions that are working or not working, and to recommend changes, if needed, in these interventions.<br><br>The monitoring instrument used for Medication Administration Observations needs to be expanded to include the appropriate procedures for medication administration. Observations of medication administration should be conducted quarterly for all nurses who administer medications. |

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| M1 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status. | Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different sections 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 code blue drills. 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 SA.<br><br><u>Staffing</u><br>Regarding nursing staffing, LBSSLC's RN and LVN staffing data at the time of the review showed that they had significant vacancies at the Facility. The department had a total of 105 nursing positions with 50 vacancies; 30 for RNs and 20 for LVNs. In order to meet minimum nursing staffing ratios, the Facility used the services of seven agencies. Due to the high use of agency nurses, the Facility implemented a two-week orientation for agency nurses rather than an abbreviated orientation.<br><br>The Chief Nurse Executive reported that the Facility had struggled for a number of years to fill its existing nursing positions, and had not been successful in its efforts to recruit nurses. Barriers to recruiting and retaining nursing staff were reported as including salaries, a need to reallocate nursing positions, and the reputation of the Facility. The Nurse Executive reported that he had submitted a proposal for the reallocation of nursing positions, but has not yet heard if it was being considered. The proposal | |

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| | | involved converting some RN positions to LVN positions.<br><br>The lack of consistent nursing staff was having a negative impact on the continuity of care, and appeared to be one of the causes for negative outcomes experienced by individuals served by the Facility, such as increased medication errors. This issue needs to be addressed to facilitate the provision of clinical care and positive outcomes to the individuals being served at the Facility.<br><br>LBSSLC had three buildings that had 24-hour nursing care. The Facility had not had an infirmary for the past five years. The Facility had a Campus Nurse that made regular rounds, and covered the buildings that did not have 24-hour nursing during the night shift. From review of LBSSLC's nursing staffing assignments, at the time of the review, the Facility had 23 positions for RN3s, 32 positions for RN2s, 34 positions for LVN3s, and five positions for LVN2s. The Chief Nurse Executive directly supervised the Hospital Nurse Liaison, Nurse Educator, the Infection Control Coordinator and support LVN, the Nurse Operations Officer, the Clinic Nurse, the Nurse Recruiter, Plan of Implementation Support/Skin Integrity Nurse, and the Administrative Assistant.<br><br>From review of LBSSLC's staffing levels, the minimum staffing requirements were based on a fixed number of nursing staff (RNs and LVNs) per specific Unit, but could be modified based on census, acuity, and staff workload related to individual or staff activities. Although the Facility's staffing data did not indicate that they had fallen below minimum staffing levels for nursing, the Facility was not using any tool to assess and track its acuity. Additional issues to consider regarding modification to staffing and acuity include the following:<br>1. The education and experience of the nurses;<br>2. The number of nurses in orientation;<br>3. The number of temporary/agency staff assigned to the Unit;<br>4. The particular shift, required activities, and duties;<br>5. The physical layout of the Unit;<br>6. Facility resources;<br>7. Available technology used on the Unit such as computers;<br>8. Unit volatility that includes admissions, transfers and discharges;<br>9. The number of high risk individuals on a Unit; and<br>10. A method to assess Unit acuity.<br><br><u>Quality Enhancement (QE) Efforts</u><br>At the time of this review, the Nursing Department had few monitoring systems in place to assess nursing care and clinical outcomes. LBSSLC had a Quality Enhancement nurse that conducted audits on various items in the areas of Medical Services, Preventative Care, Psychiatric Services, Incident Management and Nursing Services. From review of | |

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| | | the tools and results from the audits, the tools did not include any items addressing the quality of documentation, such as nursing treatment plans or nursing assessments. In addition, the sample sizes audited were very small, usually consisting of a sample of five for all areas audited.<br><br>Since the items on the auditing tool only addressed completion of a task, such as the presence or absence of documentation, rather than addressing the quality of the content of the documentation, the data generated provided little to no information regarding clinical practices. For example, the items on the Nursing Assessments auditing tool included questions regarding if focused assessments were documented appropriately in the integrated progress notes (IPNs) using the Data, Assessment, and Plan (DAP) format; were interventions, follow-up assessments and resolutions documented in the IPNs, and were assessments completed on admission, quarterly, and annually. However, there were no items addressing the quality of the notes and assessments audited. In addition, several items on the QE tools included a number of elements to be audited rather than just one element per item. The data would not be able to be interpreted, because it would be impossible to determine which elements of the item were in compliance and which were not. Consequently, the compliance scores generated from the current tools did not accurately reflect the quality of the nursing care.<br><br>From conversations with the QE Nurse during the review, he was aware of the lack of quality items contained in the current QE monitoring tool. Although the QE tools lacked items to monitor quality, the summaries noted on the audit forms themselves indicated that problematic issues were being identified. Very specific information was contained on the audit tools regarding the problems found and the methodology used by the QE Nurse was clearly documented. However, no plans of correction were found addressing the problematic issues found. At the time of the review, no system was in place ensuring that the disciplines that were being provided QE data were addressing problematic trends identified.<br><br>Although there was much potential in the auditing processes of the QE Nurse, LBSSLC's existing data regarding compliance could not accurately be interpreted since it did not include the total population being reviewed (N), and the sample of that population audited (n) to yield a percent sample size. This information is essential to accurately interpret the relevance of the compliance scores generated. Usually, compliance scores for samples under 20 percent cannot be applied to the total population. Thus, LBSSLC's QE data could not be accurately interpreted, analyzed, or evaluated to determine if it was reflective of the practices being measured.<br><br>As noted previously, very specific information was contained on the audit tools regarding the problems found and the methodology used by the QE Nurse was clearly documented. | |

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| | | However, the Facility did not produce any type of report that included an analysis of problematic trends identified by the specific disciplines, such as nursing, dental, or medical. A review of LBSSLC's Nursing Meeting minutes demonstrated that there was no mention of issues identified through the QE audits. Likewise, there was no discipline-specific documentation including the identification of the problematic issues, a summary of an analysis of such issues, descriptions and/or dates of actions implemented to correct the issues, and/or subsequent monitoring data indicating if the interventions implemented were effective. The disciplines meeting minutes could be modified to include these specific elements so that this information is in one succinct document. This will be particularly important as the QE Departments from the various Facilities, in conjunction with the State and disciplines develop and implement additional monitoring tools, and generate additional clinical data in alignment with the SA.<br><br>Based on the information reviewed and summarized above, LBSSLC needs to develop and implement a number of nursing monitoring tools that will accurately reflect the quality of nursing care being provided. This is essential in order for the Facility to quickly identify problematic trends, and implement timely plans of correction. To facilitate this process, the State and the Facility should consider using the already established tools provided by the Monitoring Teams addressing compliance with the SA and Healthcare Guidelines. In addition, the data generated from the monitoring tools should be regularly reviewed, analyzed, and addressed by the appropriate disciplines, and integrated into the Facility's Quality Management and Risk Management systems. In developing these monitoring systems to meet compliance with the SA, the Nursing Department needs to evaluate its current allocation of positions since it currently has only one QE Nurse assigned for auditing.<br><br><u>Nursing Assessments</u><br>A review of individuals who experienced acute symptoms was one of the methods used to assess nursing care. By looking at how the Facility addressed some of the most significant nursing issues, strengths as well as weaknesses in the system can be identified. A review of ten individuals' medical records who were transferred to a community hospital, including Individual #56, Individual #127, Individual #254, Individual #269, Individual #118, Individual #185, Individual #168, Individual #192, Individual #253, and Individual #41, found that there were significant problems in the documentation regarding the nurses' assessment in the following areas:<br>▪ The lack of documentation regarding the status and appropriate assessment of the individual at the time of onset of the symptoms.<br>▪ The lack of documentation regarding an assessment of the individuals' status at the time of transfer to hospital or emergency room.<br>▪ No documentation indicating that a transfer packet was sent to the receiving hospital at the time the individual was transferred. | |

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| | | ▪ Inconsistent documentation that the nurse or physician notified the receiving facility of the individual's transfer.<br>▪ Inconsistent documentation of the time, date, and/or method of transfer to the receiving facility in the progress notes.<br>▪ Lack of a complete nursing assessment upon return to the Facility.<br>▪ Lack of updating the Nursing Care Plan to reflect changes in status and new interventions.<br>▪ The lack of adequate descriptions of the site of injuries.<br>▪ The lack of lung sounds assessed and documented for respiratory issues.<br>▪ The lack of neurological checks and mental status documented for individuals with a significant change in mental status.<br>▪ Illegible progress notes.<br>▪ The lack of assessment of bowel sounds, and abdomen for individuals with constipation.<br>▪ The lack of documentation of status changes reported to team members.<br>▪ The failure to timely notify physicians regarding individuals' change of status<br>▪ The lack of assessments regarding pain.<br>▪ The lack of follow up when PRN (pro re nata – "as needed") medications were given.<br>▪ The lack of specific values documented in the progress notes, including vital signs and blood sugars.<br>▪ The lack of full sets of vital signs documented in the records for acute changes in status.<br><br>As an example of some of the problems noted:<br>▪ In the case of Individual #254, the nurse's note indicated that the blood sugar reading was greater than 300, however, the exact value was not documented. In addition, there was no note that indicated that the physician was notified of the elevated blood sugar, and there was no note indicating that the individual was being sent to the hospital for evaluation. Consequently, there was no documentation of a nursing assessment prior to the individual leaving the Facility, no time or mode of transportation or indication that anyone from the Facility accompanied the individual to the hospital. There was no mention of this individual's mental status, and/or level of consciousness during the onset of acute symptoms. In addition, the assessment of the individual upon return to the Facility from the hospital was inadequate in that the assessments did not include a complete head-to-toe assessment, or assessment of the mental status of the individual.<br><br>Overall, there were a number of significant problematic issues found regarding complete, adequate and appropriate nursing assessments of symptoms for acute changes in status. | |

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| | | As noted above, there were some cases where there was no documentation indicating that an individual was being sent to the hospital, and most cases had inadequate assessments before and upon return to the Facility. Reviews of two individuals' cases were done on-site with nursing staff who at the reviewer's request, provided feedback regarding the documentation found in the medical records. The comprehensive and critical feedback provided by the nurses involved was impressive, and this type of peer review should be cultivated when the Facility begins to monitor issues regarding acute changes in status.<br><br>LBSSLC had recently filled the position of a Hospital Liaison Nurse who will be visiting, and documenting the individuals' status while in the hospital. This is a significantly beneficial clinical position to allow the Facility to remain informed when individuals are admitted to the community hospital, and to provide necessary information to the acute care facility. Consideration should be given to placing the documentation of the Hospital Liaison in the individuals' medical records to ensure all team members have access to the clinical information to ensure continuity of care.<br><br>In addition, from a policy perspective, based upon a review of LBSSLC Nursing Policies, Procedures and Protocols, there was a policy entitled "Management of Acute Illness/Serious Injury, LBSSLC Health Services, Revised January 21, 2010." However, the policy did not address the assessment and documentation criteria that should be completed prior to an individual being sent to the hospital/ER, and upon return.<br><br>At the time of this review, the Facility had no system in place for monitoring nursing care and documentation for individuals who experienced acute changes in health status to ensure appropriate nursing practices were being implemented. This area should be viewed as a priority when developing and implementing a monitoring system to ensure that adequate nursing practices are being conducted for those in this high risk category.<br><br><u>Availability of Pertinent Medical Records</u><br>During the review, it was noted that a number of documents were not in the medical records, and had to be located since they were not timely filed. This was a consistent problematic issue throughout the review process while on-site. The Medical Director, Chief Nurse Executive, and the QE Nurse verified that there were on-going problems with record keeping due to the lack of adequate staff assigned to file documents in the records. For example, a number of chest x-rays were not found in the records for individuals who had positive PPDs. In addition, an abdominal x-ray for Individual #232 was noted to have been taken on 2/24/2010. However, it was not filed in the medical record, nor did the PA who read the x-ray results alert the team that the x-ray showed a metallic coin was in the lower quadrant of the individual's intestines, until March 17, | |

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| | | 2010. Consequently, there had been no assessment or interventions put in place for this individual for nearly one month. This oversight was identified during the week the Monitoring Team's visit to the Facility. Nursing staff called the Abuse Hotline to report it as alleged neglect. The Facility needs to ensure that documents are timely filed in the medical records so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services.<br><br><u>Nursing Peer Review</u><br>Based on an interview with the Chief Nurse Executive, he reported that there was no system currently in place for internal or inter-facility peer review for nursing. In addition, from review of LBSSLC's Nursing policies, there was no policy found addressing peer review. From previous reviews, the State policy addressing Nursing Peer Review only referred to peer review as an investigative process of review for suspected inappropriate practice. As defined by the American Nurses Association in 1988, peer review is an organized effort whereby practicing professionals review the quality and appropriateness of services ordered or performed by their professional peers. Peer Review in nursing is the process by which practicing Registered Nurses systematically assess, monitor, and make judgments about the quality of nursing care provided by peers, as measured against professional standards of practice.<br><br>Case reviews of individuals who have had to be transferred to the hospital and/or ER would be a clinically relevant area to target for nursing peer reviews at LBSSLC. A statewide policy should be developed and implemented addressing regular nursing peer reviews. Such reviews should focus on the identification of strengths and weaknesses of the Facility's nursing practices, include critical analyses of nursing practices, and identify problematic trends. When problematic trends are identified, plans of correction should be generated, and clinical outcomes should be measured to determine if improvements are realized as a result of the corrective actions.<br><br><u>Infection Control</u><br>Infection Control (IC) is an area in which it is essential that proper nursing supports are in place at the individual-level, and that there are proper systems in place to prevent the spread of infections on a facility-wide basis. The failure to appropriately monitor and address infectious disease places individuals, staff, and all visitors at significant risk. Infectious diseases affect the short-term, as well as the long-term, and even life-long health of individuals who contract them. At the time of the review, LBSSLC did not have adequate infection control procedures in place at either the individual or systematic level.<br><br>With regard to IC at LBSSLC, at the time of the review, the Facility had one registered | |

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| | | nurse as the IC Coordinator with some infection control experience in an acute care hospital, and a part-time LVN who assisted with monthly environmental surveys, but had no prior experience in IC. The Infection Control Coordinator had been in the position since 2008, and the LVN for the past two-and-a-half years. There were no other clerical or clinical employees in the department.<br><br>Review of the Facility's IC program revealed that the basic areas regarding the surveillance of Methicillin-resistant Staphylococcus aureus (MRSA); Hepatitis A, B, and C; positive Tuberculin Skin Tests (TSTs); HIV; Syphilis; immunizations; vaccines; and antibiotic use were being regularly tracked on a computerized database. However, there was no formal written system in place to ensure the reliability of the Facility's IC data. Based on interview with the IC Nurses, there were a number of systems that they could use to compare data to ensure that the department had accurate data regarding infections. For example, a formal comparison of the clinic reports, pharmacy data, cultures, and the 24-hour report could validate IC data reliability. However, there was no procedure outlining this process, and the IC nurses were not taking advantage of these data sources at the time of the review.<br><br>The Facility had Infection Control policies/procedures that outlined basic IC practices. However, some of these policies/procedures had not been reviewed yearly. For example, the policy regarding Human Immunodeficiency Virus (HIV) had not been reviewed since 1997. The Facility needs to ensure that all IC policies and procedures are in alignment with the SA and Healthcare Guidelines addressing Infection Control requirements. In addition, there were no policies or procedures that outlined the operations and duties of the IC Department. Based on the interview with the IC Coordinator, there were a number of informal systems in place that needed to be formalized into policies and procedures to ensure consistency. Also, there was no system in place that ensured that the residential units were accurately and promptly reporting required issues to the IC Department. Without ensuring that the IC data are reliable and timely reported, the Facility cannot accurately and timely identify where training on appropriate IC practices are needed, or identify IC trends and implement appropriate corrective actions. A statewide Infection Control Manual would be very useful to the Facilities.<br><br>The overall documentation of the activities of the IC Department was contained in both the IC Committee Meeting minutes, and in the Pharmacy and Therapeutics Committee Meeting minutes. The Facility used the IC Committee to address issues that pertained mainly to the overall IC issues at the Facility, and the Pharmacy and Therapeutics Committee for some limited clinical IC issues regarding antibiotics. Although the IC Committee minutes included some data related to IC issues such as a respiratory outbreak on 504 E. Mesquite, there were no comprehensive analyses regarding the problematic trends, or the findings of the Facility's basic surveillance data. In addition, | |

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| | | no report or committee meeting minutes were found that comprehensively analyzed and addressed the trends in the data, inquires into problematic trends, corrective actions addressing any problematic trends, or monitoring of outcomes in relation to the activities and interventions of the Infection Control Department in conjunction with the practices on the units. For example:<br>▪ The IC Committee minutes dated 2/25/2010 indicated that one individual was treated with an antibiotic that was resistant to the infectious organism. However, there was no additional information provided as to whether the antibiotic was changed, or the clinical outcome for the individual. In addition, there was no information provided as to whether an inquiry regarding why this occurred was initiated, and what was to be put in place to prevent this from reoccurring. Also, there was no indication that an analysis occurred to determine how the system that was in place at the Facility to monitor that the appropriate antibiotic had been prescribed when compared to the culture findings had not identified this particular issue earlier.<br><br>Although the IC Department had developed a number of graphs regarding the Facility's surveillance data by unit, there was no documentation found that included any narrative descriptions and analyses of the meaning of the data related to trends, clinical practice and/or clinical outcomes. Consequently, the department's data only represented raw numbers, rather than an analysis related to clinical outcome indicators that should be used by the Facility to monitor and improve its infection control practices.<br><br>Based on a review of the Infection Control Committee Meeting minutes, there was little to no information contained in these minutes to demonstrate that the Facility was addressing issues related to Infection Control practices rather than merely presenting anecdotal information. Modifying the format of the minutes so they contain pertinent information regarding issues discussed; corrective actions; dates, timeframes and assigned responsibility of action steps; expected and actual outcomes; and how the implementation efforts will be monitored to ensure the desired clinical outcome is achieved would guide the Committees in addressing necessary IC issues, and significantly improve the infection control documentation.<br><br>At the time of this review, the Facility was conducting monthly environmental audits using the LBSSLC Infection Control Surveillance Rounds tool. Based on a review of the completed audits and this reviewer's observations while on-site, the audits did not accurately reflect the lack of cleanliness observed at the Facility. Many of the audits also did not include the name and date of the person completing the audit. A number of the audits did not include the date when the information was provided to the Infection Control Committee, or the Chief Nurse Executive. For those audits that did include that information, the documentation indicated that notification was give over a month after | |

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| | | the audits were completed. Also, there were no reports found that addressed or analyzed the environmental data. In addition, when problematic issues were identified, there was no indication that any type of follow-up or resolution was initiated.<br><br>Based on review of the Facility's Infection Control and QE audit tools, there was no monitoring system in place that addressed issues regarding appropriate treatment practices for infection control issues. For example, there was no monitoring system in place to ensure that individuals with Hepatitis C were screened for immunizations for Hepatitis A and B, and, if needed, had received them, or that individuals with MRSA had received the appropriate antibiotic, and that contact precautions were appropriately followed on the units and in day programs as indicated by the Facility's policy. In addition, no tracking was found for individuals who refused treatments such as immunizations or PPDs indicating that their treatment teams were addressing the refusals and implementing interventions.<br><br>In addition, based on interview with the QE Nurse and IC Coordinator, the Facility did not include any infection control data as a part of key indicator data for Quality Management/Risk Management. As the Facility continues to develop these systems, Infection Control information should be integrated into this system, as well as integrated into the other disciplines' reviews regarding practices and clinical outcomes. For example, as is discussed with regard to Section O.4 of the SA, poor infection control practices were seen during mealtimes. Infection control indicators should be included on mealtime monitoring checklists, and the resulting information shared with the infection control department.<br><br>From review of the IC documentation and data, there was a lack of a connection between clinical issues at the residential unit level and the activities of the Infection Control Department. During an interview with the IC Coordinator, she reported that there was no review of the Nursing Care Plans for individuals with infectious diseases by Infection Control or nursing to ensure that they were clinically appropriate, and that the interventions were actually being implemented. As is discussed in further detail in the portion of this report that addresses Section M.3 of the Settlement Agreement, of 28 individuals' records that were reviewed who had either a chronic or acute infectious disease, only six individuals had a Nursing Treatment Plan that actually addressed or identified the infectious disease (MRSA), and all six were clinically inadequate.<br><br>The annual documentation by the physicians regarding a screening for any active signs or symptoms of Tuberculosis for individuals who are Purified Protein Derivative (PPD) positive were found to be inconsistently documented. In addition, a number of chest x-rays were noted to have been completed from the physicians' notes, but the actual chest x-rays themselves were frequently not found in the records, as mentioned previously. | |

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| | | A review of the Facility's Infection Control new employee orientation materials demonstrated that hand-washing and Standard Precautions were included in the curriculum. Although hand washing was included as an item on the Facility's current Standard Precautions Monitoring Tool, there was no summary or analysis of the data found indicating if staff was using the proper techniques, or if Standard Precautions were being routinely followed at the homes. From the lack of Nursing Treatment Plans found addressing infectious diseases, additional and on-going competency-based training regarding Infection Control issues is warranted for the Nursing staff.<br><br>At the time of the review, there was no data found that verified that all vaccines and immunizations were administered in a timely manner, and according to Centers for Disease Control (CDC) guidelines. Since many of the individuals have been at the Facility for a number of years, the original lab work was not usually found in the records making it difficult, if not impossible, to determine if individuals received the appropriate administration of vaccines.<br><br>Although the IC Coordinator had past experience and background in Infection Control and was very committed to making the changes necessary to ensure the IC Department functioned appropriately, additional expertise and staffing will likely be needed to implement systems to effectively operationalize the Infection Control Department in alignment with the Health Care Guidelines and the Settlement Agreement. In addition, the development and implementation of statewide Infection Control policies and monitoring tools would facilitate this process.<br><br><u>Code Blue Drills</u><br>From review of LBSSLC's Life Threatening Emergency Drill documentation from 3/09 to 2/10, the Facility had been conducting drills on a monthly basis on different shifts. However, there was no indication regarding what type of emergency scenarios constituted the drills. Without this information documented, there was no way to determine if a variety of scenarios were being used to illustrate different types of emergency situations, or if the same one was being consistently repeated.<br><br>At the time of the review, the Facility had the Administrative Review Team (ART) in place that met sporadically to review the Life Threatening Emergency Drill data. Based on review of the minutes from 7/2/09, 9/17/09, and 1/26/10, no actual analysis was found regarding the content and quality of the drills, trends identified, or plans generated to implement corrective actions with progress measured on anticipated outcomes. For example, the comments on some of the drills included issues such as medical staff not responding, nursing not responding, lack of privacy screens, the nurse assigned to the home not having the home pager on her person, and needing oxygen masks. However, | |

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| | | there was no indication that these issues were addressed. In addition, the minutes of the ART indicated that the Facility implemented a change in the way it conducted drills in early 2009. The procedure included having the staff who were conducting the drills go to the areas where the drills were to be held prior to the drill, and review the steps of CPR with the staff. Then, later that shift, a drill was conducted. The minutes of the ART indicated that using this procedure increased the number of "passed" drills each month. The purpose of conducting regular medical emergency drills is to identify strengths and weaknesses of the Facility's response to emergencies by continuously assessing the process, as well as the staff's knowledge and competency in executing emergency procedures. Thus, conducting a review of CPR would be more appropriate, if it were done after the drill was conducted. This would allow the Facility to obtain an accurate picture of the staff and system's strength and weakness, while at the same time offering a refresher to staff on CPR.<br><br>Based on interviews with the Chief Nurse Executive, having staff actually turn on and use emergency equipment was not part of the drill process. While on-site during the review, three out of three nurses asked to demonstrate the use of the emergency equipment were unfamiliar with how to turn on the oxygen. In addition, the nurses did not know how to check the suction machines to ensure that they were operational. Also, in the Canna building, the oxygen tank was being stored in a restroom that had urine and feces in the toilet, and the suction machine was in the back of a cabinet covered in dust in spite of the documentation on the emergency checklist indicating that the equipment was regularly checked. In addition, each unit had additional equipment such as ambu bags and other supplies that were kept in a mesh bag that appeared as if they had not been regularly checked to ensure all needed equipment was available. The Facility needs to implement a system in which nurses are regularly observed checking the emergency equipment to ensure they are familiar with the use of the equipment. It is imperative that all licensed staff receive competency-based training regarding emergency procedures and equipment use. Observations of these skills should be conducted at least quarterly and during drills.<br><br>It is essential that the Facility incorporate the actual use of the emergency equipment in the competency-based emergency training and drills. This is necessary to ensure that when an emergency arises, the nurses will be familiar with the operation of the emergency equipment. In the midst of an emergency, nurses should already have a working knowledge of the equipment, and should know exactly what supplies are needed, and where these supplies are kept. This will avoid delays in treatment during an actual Code Blue. In addition, there was no indication that physicians were participating in the Emergency Drills. It is essential that the physicians practice their role in a Code Blue medical emergency, know the Facility's emergency systems, and be familiar with the staff's knowledge of emergency procedures. | |

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| M2 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status. | Twenty-three individuals' records were reviewed, including: Individual #65, Individual #10, Individual #171, Individual #311, Individual #250, Individual #19, Individual #132, Individual #317, Individual #86, Individual #90, Individual #223, Individual #82, Individual #180, Individual #8, Individual #240, Individual #193, Individual #149, Individual #290, Individual #218, Individual #107, Individual #251, Individual #303, and Individual #51. All had quarterly nursing assessments completed in a timely manner. However, the quality of these quarterly assessments required significant improvement. The nursing assessment form used checkmarks for most of the sections, and nursing staff frequently did not add any additional pertinent information to these sections. The Nursing Summary narrative section for all of the 23 quarterly assessments reviewed contained mainly raw data without any analysis of whether the individuals were doing better or worse than the previous quarter. For example:<br>▪ Individuals who had lab work during the quarter only had the current values noted on the assessment without mention of a comparison to the previous lab values.<br>▪ A list of the nursing diagnoses was included on the quarterlies. However, there were no summaries indicating if there had been progress or lack of progress regarding the goals and objectives for each of the nursing diagnoses.<br><br>Overall, the nursing quarterly and annual assessments needed to include an analysis of progress made during the quarter rather than just listing raw data, such as lab values and appointment dates.<br><br>In addition, as mentioned above, the Quarterly Nursing Assessments reviewed did not indicate progress or lack thereof regarding individuals' measurable objectives, and service and/or supports that were included in individuals' Nursing Care Plans. As is discussed in further detail below, the current Nursing Treatment Plans at LBSSLC generally do not include appropriate measurable objectives. As Nursing works to improve these, it will be essential for the nursing quarterly assessments to include a discussion of the progress an individual is making or not making, strategies that are working or not working, and to recommend changes, if needed, in strategies, supports and services.<br><br>Based on a review of the Facility's policy regarding "Comprehensive Nursing Assessment" for Health Services, the policy was very weak in addressing Section XI: Nursing Summary. The policy stated that the summary will include an analysis of findings; however, it did not include specific criteria to include in this area. This section should represent the culmination of the clinical picture of the individual from all the objective and subjective data included in the other areas of the assessment. Training should be provided to nursing staff regarding how to write an analysis and what should be included. | |

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| M3 | Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised. | Records were reviewed for 28 individuals, including Individual #264, Individual #213, Individual #184, Individual #306, Individual #309, Individual #109, Individual #75, Individual #277, Individual #243, Individual #140, Individual #232, Individual #125, Individual #298, Individual #4, Individual #54, Individual # 106, Individual #143, Individual #76, Individual #16, Individual #182, Individual #314, Individual #62, Individual #74, Individual #283, Individual #237, Individual #292, Individual #54, and Individual #233. These reviews found that all of the Nursing Treatment Plans (100%) were of poor quality, and provided little to no direction regarding meeting the needs of the individuals experiencing a variety of health issues. Many had identical interventions listed on the treatment plans for issues such as skin integrity that included items such as: "administer medication as ordered", and "notify physician when skin problems occur." These interventions are basically services that have to be provided to all individuals. The lack of individual-specific interventions based on individualized needs in the Nursing Treatment Plans render them meaningless in providing staff direction for caring for individuals, and being able to measure individuals' progress toward their health/behavioral goals.<br><br>Although there were some objectives/goals contained in the Nursing Treatment Plans that were noted to be measurable, behavioral and/or observable, most were not or were not clinically appropriate for the specific health issue. In addition, documentation of the implementation of the interventions listed in the Nursing Treatment Plans was rarely found in the integrated progress notes. None of the nursing interventions reviewed indicated who would implement the intervention, how often they were to be implemented, where they were to be documented, how often they would be reviewed, and/or when they should be considered for modification. In addition, proactive interventions were not included in the Nursing Treatment Plans reviewed. Nursing Treatment Plans that included a problem noting that an individual was at risk for a specific issue such as aspiration included interventions that only addressed reactive care rather than preventative care. The following are some examples of the issues identified:<br>▪ The Nursing Treatment Plan for Individual #292 indicated that the licensed nurse would document constipation/impaction information in the progress notes, when indicated. However, there was no indication how often to document (e.g., daily, weekly), who would review the documentation and how often, and what constitutes "constipation/impaction information." In addition, one of the interventions stated that the individual should have adequate fluid intake without noting what "adequate" actually meant for this individual [how many cubic centimeters (cc) per day], and how adequate fluid intake was to be tracked and reviewed. In addition, the objective noted on the Treatment Plan stated that the individual would have less than five episodes of constipation or impaction. The appropriate objective would require that the individual experienced no episodes of constipation or impaction. | |

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| | | ▪ In the case of Individual #75, his Nursing Treatment Plan indicated that he was overweight. The objective noted on the Treatment Plan stated that the individual will lose weight over the next 12 months to achieve his desired weight range. No specific information was provided such as how much weight loss was safe and appropriate for this individual, and what was the exact desired weight range the team identified. The Treatment Plan included no actual interventions such as getting the individual engaged in some type of physical activity to assist the individual in reaching the desired goal.<br><br>An additional sample of individuals' records was reviewed to determine if individuals with chronic and acute infectious diseases had appropriate care plans to address their needs. Specifically, a review was completed of 29 Nursing Treatment Plans for individuals diagnosed with a variety of infectious diseases including: Individual #161, Individual #301, Individual #113, Individual #17, Individual #43, Individual #56, Individual #229, Individual #164, Individual #15, Individual #237, Individual #2, Individual #38, Individual #168, Individual #298, Individual #306, Individual #99, Individual #112, Individual #312, Individual #116, Individual #180, Individual #114, Individual #192, Individual #75, Individual #189, Individual #16, Individual #276, Individual #212, and Individual #55. Of the 28 individuals, 22 (79%) had no Nursing Treatment Plans addressing these issues, and only six individuals had a Nursing Treatment Plan that actually addressed or identified the infectious disease (MRSA), and all six were clinically inadequate. Specifically, the Nursing Treatment Plans did not address any of the essential elements for a contagious illness, including the need for precautions to be used when taking care of the individual, teaching the individual and staff to prevent the spread and transmission of the infection, and the signs and symptoms to regularly assess and document. Based on this review, there was no system in place that ensured that individuals with infectious diseases were being provided the appropriate infection control procedures, or that clinically appropriate interventions to prevent the spread of infection were being consistently implemented.<br><br>At the time of this review, LBSSLC did not have an adequate monitoring instrument addressing the quality and implementation of Nursing Treatment Plans. From the review, the current Nursing Treatment Plans did not provide an adequate and appropriate guide regarding the specific needs of the individuals. In addition, there was no evidence that even the inadequate nursing interventions listed in the Nursing Treatment Plans were actually being implemented. There needs to be a monitoring system in place ensuring that appropriate Nursing Treatment Plans are in place, and that the nursing interventions are being implemented. | |
| M4 | Within twelve months of the Effective Date hereof, the Facility | From review of LBSSLC's Nursing policies, procedures, and protocols, there appeared to be a lack of developed specific protocols. For example: | |

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| | shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served. | ▪ There were no protocols found addressing issues such as diabetes, cardiac conditions, changes in mental status, and metabolic syndrome for individuals prescribed certain psychotropic medications.<br>▪ The current nursing policy regarding nursing assessments was noted to be inadequate regarding the analysis section of the assessment. Nursing Treatment Plans were either inadequate or clinically inappropriate and provided little to no direction to staff responsible for the care and services of the individual.<br>▪ In addition, the few nursing protocols that were provided by the Facility lacked specific criteria for what should be included in the integrated progress note documentation, and/or other specifics such as timeframes for initiating and completing tasks, and specific parameters as to when to notify the physician of certain critical information.<br><br>The Nursing Department should review all existing policies and protocols, determine what revisions need to be made, and, as necessary, develop additional policies and procedures addressing nursing care. The Nursing Department also needs to ensure that all policies, procedures and protocols are in alignment with generally accepted standards of nursing practice, as well as the requirements of the SA and Health Care Guidelines. Once that is accomplished, the department then needs to develop and implement associated monitoring instruments with established inter-rater reliability at 85% or above to ensure that these practices are being adhered to consistently. | |
| 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 noted in the section of this report that addresses Section I of the SA, the Facility was using the Health Risk Assessment Tool-Nursing as the tool for the identification of clinical risk indicators for individuals. However, this tool was simply scored either "yes" or "no" for items in areas regarding Cardiac, Constipation, Dehydration, Diabetes, GI concerns, Hypothermia, Medical Concerns (other), Osteoporosis, Respiratory, Seizures, Skin Integrity, Urinary Tract Infection, and Aspiration/Choking. However, the tool was not an adequate risk assessment for any of the areas mentioned, and its implementation did not result in the appropriate identification of clinical risk indicators. The Facility was however, using an appropriate standardized tool, the Braden Scale, to assess skin integrity issues.<br><br>Standardized risk assessments with established reliability and validity should be used by all the Facilities in assessing and documenting clinical indicators of risk. Once this system is implemented and individuals' risks are appropriately identified, the teams need to conduct integrated team reviews, and develop appropriate proactive treatment plans to address identified areas of risk. | |

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| M6 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. | From interviews with nursing staff and review of LBSSLC's QE data regarding Medication Administration Surveillance data for August, November, and December 2009, there had been little supervision provided for licensed nurses in the administration, monitoring, and recording of the administration of medications. In addition, the observation tool that was being used at LBSSLC to monitor medication administration was not comprehensive, and needed to be revised to include all the basic elements of medication administration orally, by injection, or via tube. For example, the tool did not include the procedure for observing medications given via tube that constitutes a large number of individuals at the Facility. The tool also did not contain all the appropriate steps to administering medications such as three checks of the MAR, and initialing the MAR immediately after administration of medications.<br><br>In addition, the current procedure at LBSSLC for the medication observations was that nurses were only observed administering medication annually, which is too infrequent to ensure that appropriate medication administration practices are being consistently followed, especially in a facility that has significant nursing vacancies and uses a number of agency nurses. Nurses should be observed administering medication at least on a quarterly basis. The Facility will need to develop and implement a tracking system to ensure that each nurse is observed at least quarterly, including agency nurses.<br><br>When observing medication administration while on site for individuals who received their mediations via tube, the following significant issues were identified. Specifically, the nurse did not:<br>▪ Consistently provide privacy to individuals during medication administration;<br>▪ Provide information to the individual prior to medication administration; and<br>▪ Ensure the individual was in the proper position prior to medication administration.<br><br>While LBSSLC's observation tool for medication administration is not in alignment with appropriate practices, a number of nurses at the Facility also used various procedures for administering medications that were inappropriate. Based on discussions with several LBSSLC nurses, a number of them indicated that they did not consistently use the Medication Administration Records when administering medications, because they believe they know the individuals and what medications they take. This practice is not in accordance with accepted standard of practice, and places individuals at risk to receive the wrong medication, the wrong dose of medications, and/or another individual's medication. Medication errors are discussed in further detail regarding Section N.8 of the SA. | |

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

1. It is essential that efforts in recruiting and maintaining a stable nursing staff continue to be implemented, and expanded. This will require an analysis of the issues negatively impacting the Facility's ability to hire and retrain a stable nursing workforce, and the development of a plan to address the issues identified.
2. A monitoring system and quality enhancement system should be developed and implemented to ensure:
   - Completion, quality and timeliness of Nursing Assessments;
   - Nursing Treatment Plans are individual-specific and meet professional standards of care as set forth in the SA and HCG;
   - Interventions listed in Nursing Treatment Plans are proactive, are being timely and appropriately implemented, and are modified in response to the individuals' progress;
   - Individuals who experience changes of status are reviewed, including reviews of individuals who were sent to community hospitals and Emergency Rooms;
   - All nurses who administer medications are appropriately supervised in the administration, monitoring, and recording of the administration of medications and any errors. Review of each nurse responsible for medication administration should occur at least quarterly. The current medication administration monitoring tool should be modified to reflect appropriate standards of practice.
   - Infection Control practices are being appropriately and timely implemented.
3. As monitoring tools are implemented, the results should be analyzed, and, as appropriate, action plans developed and implemented to address issues identified. Such action plans should include the actions to be implemented, person(s) responsible, timeframes for completion, and anticipated outcomes. The plans' implementation then should be monitored to ensure completion, as well as to determine if the expected outcome has been achieved. Action plans should be modified, if they do not result in the intended outcomes. These efforts should be documented, for example, in discipline meeting minutes.
4. Inter-rater reliability for all monitoring tools should be established at 85 percent or better.
5. The current allocation of nursing positions should be evaluated to meet requirements for developing departmental monitoring activities.
6. With the addition of a Hospital Liaison nurse, consideration should be given to placing the documentation of the Hospital Liaison in the individuals' medical records to ensure all team members have access to the clinical information to ensure continuity of care.
7. The policy entitled "Management of Acute Illness/Serious Injury, LBSSLC Health Services, Revised January 21, 2010" should be modified to include clear criteria regarding the assessment and documentation process that should occur when an individual is being transferred to and from an acute care setting. Once established, nurses should be trained on the policy and expected to adhere to it.
8. The Facility needs to ensure that documents are timely filed in the medical records so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services.
9. A statewide policy should be developed and implemented addressing regular nursing peer reviews. Such reviews should focus on the identification of strengths and weaknesses of the Facility's nursing practices, include critical analyses of nursing practices, and identify problematic trends. When problematic trends are identified, plans of correction should be generated, and clinical outcomes should be measured to determine if improvements are realized as a result of the corrective actions.
10. The Nursing Assessment forms and processes should be revised to ensure that a comprehensive nursing assessment is conducted. The current form consists of a checklist that does not set the expectation for a comprehensive analysis of information. As noted above, the current format for nursing assessments results in only raw data being reported, but not analyzed.
11. Nurses and any other staff responsible should be required to complete competency-based training on:
    - Nursing Assessments;
    - Writing and monitoring Nursing Treatment Plans; and
    - The proper administration and documentation of medication.
12. Nursing Treatment Plans should be revised to include specific goals/objectives that are objective and measurable, as well as interventions that identify who is responsible for implementing the interventions, how often they are to be implemented, where they are to be documented, how

often they are to be reviewed, and when they should be modified.

13. The role of nursing in the interdisciplinary treatment team process should be expanded to ensure that treatment plans are derived from an integration of the individual disciplines' assessments, and that goals and interventions are consistent with clinical assessments.
14. Nursing Procedures/Protocols should be revised and/or developed and implemented to ensure that:
    - The appropriate assessments and documentation requirements are in alignment with generally accepted standards of practice, as defined by the requirements of the SA and Health Care Guidelines; and
    - Address acute change in status.
15. The Nursing Department should review all existing policies and protocols, determine what revisions need to be made, and, as necessary, develop additional policies and procedures addressing nursing care. The Nursing Department also needs to ensure that all policies, procedures and protocols are in alignment with generally accepted standards of nursing practice, as defined in the SA and Health Care Guidelines.
16. Consideration should be given to securing the services of an expert in the area of Infection Control to provide consultation to the State and the Facilities.
17. The need for additional staff for the Infection Control Department at LBSSLC should be evaluated.
18. The IC policies and procedures should be revised as needed to reflect current standard of practices and requirements as outlined in the Settlement Agreement and Health Care Guidelines.
19. A departmental monitoring system should be developed and implemented in alignment with IC standards of practice and Facility policies.
20. Statewide IC monitoring instruments should be developed and implemented to ensure that individuals with infectious diseases are adequately treated, protected from additional infections or re-infection, and that other individuals who live in the same buildings as well as staff and visitors are appropriately protected from transmission of infections.
21. Systems should be developed and implemented to ensure reliability of IC data.
22. The structure of the IC minutes should be revised to include a systematic review of data trends for individuals and employees that include an analysis, an inquiry into the issue, a plan of action that includes the name of the person responsible for follow-up and the date when it will be implemented, and updates on the desired outcomes.
23. The nurse(s) in the Infection Control Department should collaborate with nursing regarding the development and implementation of individualized–specific, appropriate Nursing Care Plans for IC issues.
24. The nurse(s) in the Infection Control Department should collaborate with nursing to ensure that unit staff receive appropriate on-going competency-based IC training.
25. Infection Control Environmental Surveillance audits should accurately reflect the environmental conditions, and corrective actions should be taken and documented.
26. IC data should be integrated into the Facility's Quality Management system.
27. The Facility should ensure that Medical Emergency Drills are conducted at least quarterly, on every unit, and every shift and include the use of emergency equipment. Staff participating in the drills should not be told about them ahead of time, nor should staff in the homes/day programs be provided refresher training, on CPR, for example, immediately preceding the drills. The drills should be used to determine accurately if staff have the skills necessary to implement the emergency procedures. If "passing" grades are not achieved on the drills, this should trigger analysis and response to the issues identified.
28. A policy/procedure should be developed and implemented outlining the levels of committee review for Medical Emergency Drills, actual Code Blues and emergency procedures.
29. A system should be developed and implemented to ensure that Medical Emergency Drills and actual Code Blues are critically analyzed, and plans of correction developed and implemented to address problematic issues.
30. Competency-based training should be implemented for nurses regarding emergency procedures that include the use of emergency equipment.
31. Ongoing competency-based training should be provided to all licensed staff regarding the appropriate procedures for checking emergency equipment.

32. A monitoring system should be developed and implemented requiring nurses to demonstrate the use of the emergency equipment when checking it to ensure that it is in good working condition.
33. Physicians should be involved in Medical Emergency Drills. Standards should be developed and implemented requiring physician participation in emergency drills at least once per quarter.
34. As is recommended with regard to Section I of the SA, standardized risk assessments with established reliability and validity should be used by all the Facilities in assessing and documenting clinical indicators of risk. Once this system is implemented and individuals' risks are appropriately identified, the teams need to conduct integrated team reviews, and develop appropriate proactive treatment plans to address identified areas of risk.

| SECTION N: Pharmacy Services and Safe Medication Practices | |
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| 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:<br>▪ **Review of Following Documents**:<br>o LBSSLC's Pharmacy policies: Pharmacy Services; Pharmacy and Therapeutics Committee policy; Adverse Drug Reaction; Automatic Stop Order of Medications; Communication Between Pharmacy, Medical, and Nursing Regarding Medications; Controlled Medications; Lost-Found Medications; Medication Adjustment; Medication Errors and Reporting; Medications That Leave LBSSLC; Pharmacy Services and Safe Medication Practices; Physician's Orders Relayed to Pharmacy; Pick-up and Delivery of Medications for Individuals who Live at LBSSLC; Polypharmacy Definition Non-Psychotropic Medications; Polypharmacy Definition Psychotropic Medications; Quarterly Drug Regimen Review; and Receipt of Pharmaceuticals;<br>o LBSSLC's Monthly Unit Check List;<br>o Medication Error Committee meeting minutes, dated 6/23/09, 9/3/09, 11/18/09, and 12/30/09;<br>o The following Drug Utilization Reviews (DUEs): March 2009 for Zyprexa; June 2009 for Risperdal, Seroquel and Geodon; September 2009 for Levaquin; December 2009 for Depakote and Depakene; and March 2010 for Keppra;<br>o Pharmacy and Therapeutics Committee Meeting minutes, dated 9/22/09, 12/15/09, 5/28/09, and 1/28/10;<br>o Medication error data from June to December 2009;<br>o Medical records for the following individuals: Individual #193, Individual #250, Individual #86, Individual #303, Individual #193, Individual #180, Individual #149, Individual #311, Individual #171, Individual #65, Individual #218, Individual #251, Individual #132, Individual #156, Individual #125, Individual #243, Individual #213, Individual #298, Individual #232, Individual #292, and Individual #75; and<br>o Quarterly Drug Regimen Review forms; and<br>▪ **Interviews with**:<br>o Billy Bob Beck, R. Ph., Pharmacy Director;<br>o Anita Blackburn, R.Ph. Tech, Administrative Assistant;<br>o Don Minnis, RN, BSN, Chief Nurse Executive;<br>o Jeremy Ellis, RN, QE Nurse;<br>o Jim Todd, J.D., Assistant Attorney General, Texas; and<br>o Valerie Kipfer, RN, MSN, State Office Nursing Services Coordinator |
| | **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |

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| | **Summary of Monitor's Assessment:** Whenever an individual is prescribed a new medication, a system is in place to check for potential issues with the existing medication regimen. Although the pharmacy maintained all physicians' orders for three years, a formal written procedure describing the system needs to be developed and implemented to ensure that there is supporting documentation of the notification of a physician that the addition of a newly prescribed medication may have adverse effects in combination with the existing medication regimen. In addition, the physician's response to this notification needs to be documented.<br><br>Although the Facility had been conducting Drug Regimen Reviews (DRRs) that were overall very comprehensive, the Facility needs to develop a system to ensure that the DRRs are timely completed, that there is documentation addressing the acceptance or refusal of the pharmacists' recommendations, and that there is specific supporting documentation that the recommendation was implemented by the physician or practitioner or justification for not implementing it.<br><br>At the time of the review, LBSSLC did not have a system to monitor the use of "Stat" (i.e., emergency medication) and chemical restraints in alignment with the SA to ensure that medications are used in a clinically-justifiable manner, and not as a substitute for long-term treatment.<br><br>The Facility's Pharmacy and Therapeutics Committee, headed by the Clinical Pharmacist, had conducted drug utilization evaluation (DUE) in March 2009 for Zyprexa; June 2009 for Risperdal, Seroquel and Geodon; September 2009 for Levaquin; December 2009 for Depakote and Depakene; and March 2010 for Keppra. Compliance data was generated for each DUE conducted. For each indicator falling below an established threshold of 70 percent, a plan of correction was supposed to be developed and implemented. These were not found, though, for indicators meeting this threshold. The Facility should consider adding any plan of correction with dates implemented or clinical justifications to the meeting minutes to keep the process succinct and complete. The State's Medical Director had been working on this requirement with all the SSLCs in continuing to develop the DUE process in alignment with the SA and Health Care Guidelines.<br><br>There appeared to be significant underreporting of medication errors. Nursing staff at the Facility did not consistently agree on what constituted a medication error that needed to be reported. Since medication error reporting was not yet reliable, increasing medication observations and a spot check system should be initiated. The spot check system should include a review of the Medication Administration Records (MARs), and narcotics log at some time during the shift. The spot checker (auditor) should make sure that the MAR has been completed appropriately, and that both the on-coming and off-going nurse has signed the narcotics log. |

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| N1 | Commencing within six months of the Effective Date hereof and with full implementation within 18 | A review of the LBSSLC's pharmacy policies found that although a number of them had been recently revised, there were a number that had not been reviewed since 2006, and had not been revised to include the requirements of the SA and Healthcare Guidelines. | |

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| | months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature. | There should be a statewide Pharmacy Manual developed and implemented at all facilities. In addition, a monitoring system needs to be developed and implemented to ensure that these policies are consistently being implemented.<br><br>An interview with the Pharmacy Director indicated that when a new medication was ordered for an individual, the pharmacist received a fax of the order, and entered it into the WORx software system that did an automatic review of the new medication. This review assessed the newly prescribed medication regarding the appropriate dosing, listed allergies, and potential interactions with the individual's current medication regimen. If a problem was identified, the physician was notified, in most cases informally by phone or in person. The pharmacist then used the physician's order to document the problematic issue. The pharmacy then maintained the physicians' order for three years. Although the Facility had a system in place addressing this requirement, portions of the system were informal without consistent supporting documentation. A system needs to be developed and implemented to ensure that there is supporting documentation of the notification of a physician that the addition of a newly prescribed medication may have adverse effects in combination with the existing medication regimen. In addition, the physician's response to this notification needs to be documented. | |
| N2 | Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values. | A review of the Quarterly Drug Regimen Reviews was completed for 13 individuals, including: Individual #193, Individual #250, Individual #86, Individual #303, Individual #193, Individual #180, Individual #149, Individual #311, Individual #171, Individual #65, Individual #218, Individual #251, and Individual #132. This review identified the following issues:<br>▪ There was no place on the Drug Regimen Review forms that included documentation that a recommendation was actually implemented by the physician or practitioner. The form only required that the physician or practitioner place a checkmark by a statement indicating that they agree or disagree with the pharmacist's recommendation. From example, five of the 13 DRRs reviewed indicated that the physician or practitioner agreed with a recommendation made by the pharmacist. However, there was no documentation indicating that the recommendation was actually implemented. A modification to the form could address this issue. The following were examples of individuals for whom the physician had indicated he/she agreed with the recommendation, but not documented the actions taken to implement the recommendation:<br>o Individual # 193: Calcium and Dilantin should be given 2 hours apart;<br>o Individual # 250: Calcium and Dilantin should be given 2 hours apart;<br>o Individual # 311: Potassium level needed since individual is on diuretic | |

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| | | o Individual #171: Consider adding Folic Acid since individual is on Dilantin; and<br>o Individual #125: Elevated Depakote level (138.9) found on 1/6/2010. Repeat level from 1/8/2010, not on chart as of 1/13/2010.<br>▪ The DRRs for two out of 13 (15%) individuals were not timely.<br>▪ The DRRs for four out of 13 individuals (31%) did not indicate if the physician or practitioner agreed or disagreed with the pharmacist's recommendations.<br>▪ There were no comments from the pharmacist if the MOSES and DISCUS were completed as required for individuals on psychotropic medications.<br><br>Overall, the comments on the DRRs by the pharmacist were appropriate and comprehensive. In addition, for individuals prescribed psychotropic medications, the DRRs were routed to both the individuals' primary care physician and the psychiatrist for review of pharmacy recommendations. This is an excellent practice and should be adopted by all Facilities to ensure collaboration and safe medication practices.<br><br>The Facility needs to develop a system to ensure that the DRRs are timely completed, that there is documentation addressing the acceptance or refusal of the pharmacists' recommendations, and that there is specific supporting documentation that the recommendation was implemented by the physician or practitioner. | |
| 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. | A review of the LBSSLC's Pharmacy Policies found no policies that specifically addressed the elements of this requirement. Based on a review of the Pharmacy and Therapeutics Committee Meeting minutes, the Committee was in the process of defining "Stat" versus "Now" medications, and the Facility was using a form to review individuals who received a chemical restraint. However, neither of these systems adequately addressed the requirements of the SA regarding Stat and chemical restraints. These systems could be enhanced to meet the requirements. | |

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| 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. | This is discussed above with regard to Section N2 of the SA. | |
| 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. | At the time of the review, LBSSLC's had a current policy in place addressing this requirement. As noted above, the DRRs reviewed did not include a statement if a MOSES or DISCUS was needed or timely completed. The Facility's QE Nurse was monitoring this requirement.<br><br>The MOSES is for monitoring side effects of psychotropics, and the DISCUS is for monitoring Tardive Dyskinesia. They are two tools for two different issues. LBSSLC was using both to monitor for the appropriate clinical issue. The HCGs require: "Tardive dyskinesia screening to include DISCUS immediately prior to initiating therapy as a baseline and every three months during treatment and for six (6) months following discontinuation of a neuroleptic medication. The MOSES will also be completed every six (6) months."<br><br>A review of eight individuals (Individual #156, Individual #125, Individual #243, Individual #213, Individual #298, Individual #232, Individual #292, and Individual #75) found that all eight had a MOSES completed, but seven were not completed timely. Whereas, all eight had the DISCUS completed timely.<br><br>In addition, only one of eight had a Nursing Treatment Plan that briefly addressed the side effects of psychotropic medications, and the need to conduct MOSES and DISCUS monitoring. However, even this plan was not adequate regarding the array of goals and objectives necessary for an individual on psychotropic medication. Individuals prescribed psychotropic medication need to have a nursing treatment plan in place addressing individual goals and objectives, as well as the need for conducting MOSES and DISCUS (if appropriate) monitoring. | |
| N6 | Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely | At the time of this review, LBSSLC had a policy addressing Adverse Drug Reactions (ADR) in place that had not been reviewed since 10/06. The minutes of the Pharmacy and Therapeutics Committee indicated that the Facility has been working on defining what an adverse drug reaction is and how it is different from a medication side effect. The | |

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| | identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions. | Chief Nurse Executive indicated that a drug reaction had occurred sometime last year, but was not accurately identified as an ADR, and thus was not reported as such. Fortunately, the individual was seen and released at the hospital without any long-term side effect. The Facility needs to continue to develop a system for identifying and reporting ADRs. A statewide policy, in alignment with standards of practice, the SA, and Healthcare Guidelines should be considered in addressing this requirement. From the report of the Pharmacy Director, there had been no Adverse Drug Reactions reported to the Food and Drug Administration in the past several years. | |
| N7 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. | Documentation submitted by the Facility indicated that since March 2009, the LBSSLC Pharmacy and Therapeutic Committee had adopted the Medication Audit Criteria and Guidelines established by the Texas Department of State Health Services (DSHS) Texas Department of Aging and Disability Services Executive Formulary Committee. The documentation indicated that the DSHS had not chosen to broaden the drug classes beyond psychotropic medications and thus, the Facility took it upon themselves to create their own audit criteria for anticonvulsants and antibiotics.<br><br>At the time of this review, the Pharmacy and Therapeutics Committee, headed by the Clinical Pharmacist, had conducted drug utilization evaluation (DUE) in March 2009 for Zyprexa; June 2009 for Risperdal, Seroquel and Geodon; September 2009 for Levaquin; December 2009 for Depakote and Depakene; and March 2010 for Keppra. Compliance data was generated for each DUE conducted. The DUE reports indicated that for compliance scores 70 percent or less were an indication of systematic problems, and a plan of correction would be developed and implemented. Although a majority of the Facility's compliance scores were noted to be well above 70 percent, there were DUEs that had compliance scores noted to be 70 percent or below for March 2009, June 2009, and March 2010. However, no plan of correction or clinical justification for the deviation in practice was noted on the DUE. For each indicator falling below the 70 percent threshold, the Facility should consider adding any plan of correction with dates implemented or clinical justifications to the meeting minutes to keep the process succinct and complete.<br><br>The State's Medical Director had been working on this requirement with all the SSLCs in continuing to develop the DUE process in alignment with the SA and Health Care Guidelines. The initial implementation of the process at LBSSLC was promising. | |
| N8 | Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular | Based on review of the Medication Error Committee Meeting minutes, interviews with the Chief Nurse Executive, QE Nurse, and unit medication nurses, LBSSLC had significant problematic issues regarding the integrity of the medication error/variance system. The current policy at the Facility, although revised in May 2009, is based on a medication | |

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| | documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances. | error system rather than a medication variance system.<br><br>From review of the Facility's medication error data from June to December 2009, there appeared to be a significant problem with the under-reporting of medication errors based on the census, and the number of medications given on a daily basis. The Facility's data indicated that there were between two and eight medication errors per month, with the exception of 32 in April 2009. However, the Facility had noted that on several occasions, there was an excess of individuals' medications returned to the pharmacy with no explanation as to why the individuals' medication cart bins that were sent to the units with the exact number of medications needed for the week had medications left over without any changes made in the medications. This problem had become so pervasive that in certain residential units the nurses were instructed to only place three days-worth of medications in the individuals' bins to better identify when individuals were not receiving their medications correctly.<br><br>Based on information contained in the Medication Error Committee Meeting minutes, a number of the errors actually identified were attributed to agency nurses. The Facility's practice at the time of the review was to conduct medication observations annually. However, annually is not adequate, especially since LBSSLC has significant staffing issues and uses a number of agency nurses who administer medications. The Facility needs to increase its medication observations from annually to quarterly for all nurses who administer medications.<br><br>From conversations with nurses' who administer medications, there was significant confusion regarding what constitutes a medication error/variance, and the procedure to be used when Medication Administration Records (MARs) were found blank.<br>As mentioned previously, nurses reported that they were not consistently using the MARs when administering medication, because they felt they knew the individuals and their medication regimens. This inappropriate practice can result in the nurse not being aware of medication and/or dosage changes, and either pre-signing or post signing the MARs. Any and all of these deviations from appropriate standards of practice renders the Facility's medication administration system unreliable, and places individuals at risk.<br><br>When unit nurses were asked if missing initials on the MARs constituted a medication error/variance, some thought they did, some thought they had a certain timeframe to initial the MAR for it not to be an error/variance, and some stated that they did not know. However, all of the nurses asked stated that they were not responsible for completing a Medication Error Report if they had found a blank space on the MAR. Most stated it was the supervisors' job to deal with any medication errors. The Facility needs to develop and implement a system to ensure that MARs are regularly checked to determine that | |

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| | | medications were given as prescribed. When issues such as missing initials on the MARs are identified, a review needs to be completed to determine whether the individual actually received the medication, and a Medication Error/Variance Report needs to be submitted since the MAR blank constitutes a variance from the appropriate procedure.<br><br>Since medication error reporting was not yet reliable at LBSSLC, increasing medication observations and a spot check system should be initiated to include a review of the MARS and narcotics logs during each shift. The spot checker (auditor) should make sure that the MAR has been completed appropriately, and that both the on-coming and off-going nurses have signed the narcotics log indicating that the narcotic count was conducted by both nurses.<br><br>At the time of the review, LBSSLC's policy only indicated that "two nurses" are to count the narcotics. However, the policy needs to be revised to include the on-coming and off-going nurses conducting a simultaneous count.<br><br>In addition, the State should give consideration to moving from a medication error system to a medication variance system. Such a system focuses on all aspects of the medication delivery system, and places an emphasis on identifying potential areas that could lead to errors. Once such areas are identified, the focus would be on implementing proactive measures to prevent such errors from occurring.<br><br>In reviewing the minutes from the Medication Error Committee, there was no documented comprehensive narrative analysis, or plans of correction that included interventions and/or anticipated outcomes as a result of the actions taken. The minutes merely represented a review of the numbers of medication errors each month without any of the necessary clinical analysis.<br><br>Although the Facility had implemented a modification regarding the number of days of medications that were placed in the individuals' medication cart bins on certain units, and had changed some of the medication times to give nurses more time for medication administration in attempts to avert errors, these actions appeared to have made little impact on this system. A more thorough analysis needs to be completed, and the results used to develop and implement a plan of correction. | |

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

1. A system should be developed and implemented to ensure that there is supporting documentation of the notification of a physician that the addition of a newly prescribed medication may have adverse effects in combination with the existing medication regimen, as well as the

physician's response to this notification. If the physician makes the decision not to follow the recommendations made by the pharmacist, an entry must be made in the progress notes clinically justifying such a decision.

2. The Facility needs to develop a system to ensure that the DRRs are timely completed, that there is documentation addressing the acceptance or refusal of the pharmacists' recommendations, and that there is specific supporting documentation that the recommendation was implemented by the physician or practitioner, or clinical justification for decisions not to implement the recommendation. A modification to the existing DRR form could address the issue regarding documentation that demonstrates the implementation of the accepted recommendation by the pharmacist.
3. A system should be developed and implemented to ensure that the prescribing medical practitioners and the pharmacist collaborate in: a) 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; b) monitoring the use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justifications and attention to associated risks; and c) monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.
4. The Facility should finalize the process of updating the policy on adverse drug reactions, and ensure that there is timely identification, reporting, and remedial action regarding all significant or unexpected adverse drug reactions.
5. State Office and the Facility should continue the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care, as defined by the SA and Health Care Guidelines. Consideration should be given to including any plans of correction on the drug utilization evaluation form for compliance scores of 70 percent and below in the discussion and meeting minutes of the Committee.
6. The Facility should ensure that policies regarding medication errors/variances identify all failures to properly sign the Medication Administration Record and/or the Narcotics Logs as errors/variances, and that appropriate follow-up occurs to prevent recurrence. The Facility should move from a medication error system to a medication variance system in alignment with the requirement of the SA.
7. The Facility should implement increased medication administration observations to quarterly.
8. The Facility should implement documented spot checks to ensure the MARs and Narcotic Count Logs are documented appropriately.
9. Nurses should conduct counts of narcotics and document such counts in the Narcotic Log at the beginning/end of each shift, as well as when the keys are passed to another nurse for breaks and when the keys are returned to the originally assigned nurse. The Facility's policy needs to be revised to include these specific elements.
10. The Facility should conduct an analysis and implement a plan of correction with nursing to address the underreporting of medication errors/variances.
11. Training should be provided to all nursing staff regarding the reporting of medications errors.
12. The Medication Error Committee should conduct regular analyses regarding medication errors to identify trends and implement plans of correction aimed at the prevention of such errors. For example, the already identified trend of medications being returned to the pharmacy that should have been administered needs to be analyzed thoroughly, and a plan of improvement developed and implemented to address underlying issues.
13. The Facility, specifically nursing, should develop and implement a monitoring system to ensure that MOSES and DISCUS are conducted quarterly, and that for individuals who require this, that there is a Nursing Care Plan addressing these needs.

| SECTION O: Minimum Common Elements of Physical and Nutritional Management | |
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| | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o Health Status List, dated 3/8/10, Aspiration (TX-LB-1003-VI.3.a);<br>o Master Habilitation Therapies PNMP data, dated 2/2/10 (TX-LB-1003-VI.3.b);<br>o Health Status List, dated 3/8/10, Respiratory (TX-LB-1003-VI.3.c);<br>o At Risk Individuals, dated 3/11/10, Contractures (TX-LB-1003-VI.3.d);<br>o Health Status List and Master HTPNMP data spreadsheet, dated 3/8/10 (TX-LB-1003-VI.3.e);<br>o Health Status List and Master HTNPMP data spreadsheet, Choking, dated 3/8/10 (TX-LB-1003-VI.3.f);<br>o Master HTPNMP data, dated 2/2/10, Dysphagia (TX-LB-1003-VI.3.g);<br>o Individuals w/4 or more slip/trip/fall, not dated (TX-LB-1003-VI.3.h);<br>o LBSSLC Total-RNCM Tracking Tool-Decubitus and Weight Gain/Loss, dated 3/8/10 (TX-LB-1003-VI.3.i);<br>o Health Status List, dated 3/8/10, Skin Integrity (TX-LB-1003-VI.3.j);<br>o PSPA's and Health Status List, dated 3/9/10, Challenging Behavior (TX-LB-1003-VI.3.k);<br>o Health Status List, dated 3/8/10, Constipation (TX-LB-1003-VI.3.l);<br>o Health Status List, dated 3/8/10, Dehydration (TX-LB-1003-VI.3.m);<br>o Enteral Feeding and Frequency Report, dated 2/1/10;<br>o Nutritional Management Team Report;<br>o Health Status/NMT Report (TX-LB-1003-X.16);<br>o Therapist license list, dated 02/10;<br>o Debbie Jones-Ellison MS, CCC-SLP (certification);<br>o Nursing License Verification/Expiration, not dated (TX-LB-1003-XII.1);<br>o LBSS-PST Process-Program Development, Physical Nutritional Management Plan (PNMP) and Nutritional Management Team (NMT), dated 2/22/10 (TX-LB-1003-XII.2);<br>o Resumes (TX-LB-1003-XII.4);<br>o Continuing Education; Courses; Certificate of Attendance/Credit (TX-LB-1003-XII.5.a);<br>o PNMP Clinic sign-in sheet; NMT Meeting Attendees; Meeting notes, various dates (TX-LB-1003-XII.5.b.i);<br>o NMT/PST Meetings; Health Status/NMT/PST Meetings-Updated Minutes, various dates (TX-LB-1003-XII.5.b.ii);<br>o HT/NMT/PNMP/Dining Plan Meetings-updated minutes, various dates (TX-LB-1003-XII.5b.iii);<br>o Health Status Team Meeting, dated 1/22/10, format/guidelines (TX-LB-1003-XII.6);<br>o Master HTPNMP data from 1/09 thru 1/10;<br>o Occupational Therapy (OT)/Physical Therapy (PT) Evaluation, not dated;<br>o NMT List Form, not dated; |

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| | o OT/PT PNMP Review, not dated;<br>o Wheelchair/PNMP Clinic, dated 2/22/10 (TX-LB-1003-XII.7);<br>o Master HTPNMP data.xls, dated 3/1/10 (TX-LB-1003-XII.8);<br>o Wheelchair/PNMP clinic/screening documents, dated 2/22/10 (TX-LB-1003-XII.9);<br>o Occupational/Physical Therapy Update, various dates (TX-LB-1003-XII.9 for 504 E, 504 W, 513, 514, 515, 516, 517, 518, 521, 525, 526, 527, and 528);<br>o Criteria for Creating a PNMP/Dining Plan, not dated;<br>o OT/PT Evaluation form, not dated;<br>o Guidelines for PNMP/Wheelchair/AAC Clinic Documentation, not dated;<br>o OT/PT Assessment, Update, and Consult Process, dated 2/21/10;<br>o OT/PT-PNMP Review, not dated;<br>o Protocol to Identify and Track Wheelchair Needs, not dated (TX-LB-1003-XII.10);<br>o List of December, January, February Assessments/Updates, not dated (TX-LB-1003-XII.11);<br>o Physical/Nutritional Management Plan, various dates (TX-LB-1003-XII.13 504 E, 504 W, 513, 514, 515, 516, 517, 518, 521, 525, 526, 527, 528);<br>o Habilitation Therapy Meal Observation, 11/09;<br>o Physical/Nutritional Management Plan, not dated;<br>o PNMP Observation Sheet, not dated (TX-LB-1003-XII.14);<br>o Habilitation Therapies-PNMP Observation Sheet, not dated;<br>o Meal Observation, dated 11/09 (TX-LB-1003-XII.15);<br>o PT/OT Form/Questionnaire, not dated;<br>o Competency-Based Training Form/Questionnaire, not dated;<br>o Physical and Nutritional Management PNMP, not dated (TX-LB-1003-XII.16);<br>o Review of Logs/Observation Notes for Significant Incidents/Injuries PNMP and Corrective Action Plans, dated 11/2/09;<br>o OT/PT Quarterly Questionnaire/Report;<br>o Physical and Nutritional Support/PNMP, various dates (TX-LB-1003-XII.17);<br>o Health Risk Assessment Tool 2009;<br>o Physical Nutritional Management/Dysphagia Team Information for Meetings;<br>o Steps for Feeding Evaluations/Nutritional Management;<br>o PST/NMT Meeting/Consultation Feeding Evaluation;<br>o SLP form;<br>o Meal Monitoring Training Program Outline, not dated;<br>o LBSS-IDT Process-Program Development/NMT, dated 2/16/10 (TX-LB-1003-XII.18);<br>o Dining Plan Template;<br>o Criteria for Creating a PNMP/Dining Plan, not dated;<br>o Adaptive Feeding Equipment, not dated (TX-LB-1003-XII.19);<br>o Physical/Nutritional Management Plan; Meal Positioning; Dining Plan; Recliner Positioning; Wheelchair Position, not dated (TX-LB-1003-XII.20);<br>o Meal Positioning/Dining Plan, various dates in 2009 (TX-LB-1003-XII.21 B-C, C-C, D-G, H-J, L-M, N-R, S-S, and T-W); |

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| | o PNMP; Wheelchair/Recliner Positioning; Bed Elevation; MP/DP, various dates in 2009 (TX-LB-1003-XII.21 W-W);<br>o List of Individuals on Enteral Feeding, various dates from 01/09 thru 02/10 (TX-LB-1003-XII.22);<br>o Master HTPNMP data, various dates from 01/09 through 07/09, 8/09 through 9/09, and 10/09 through 2/10 (TX-LB-1003-XII.22);<br>o Wheelchair/PNMP Clinic (by Home), various dates from 05/09 thru 09/09 (TX-LB-1003-XII.22);<br>o Wheelchair/PNMP Clinic (by Home), various dates from 10/09 thru 01/10 (TX-LB-1003-XII.22);<br>o NMT List form, dated 03/08/10 (TX-LB-1003-XII.22);<br>o Master HTPNMP data thickit.xls and List of Individuals on Modified Texture, dated 03/10 (TX-LB-1003-XII.23.a);<br>o Physical and Nutritional Supports-diets downgraded within past 12 months, dated 03/10 (TX-LB-1003-XII.23.b);<br>o List of Individuals Body Mass Index (BMI) greater than 30, not dated (TX-LB-1003-XII.23.c);<br>o List of Individuals BMI less than 20, not dated (TX-LB-1003-XII.23.d);<br>o Weight Variance Charts, dated 02/09 thru 09/09;<br>o Six (6) month Weight Tracking, dated 06/09 thru 12/09 (TX-LB-1003-XII.23.e);<br>o Nutritional Management Team Report; Consultation Reports; Habilitation Therapies; Monthly Summaries, various dates in 2009 (TX-LB-2003-XII.24-part I through IV);<br>o Weekly Meal Service Schedule, not dated (TX-LB-1003-XII.25):<br>o March 2010 Calendar, dated 03/05/10 (TX-LB-1003-XII.26);<br>o New Hire Orientation Curriculum, not dated;<br>o PNPM, dated 11/20/09;<br>o Wheelchair and PNMP Quiz, dated 10/13/09;<br>o Mealtime Assistance Quiz, not dated;<br>o Physical Management in Feeding Developmental Disabilities Questionnaire, not dated (TX-LB-1003-XII.27);<br>o Training Program Outline for PNMP, Assistive Equipment, and Wheelchairs-various dates (TX-LB-1003-XII.28.a);<br>o Power Point presentation: Hearing Loss, Visually Impaired, Feeding In-service Program Outline, dated 02/10 (TX-LB-1003-XII.28.b);<br>o Active Employee Course Participation Report, dated 2/18/10 (TX-LB-1003-XII.29);<br>o Active Employee Course Participation Reports (3), 02/18/10 (TX-LB-1003-XII.30);<br>o NMT/PST Meetings-Updated Minutes, various dates from 2009-2010 (TX-LB-1003-X.17.f);<br>o Guidelines for Meal Monitors, dated 05/16/08;<br>o Dining Room Protocol, revised 10/02/07;<br>o Dining Room Test, revised 10/02/07;<br>o Training Program Outline PNMP Monitoring (Plan of Correction), not dated;<br>o Nutritional Management Risk Rating Guidelines, dated 03/08/10, (TX-LB-1003-NW.4.P); |

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| | ○ Habilitation Therapy Meal Observation (Monitoring), dated 01/22/10;<br>○ Habilitation Therapies PNMP Observation Sheet, dated 01/13/10;<br>○ Completed Mealtime Observation (Monitoring ) forms for November 2009 through January 2010 (TX-LB-1003-NW-4.r.1-2)<br>○ Completed Mealtime Observation (Monitoring) forms for December 2009 (TX-LB-1003-NW.4r.2)<br>○ Completed Habilitation Therapies PNMP Observation forms for December 2009 and January 2010 (TX-LB-1003-NW.4)<br>○ Records including OT/PT/SLP and Nutrition assessments; Habilitation Therapy Activity Plan; Habilitation Therapy Data Sheet, nursing assessment; medical assessment; health care plans; Positive Behavior Support Plan; PNMP; Dining Plan; PNMP Data Collection Sheets for December 2009, January and February 2010; Therapy and Nutrition Consultations; MBS, Nutritional Management Team Report; Health Status Meeting by Home; PNMP Clinic Documentation; PSP; Food and Fluid Intake for December 2009, January and February 2010; Bowel Management Documentation for December 2009, January and February 2010; Integrated Progress Notes; GI consultations; and Dental Progress Notes for the following individuals: Individual #192, Individual #161, Individual #196, Individual #301, Individual #228, Individual #185, Individual #128, Individual #135, Individual #6, Individual #160, Individual #45, Individual #290, Individual #51, Individual #208, Individual #108, Individual #285, Individual #74, Individual #72, Individual #312, Individual #263, Individual #283, Individual #48, Individual #203, Individual #134, Individual #119, Individual #242, Individual #250, Individual #164<br>▪ **Interviews with**:<br>○ Linda Thomas, OTR/L, Director of Habilitation Therapies;<br>○ Debbie M. Jones, MS, CCC-SLP, Chairperson of NMT;<br>○ Occupational Therapists (all);<br>○ Physical Therapists (all);<br>○ Speech Language Pathologists (all);<br>○ Dietitians (all); and<br>○ Dawn Ripley, Director of Quality Enhancement, and Alena Richardson, Program Compliance Monitor<br>▪ **Observations of**,<br>○ NMT Meeting, on 03/19/10;<br>○ Health Status Meeting, on 03/18/10;<br>○ Meals in Quail/Sparrow, Iris, Rose, Zinna, Oak, Aspen, and Rose;<br>○ Medication Administration in Iris; and<br>○ Direct Services Management Team, on 03/16/10 |
| | **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| | **Summary of Monitor's Assessment:** Although the Nutritional Management Team (NMT) met regularly, |

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| | risk levels were assigned to individuals that were not consistent with the Nutritional Management Screening Tool. Individuals who were identified at high risk did not receive a comprehensive assessment resulting in recommendations for measurable, functional outcomes, and leading to the development of strategies to minimize and/or remediate identified health concerns. Individual-specific monitoring was not implemented for those individuals at highest risk.<br><br>Per LBSSLC policy, individuals were to be assigned a NMT risk level: 1-High Risk, 2-Medium Risk, and/or 3-Low Risk. The policy did not define the criteria for these risk levels. There were identified health risk indicators related to nutritional management, but it did not identify additional health risk indicators such as decubitius ulcers, obesity, fecal impactions, recurrent hospitalizations, fractures, mobility-related falls, etc. An analysis of information about some individuals who had identified physical and nutritional problems did not support the risk level assigned, or it was not clear why a particular risk level was assigned.<br><br>The *Criteria for Creating a PNMP/Dining Plan* did not incorporate strategies for bathing/showering, oral hygiene, and/or medication administration to minimize risk for individuals throughout the 24-hour day. There needed to be collaboration between nursing and Habilitation Therapies to ensure that individual PNMP content was integrated with medication administration, as well as nursing/health care plans.<br><br>The reviewer observed significant mealtime errors that had the potential to place individuals at risk. There were a number of factors that appeared to impact this. The time allotment for mealtime foundational training was not sufficient for new employees. Mealtime observations showed that staff had not acquired the foundational knowledge and skills to follow dining plans to support safety at mealtimes. Dining plans within each home needed to be analyzed to determine the appropriate staffing ratio to ensure their consistent implementation. Oversight was needed during mealtimes to support staff and individuals, and to provide a safe mealtime environment.<br><br>Policies did not provide clear direction for the implementation of the PNMP monitoring process. Such a policy should include criteria for and identification of PNMP monitors, definition of the PNMP monitoring tool with description of each performance indicator, definition of the competency-based training process for PNMP monitors to support confidence in monitoring results, definition of staff re-training thresholds, explanation of validation or inter-rater reliability process for PNMP monitors, definition of the analysis process of PNMP monitoring results to assist in the formulation of corrective strategies to address systemic areas of deficiency for specific indicators, and integration of the PNMP monitoring system into the facility Risk Management and Quality Improvement systems.<br><br>The Facility did not have a policy/procedures for choking incidents. A choking policy/procedure should be developed to include criterion for referrals to a mealtime incident response team based on operational definitions for choking, partial airway obstruction, and aspiration/dysphagia risk. These procedures should define team membership, functional roles and responsibilities, action response timeframes, documentation requirements, follow-up and review guidelines, and ensure operational linkage to LBSSLC Risk Management and Quality Improvement. |

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| | Based on the policies submitted, there were no policies that defined the frequency and depth of evaluations related to enteral nutrition to be completed by the following disciplines: nursing, physician, Speech/language pathologist and occupational therapist. |

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| O1 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a | Due to multiple requirements included in this provision of the SA, each requirement is discussed in detail below:<br><br>PNM team consists of qualified SLP, OT, PT, Registered Dietitian, and, as needed, ancillary members [e.g., Medical Doctor (MD), Physician Assistant (PA), and Registered Nurse Practitioner (RNP)]. The LBSSLC Nutritional Management Team (NMT) policy, revised 02/22/10, defined the NMT as "a team of specialists with knowledge of the causes and treatment of dysphagia who meets to discuss specific nutritional problems to determine appropriate intervention." According to the policy, the NMT members included: Team Coordinator who was a Speech Language Pathologist (SLP) who specialized in dysphagia/nutritional management issues; Physician/Physician Assistant; Occupational Therapist (OT); RN Case Manager; Dietitian; QMRP; and other disciplines as indicated by need including but not limited to Physical Therapists, Certified Occupational Therapist Assistant (COTA), Licensed Vocational Nurse (LVN), Psychologist, Home staff and others.<br><br>A review of the policy and NMT Meeting Minutes from 1/8/09 to 12/29/09 documented a physical therapist was not an established member of the NMT.<br><br>There is documentation that members of the PNM team have specialized training or experience in which they have demonstrated competence in working with individuals with complex physical and nutritional management needs. The Occupational Therapists, Speech Language Pathologists and Registered Dietitians had completed some continuing education related to supporting individuals with complex physical and nutritional support needs. Continuing education courses offered by Texas Tech University Health Sciences Center Department of Internal Medicine and Office of Continuing Medical Education were completed by the Medical Director and Physician Assistant. These courses would have been beneficial for therapists and dietitians to attend such as Barrett's Esophagus-Management and Surveillance; Update in Appropriate Screening and Management of Osteoporosis - A Call to Action; and Eosinophiic Esophagitis: An Update.<br><br>There did not appear to be a comprehensive plan to provide continuing education to support NMT members in their roles and responsibilities of providing supports to individuals with the most complex physical and nutritional supports needs. NMT | |

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| | 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. | members had participated in a variety of training, but a number of members had had limited training in the last year directly related to the provision of supports to individuals with complex PNM needs. The following provides examples of a couple of members who had had minimal training:<br>▪ An OT who had completed the following continuing education in 2009: PNMP and Wheelchair Clinic Teleconference, Dysphagia in the Elderly, Habilitation Therapies Annual Conference, Visually Impaired Students with Vestibular Issues, and Orientation and Mobility (O&M) for Multiply and Visually Impaired/Deaf Blind Students.<br>▪ A registered dietician who had completed Green Tea and Bone Health, and Facility Support Services Synergy Forum in 2009.<br>▪ A registered dietician who had completed Nutrition Assessment In Adult Developmentally Disabled Population, Artificial Nutrition and Hydration, and Carbohydrate and Lipid Metabolism in 2009.<br>▪ An OT completed PNMP and Wheelchair Clinic Teleconference in 2009.<br><br><u>PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.</u> NMT Meeting Minutes submitted for the period between 01/08/09 and 12/29/09 documented 112 meetings. The NMT Meeting Minutes log documented the name of the individual, risk level, reason for review including NMT problems, discussion/recommendations, and next review date.<br><br>The NMT met regularly to review individuals within all three risk categories. A Nutritional Management Team Report was completed for individuals reviewed that tracked:<br>▪ Videos that had been completed;<br>▪ Gastrointestinal (GI) status;<br>▪ Esophagogaastroduodenoscopies (EGD) date;<br>▪ Annual NMT Review;<br>▪ Nutritional Management (NM) Problems;<br>▪ Estimated Desired Weight Range;<br>▪ Review date(s);<br>▪ Reason for review; and<br>▪ Discussion/recommendations.<br><br>Although the NMT met regularly and despite the fact that the Habilitation Therapies Handbook required the completion of comprehensive assessments, individuals identified at high risk did not receive a comprehensive assessment to identify recommendations with measurable, functional outcomes leading to the development of strategies to minimize or remediate identified health concerns. The NMT should develop and implement these support strategies. These strategies should be monitored on a frequent | |

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| | | basis to ensure efficacy of these interventions and/or revision of the strategies that were not effective. For example, documentation for the following individuals did not contain comprehensive assessments:<br>▪ Individual #161 was reviewed five times by the NMT between January 16, 2009 and February 19, 2010. Per the NMT Report, she had been hospitalized at least seven times during the same period, although the Report did not consistently document the dates of her hospitalizations. The NMT did not consistently meet to review her status after hospitalizations. During a PST meeting on 06/16/09, there were discussions about consideration of a Percutaneous Endoscopic Gastrostomy (PEG) tube placement, but the physician recommended continuing with attempts to assist her to eat orally. In January 2010, during a PSPA meeting, the "team was informed that the decision had already been made to place PEG." Individual #161 had a PEG tube placed on 01/06/10, and subsequently had to have the PEG tube replaced three times within a ten-day period, according to a 01/20/10 PSPA. Individual #161, due to her nutritional status, was a candidate for enteral nutrition from the time of her admission to LBSSLC. The NMT did review Individual #161, and there were multiple consultations, but a comprehensive assessment to address her significant health concerns, including her underweight status, dehydration, constipation, urinary tract infections, etc., and develop recommendations with measurable, functional outcomes to minimize these health risk indicators had not been completed.<br><br>In addition, individuals at high risk, such as Individual #161, should be prioritized for frequent individual-specific monitoring. Individual monitoring sheets for fluid intake, bowel management, and the PNMP were reviewed. Physical/Nutritional Management Data Sheets for December 2009, January 2010 and February 2010 submitted for Individual #161 had significant data collection gaps. An analysis of these PNMP data collection sheets did not provide sufficient discrete information to ensure that components of her PNMP were being implemented correctly. The Bowel Management Records for December 2009, January 2010, and February 2010 showed data collection gaps. For example, the February Bowel Management Record had only two entries. This was a concern because Individual #161 had a history of constipation, and tracking of her bowel movements was essential to ensure her health. The Enteral Flow Sheet for December 2009, January 2010 and February 2010 also had significant documentation gaps. The Enteral Flow Sheet for February was blank from February 1 through 21, 2010. Due to the high risk status of Individual #161, individualized monitoring should have been defined, implemented, and analyzed to ensure staff was implementing her dining plan, PNMP and other strategies as written. | |

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| | | It also was of concern that the decision was made to place a PEG tube without review by the NMT. It appeared from a review of Individual #161's NMT Report that the NMT and medical staff were not communicating effectively.<br>▪ According to the NMT/PST Meeting-Update, dated 03/05/10, Individual #192 was reviewed by the NMT upon discharge from UMC (hospital). She had been hospitalized from 02/27/10 to 03/05/10 with discharge diagnoses of acidosis, resolved, and dehydration, resolved. At the meeting, home staff stated it was difficult to get her to drink. Home staff reported: "at this time no one is responsible for monitoring fluid sheet to determine if fluids need to be encouraged more often." The Occupational Therapist recommended a successful hydration plan utilized for another individual in the Facility in "which all PST members were actively and aggressively involved." The PST representative stated: "they would come up with a plan to increase accountability with fluids," but no plan was actually discussed or agreed upon at the meeting.<br><br>An addendum documented that Individual #192 was re-admitted to UMC on 03/06/10 with an admission diagnoses of pleural effusion and aspiration pneumonia. The NMT did not recommend a comprehensive assessment to address Individual 192's high-risk status for aspiration pneumonia and/or dehydration, leading to strategies to minimize these identified health risks. Of further concern, was the failure of the PST representative to support the implementation of a hydration plan. This was particularly concerning because it was reported that no one in the home was responsible for monitoring Individual #192's fluid intake sheet, and a review of the December 2009, January 2010 and February 2010 Food and Fluid Intake Sheets documented that Individual #192 was not receiving the daily prescribed fluids, which continued to place her at risk of dehydration and recurrent hospitalizations.<br>▪ Individual #196's NMT Report (09/16/09 PST) documented a hospitalization from 09/07/09 to 09/15/09 with aspiration pneumonia. The NMT did not review Individual #192 or complete a comprehensive assessment after her hospitalization.<br>▪ Individual #74's Nutritional Management Team Report documented a Modified Barium Swallow Study (MBS) was completed on 02/19/09, during a hospitalization for pneumonia. The MBS recommended diet texture changes. The NMT discussion stated that Individual #74's pneumonia status would be followed-up at the March Health Status meeting. It was unclear why the NMT would not continue to follow up on Individual #74 as her Risk Level was high.<br>▪ Individual #72, Individual #312, Individual #301, Individual #263 were hospitalized multiple times, but these individuals were not consistently reviewed by the NMT after hospitalizations, and did not have a comprehensive assessment completed. | |

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| | | The NMT made recommendations for revisions to individual's PNMPs, but these recommendations were not addressed in subsequent NMT meeting minutes to ensure that an individual's PNMP had been modified appropriately, as illustrated below:<br>▪ On 1/16/09, the NMT recommended that Individual #208's PNMP be revised to add Ensure for meal refusals or less than 50% consumption. His risk level was High-Level 1. He was reviewed by the NMT on 02/12/09, and it was reported that he had gained two pounds in the last month but he remained eight pounds below his desired weight range (DWR). There was no documentation that his PNMP had incorporated the revisions from the preceding NMT meeting.<br>▪ On 7/28/09, Individual #217 was reviewed by the NMT as a follow-up to his Modified Barium Swallow (MBS). His PNMP was to be revised to: 1) reduce the size of spoon immediately; 2) reduce meal size to rule out fatigue factor which could contribute to increased coughing during meal progression; 3) reduce meal size to half portions, and provide snacks daily to ensure adequate nutrition. His PNMP/Dining Plan was to be updated, and staff were to be in-serviced on new feeding strategies. The RN/Dietitian/staff were to continue to monitor coughing at meals. His identified risk was High – Level 1. The NMT List Form documented that Individual #217 was reviewed by the NMT on 08/21/09, but NMT minutes were not submitted for this date, and it was not clear that follow-up had occurred to ensure these recommendations had been incorporated.<br><br><u>PNM plans are incorporated into individuals' Personal Support Plans (PSPs).</u> Review of individual PSPs submitted incorporated the individual's PNMP into the PSP. PNMP information could be located under OT, PT, SLP, Nutrition sections.<br><br><u>Identification, assessment, interventions, monitoring, training as outlined in sections O-2 through O-8 of the Settlement Agreement occurs.</u> Individuals who experienced complex physical and nutritional support needs did not receive comprehensive PNMT assessment, interventions, monitoring and training as illustrated below:<br>▪ The NMT List Form documented the reason for review and NMT problems for Individual #228 as:<br>o 1/13/09 for pneumonia;<br>o 3/31/09 for follow-up for pneumonia (no NMT minutes submitted);<br>o 7/23/09 for meal consumption;<br>o 8/21/09 for feeding assessment (no NMT minutes submitted);<br>o 8/24/09 for feeding assessment/pneumonia;<br>o 9/18/09 for follow up pneumonia (no NMT minutes submitted);<br>o 10/22/09 for pneumonia; and<br>o 11/20/09 for addendum for NMT discussion and annual update (no NMT minutes submitted). | |

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| | | It was unclear why her identified risk level was Medium Risk - 2, because she had experienced multiple episodes of pneumonia. The NMT met on 8/24/09, to review her feeding assessment and a recent diagnosis of pneumonia, and made the following recommendations: 1) defer a formal feeding evaluation until the second week of September. The status of a formal feeding evaluation was not discussed at the next NMT Meeting on 10/22/09; 2) she should be seen in the ENT Clinic due to pansinusitis; 3) staff should follow her PNMP regarding positioning; 4) staff should follow her dining plan/techniques; and 5) she should be followed up in the September NMT meeting. The NMT did not complete a comprehensive assessment, which should have resulted in the development of measurable, functional outcomes to address her health risk indicators. An Occupational/Physical Therapy Update was completed on 11/13/09, and 12/05/09, but did not identify recommendations. Individual #228's PNMP was revised on 2/24/10, but did not address strategies to minimize her risk for aspiration during bathing/showering, tooth brushing, and medication administration.<br>▪ On 1/16/09, Individual #161, a new admission at the time, was reviewed by the NMT due to her low weight status. She was assigned a risk level of High Risk - 1. Her recorded weight during this meeting was 88 pounds. She received a high calorie, ground diet with Ensure, and Juven and pudding were to be added to her diet. Her weight status was to be followed up at the February Health Status meeting. It was unclear why the NMT did not review her in February. She was reviewed by the NMT on 3/10/09 to address MBS recommendations made on 3/10/09. Her Risk Level changed to Medium - 2 during this meeting without explanation. She was reviewed by the NMT on 05/27/09, due to two hospitalizations on 5/21 and 5/24/09. Her Body Mass Index (BMI) was 15.5 (normal range 18.3-24.9), which was underweight for her height and body build. The SLP and OT reported monitoring meals intermittently to assist in establishing strategies due to her inconsistent patterns during meals. The OT requested assistance from "core PST members to monitor and assist staff to ensure strategies are being followed in exact steps as directed in order to establish stability and to determine which strategies are the most successful." The following strategies were identified:<br>o Ensure was to be changed to Ensure Plus, and to be given three times daily;<br>o If meal consumption was less than 50%, an additional milkshake was to be provided;<br>o Habilitation Therapies had provided a gel cushion to be used in wheelchair, recliner, and at dining table;<br>o Wheelchair changed from a standard to reclining back to prevent skin issues, and provide additional positioning options; | |

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| | | o Home was to notify Habilitation Therapies if any redness was noted; and<br>o Food intake to be documented.<br><br>The NMT reviewed her on 06/03/09. Her weight in April was 93 pounds, and her current weight in June was 85.8 pounds, which reflected a weight loss of 7.2 pounds. The Dietitian reported that her snacks were being returned to the kitchen. Her Dining Plan was to be updated to indicate that if she consumed less than 75 percent of her meal, staff should notify nursing. Meal refusals were to be documented by staff, and staff were to be in-serviced. She was receiving 4000 calories per day. Referrals were made for GI, EGD, and colonoscopy. Follow-up was to occur in two weeks.<br><br>The NMT reviewed her on 06/16/09. She was hospitalized for dehydration on 06/14/09. Her physician recommended continuing with attempts to feed her orally instead of considering a PEG tube.<br><br>The next NMT review was 09/10/09, at which time it was documented she had been eating well until recent episodes of constipation. She was hospitalized with cystitis. On 12/10/09, the NMT review documented that the QMRP reported that Individual #161 was "holding food," and had difficulty swallowing. Fluids were being encouraged due to repeated episodes of dehydration. She was hospitalized again with hypernutremia, and a urinary tract infection. The NMT List Form documented she was hospitalized, on 1/06/10, and received a PEG tube.<br><br>Individual #161 experienced complex physical and nutritional support needs that were not consistently addressed by the NMT. The NMT made recommendations, but staff did not consistently follow these recommendations as evidenced by Individual #161 weight fluctuation, multiple episodes of dehydration and UTIs, resulting in hospitalizations. The NMT recommendations were to be incorporated into her PNMP, but there were no established timeframes to ensure these recommendations were integrated into her PNMP The NMT also did not develop and implement a person-specific monitoring schedule to ensure compliance. Individual #161 was identified at a Risk Level 1, but a comprehensive assessment and plan had not been developed, and/or implemented to address her risk for receiving enteral nutrition. | |
| O2 | Commencing within six months of the Effective Date hereof and with full implementation within two | A process is in place that identifies individuals with PNM concerns (HCG VI.C.2 and 3). The process includes levels of risk based upon physical and nutritional history, current status and includes specific criteria for guiding placement of individuals in specific risk | |

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| | years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems. | levels (HCG VII.C.1; VI.B.1). The LBSSLC Nutritional Management Team Policy, revised on 2/22/10, stated: "the purpose of this policy is to identify, treat, and monitor eating, swallowing, and digestive problems; to prevent respiratory difficulties and complications from enteral nutrition; to address gastrointestinal concerns and other high risk medical conditions of individuals residing at State Supported Living Centers." The NMT referral process was described as:<br>▪ Referrals to the NMT were to be made as needed by physicians, nurses, the HST, NMT, PST, and others who have concerns about the individual's nutritional status or condition;<br>▪ Individuals who exhibit signs of dysphagia were to be referred for further evaluation;<br>▪ Individuals were to be scheduled for the assessment by the coordinator (SLP);<br>▪ Therapists were to complete assessments to address identified issues;<br>▪ A referral was to be made to physician and/or RN, if needed; and<br>▪ The evaluation/assessments could include mealtime evaluations, referral for videoesophagram or other radiological procedures, EGDs, colonoscopies, lab work, and other evaluations as needed.<br><br>Per policy, individuals would be assigned a NMT risk level:<br>▪ 1-High Risk;<br>▪ 2-Medium Risk; and/or<br>▪ 3-Low Risk.<br>There were identified health risk indicators related to nutritional management, but the policy did not identify additional health risk indicators such as decubitius ulcers, obesity, fecal impactions, recurrent hospitalizations, fractures, mobility-related falls, etc. An analysis of information about some individuals who had identified physical and nutritional problems did not support the risk level assigned, or it was not clear why a particular risk level was assigned. For example:<br>▪ On 8/20/09, Individual #34 was reviewed by the NMT for her weight. Her BMI indicated extreme obesity. It was unclear why the NMT identified her as Risk Level 3 - Low Risk, with a designation of "extreme obesity."<br>▪ Individual's #109 August weight was 160. His weight on 08/29/09 was 166 pounds. His tube feedings were decreased. It was unclear why his Risk Level was 2, because his weight was not significantly above his ideal body weight range.<br>▪ Individual #237's weight was 273 pounds. His desired weight range was 161-183. His body mass index was 39.2%, which documented he was significantly overweight. It was unclear why his risk level was 3 (low) based on his weight status.<br>▪ Individual #258's current weight was 125 pounds. His desired weight range was 110 to 121. He received a high calorie, pureed diet with fluids thickened to | |

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| | | nectar consistency. His guardian had given consent for a MBS to determine if fluid consistency was appropriate. His past year's illness was constipation. It was unclear why his risk level was high (1).<br><br>Another concern was the discrepancy between the risk levels assigned by the NMT to individuals, and those assigned by the Health Status Team. These two entities should have been working together to identify individuals at risk in a consistent manner. The following are examples of the discrepancies found:<br>▪ The 3/8/10 LBSSLC Health Status List documented two individuals, Individual #161 and Individual #62, at high risk for aspiration. NMT minutes documented multiple individuals who had documented episodes of pneumonia and/or aspiration pneumonia with a Risk Level 1 – High Risk, including: Individual #239, Individual #246, Individual #312, Individual #176, Individual #72, Individual #74, Individual #315, Individual #138, Individual #55, Individual #118, Individual #269, Individual #211, Individual #281, Individual #193, Individual #228, Individual #280, Individual #182, Individual #263, Individual #226, Individual #196, Individual #66, Individual #301, Individual #78, Individual #128, Individual #313, Individual #182, Individual #281, Individual #17, Individual #104, Individual #323, Individual #62, and Individual #122.<br>▪ The 3/8/10 LBSSLC Health Status List did not identify any individual at high risk of choking. The NMT Meeting Minutes documented choking incidents for Individual #135 and Individual #156.<br><br><u>Individuals identified as being at an increased risk level are provided with a comprehensive assessment that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake by the PNM team.</u> As is discussed above with regard to Section O.1 of the SA, comprehensive assessments were not being completed for individuals identified as at risk. The following provides additional examples of individuals for whom this did not occur:<br>▪ The 2/22/10 NMT List Form documented that Individual #312 was reviewed and/or followed up for pneumonia eight times between 01/20/09 and 01/11/10. NMT recommendations were:<br>o On 1/20/09, his PNMP/positioning was reviewed, and determined to be current;<br>o Follow-up status at February NMT, but Individual #312 was not reviewed in February by the NMT<br>o On 7/22/09, staff were to be in-serviced to never allow fan to blow directly into his face;<br>o The 7/22/09 minutes also reflected that he was receiving chest percussion therapy twice daily for next week; | |

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| | | o The 7/22/09 minutes stated that reflux, osteoporosis, aspiration and seizure precautions are in place;<br>o The 7/22/09 minutes indicated he was not a candidate for oral feeding;<br>o On 11/17/09, his room was to be rearranged, so his bed was not near window;<br>o On 11/17/09, it was noted that the home continued to practice universal precautions; and<br>o On 11/17/09, his PNMP was reviewed and determined to be current.<br>Although Individual #312 had recurrent hospitalizations for pneumonia and was identified at high risk, the NMT did not complete a comprehensive assessment. His PNMP, revised 02/09/10, did not address strategies for bathing/showering, oral hygiene, and medication administration to minimize his risk for and "history of pneumonia/silent aspiration."<br>▪ The 2/23/10 NMT List Form documented that Individual #285 was reviewed 10 times for pneumonia from 01/27/09 to 01/14/10. The 5/12/09 NMT Meeting Minutes documented concerns that Individual #285 had been hospitalized five times already in 2009, including from:<br>o 12/28/08 to 01/02/09, for dehydration and fever;<br>o 1/26/09 to 01/30/09, for pneumonia, and early cellulites;<br>o 3/03/09 to 3/09/09, for upper GI issues;<br>o 4/18/09 to 4/27/09, for pneumonia; and<br>o 5/3/09 to 5/13/09, for Gram positive and sepsis, secondary to aspiration pneumonia.<br>The NMT discussed shower positioning and bed positioning. She was to reviewed during the NMT June meeting. NMT Meeting Minutes did not document that Individual #285 was reviewed in June. The NMT reviewed Individual #285 on 07/21/09 for an "update annual evaluation," and her Risk Level was changed from 1- High Risk to 2 - Medium Risk, without documented justification. The NMT did not complete a comprehensive assessment for Individual #285, even though she had recurrent hospitalizations and was identified as high risk.<br><br>The 2/1/10 LBSSLC Clients on Enteral Feeding list documented 51 individuals who were enterally nourished. Two of these individuals had recently received PEG tubes, including Individual #161, who started on 01/08/10, and Individual #128 who started on 12/07/09. Review of these two individuals who most recently received tubes showed that the NMT did not complete comprehensive assessments before or after they received their tubes. More specifically:<br>▪ The NMT Report documented a review for Individual #161 on 10/23/09, with an assignment of Risk Level 2. Individual #161 received a PEG tube on 01/08/10. The NMT did not complete a comprehensive assessment prior to or | |

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| | | after the placement of the PEG tube.<br>▪ Individual #128's PST completed a review for a previous hospitalization on 10/10/09, during which the she received the diagnoses of Oxacillin-resistant Staphylococcus Aureus and aspiration pneumonia. Her Dining Plan was sent to the hospital, but she was enterally fed during her hospital stay. Her team agreed that she should return to "oral eating immediately as pneumonia was most likely due to vomiting." She received a PEG tube on 12/07/09. However, the next review by the NMT occurred on 01/22/10, almost six weeks later. The NMT did not complete a comprehensive assessment prior to or after the placement of her PEG tube.<br><br>Updates are provided as needed or at a minimum annually for all individuals with identified PNM supports. This indicator will receive further review during the next on-site visit. | |
| 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. | All persons identified as being at risk (requiring PNM supports) are provided with a comprehensive Physical and Nutritional Management Plan (PNMP). LBSSLC's Criteria for Creating a PNMP/Dining Plan, not dated, indicated that individuals must have a PNMP for:<br>▪ Specific lifting/transferring/mobility instructions;<br>▪ Specific assistive equipment including orthotics;<br>▪ Positioning needs;<br>▪ Modified seating/mobility systems; and<br>▪ Nutritionally compromised individuals, including those who receive enteral nutrition.<br>Individuals for whom no PNMP was required included:<br>▪ Individuals served who did not require 24 hours set of instructions/techniques addressing (in other words, were independent and did not need additional supports throughout a 24 hour day) use of assistive equipment, transfers/lifting, positioning, handling, and/or complex nutritional needs.<br>Individuals who must have a dining plan included:<br>▪ Individuals who eat orally, but a PNMP may not be required.<br>The dining plan as part of the PNMP for individuals served who receive enteral nutrition was to consist of their specific positioning/pictures/instructions included in their PNMPs.<br><br>The PNMP criteria did not incorporate strategies for bathing/showering, oral hygiene and/or medication administration.<br><br>As appropriate, PNMP consists of interventions /recommendations regarding: Positioning/alignment; Oral intake strategies for mealtime, snacks, medication | |

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| | | administration, and oral hygiene; Food/Fluid texture; Adaptive equipment; Transfers; Bathing; Personal care; In-bed positioning/alignment; General positioning (i.e., wheelchair, alternate positioning); Communication; and Behavioral concerns related to intake. PNMP/Dining Plans were submitted from and reviewed for the following residences: 504 E. Mesquite Drive, 504 W. Mesquite Drive, 513 S. Cedar Avenue, 515 S. Cedar, 516 S. Cedar Avenue, 517 Cedar Avenue, 518 S. Cedar Avenue, 521 N. Cedar Avenue, 525 S. Cedar Avenue, 526 N. Cedar Avenue, 527 N. Cedar Avenue, 528 N. Cedar, and 514 S. Cedar Avenue. The standard PNMP format submitted contained the following categories: focus, assistive equipment, communication, mobility, transfer, movement, positioning, and dining plan. Additional categories documented included skin care, foot care, and rest period, but these categories were observed found for a small group of individuals. The PNMPs reviewed did not provide instructions for bathing/showering, or strategies for oral care and/or medication administration.<br><br>People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above. The LBSSLC "Clients on Enteral Feeding Enteral Feeding and Frequency Report as of 02/01/10" listed 51 individuals receiving enteral nutrition. Ten PNMPs for individuals who were enterally nourished were reviewed, including the plans for Individual #323, Individual #63, Individual #37, Individual #226, Individual #74, Individual #161, Individual #176, Individual #136, Individual #167, and Individual #7. This reviewed identified that their PNMPs did not provide instructions for bathing/showering, and/or strategies for oral care, and/or oral medication administration.<br><br>PNMPs are developed with input from the IDT, home staff, medical and nursing staff and the physical and nutritional management team. PNMPs are reviewed annually at the PSP meeting, and updated as needed. The LBSSLC Physical Nutritional Management Program (PNMP) Policy, revised 02/22/10, Section III. entitled "Physical Nutritional Management Plan (PNMP) Critical Elements" documented indicated:<br>▪ The PNMP shall be written to meet identified needs and based on input from Habilitation Therapies, medical/nursing staff, Health Status Team, Nutritional Management Team, PNMP Team/Clinic, home staff, the PST, and others as appropriate.<br>▪ The PNMP shall be addressed at the annual planning meeting and as often as needed, approved by the Personal Support Team, and included as part of the Personal Support Plan<br><br>This indicator will receive further review during the next on-site review.<br><br>PNMPS are reviewed and updated as indicated by a change in the person's status, transition (change in setting) or as dictated by monitoring results. According to the | |

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| | | LBSSLC Physical Nutritional Management Program (PNMP) Policy, revised 02/22/10, Section III, entitled "Physical Nutritional Management Plan (PNMP) Critical Elements, PNMPs will be reviewed at Health Status meetings:<br>▪ If risk levels are changed, at the physician's morning meeting-the PNMP will be immediately reviewed.<br>▪ If changes are needed as a result of the Health Status discussion or physician's morning meeting, a consultation with recommendations and new PNMP will be routed to the PST.<br><br>Based on review of the NMT minutes, the NMT made recommendations for changes to PNMPs, but follow-up to determine if the recommendations had incorporated into the PNMP was not documented, nor was monitoring in place to ensure that such changes were being followed by staff on a daily basis.<br><br><u>There is congruency between Strategies/Interventions/ Recommendations contained in the PNMP and the concerns identified in the comprehensive assessment.</u> This indicator will receive further review during the next on-site visit. | |
| O4 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties. | <u>Staff implements interventions and recommendations outlined in the PNMP and or Dining Plan.</u> Mealtime observations were conducted in the following homes: Quail/Sparrow, Iris, Rose, Zinna, Oak, Aspen, and Rose.<br><br>It should be noted that the meal observation in Aspen did not reveal mealtime errors. In this home, staff were checking food as trays were picked up to ensure the correct diet texture; dining cards were accessible and referred to during the meal; staff were attending to position and alignment; they were following presentation techniques on dining cards; staff were cueing individuals who were independent per the dining card, and staff were communicating with individuals throughout the meal. This home was to be commended for the mealtime environment but, most importantly, it was a safe mealtime environment that provided exceptional opportunities for communicating and learning.<br><br>The following 52 individuals were observed during meals: Individual #228, Individual #195, Individual #215, Individual #217, Individual # 258, Individual #185, Individual #223, Individual #302, Individual #296, Individual #250, Individual #45, Individual #160, Individual #170, Individual #290, Individual #210, Individual #51, Individual #59, Individual #291, Individual #52, Individual #208, Individual #97, Individual #6, Individual #100, Individual #164, Individual #172, Individual #126, Individual #267, Individual #242, Individual #206, Individual #316, Individual #47, Individual #13, Individual #41, Individual #317, Individual #44, Individual #205, Individual #225, Individual #76, Individual #308, Individual #198, Individual #243, Individual #53, | |

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| | | Individual #257, Individual #193, Individual #254, Individual #73, Individual #179, Individual #74, Individual #314, Individual #127, Individual #272, and Individual #137.<br><br>The following mealtime errors were observed in homes other than Aspen:<br>▪ Individuals in poor alignment and support in their wheelchairs and/or regular dining chairs:<br>▪ Staff did not reposition the individuals before or during the meal to achieve better alignment and support;<br>▪ Staff standing during meal to assist individuals;<br>▪ Staff seated on the wrong side of an individual who needed physical prompts to slow down (i.e., individual was right handed and staff was seated on the left)<br>▪ Wheelchairs not locked during the meal;<br>▪ Multiple individuals coughing during the meal;<br>▪ Staff not cueing individuals to slow pace for food and/or fluids;<br>▪ Individuals with significant loss of food and fluid;<br>▪ Staff presented too large a bite of food;<br>▪ Staff presented too large an amount of fluid;<br>▪ Food service presenting incorrect diet texture for breads;<br>▪ Staff presented incorrect diet texture;<br>▪ Staff presented incorrect fluid consistency;<br>▪ Staff not correcting puree that was too runny;<br>▪ Staff ratio not sufficient to implement dining plans presentation techniques and provide adequate supervision;<br>▪ Individuals seated in dining room and waiting an extended amount of time (exceeding 30 minutes) for food;<br>▪ Staff not following dining plan presentation techniques (i.e., not offering fluids throughout meals or cueing individuals to take a drink between bites of food);<br>▪ Minimal staff engagement during meals;<br>▪ Staff not completing food/fluid intake sheet after meal; and<br>▪ Cross contamination by staff not washing hands or using hand sanitizer between assisting different individuals.<br><br>These mealtime errors placed individuals at risk during mealtime. Staff need to be aware of identified triggers that would initiate a mealtime assessment so that they can report them. Such triggers include, but are not limited to choking, coughing with struggle, refusing to eat or drink, vomiting, wheezing, watery eyes, significant loss of food and/or fluid, frequent sneezing, fatigue during meal, increase in drooling, frequent throat clearing, diminished alertness, etc. These triggers should be incorporated into foundational mealtime training.<br><br>There was a need to analyze dining plans within each home to determine the appropriate | |

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| | | staffing ratio to ensure dining plans were implemented. Mealtime oversight was needed during mealtimes to support staff and individuals to provide a safe mealtime environment.<br><br>Individuals are in proper alignment and position. Observations of individuals at mealtimes, in their homes, and in day programs/workshops revealed that multiple individuals in their seating systems were not positioned correctly. Their pelvic positioning devices were not snug, and did not secure their pelvis to provide optimal alignment and support. Staff did not reposition individuals who were in poor alignment and support.<br><br>Plans are properly implemented across all activities that are likely to provoke swallowing difficulties and or increased risk of aspiration. Medication administration was observed in Iris. An agency nurse was administering medication with prompts from an RN Case Manager and a Direct Support Professional. The agency nurse did not ask staff for assistance with repositioning, nor did staff reposition individuals. The agency nurse did not refer to strategies on an individual's PNMP/Dining Plan to ensure the appropriate adaptive equipment was utilized, and the correct diet texture/fluid consistency was presented, which placed individuals at risk. The following observations illustrated errors during medication administration:<br>▪ Individual #209 received his medication in poor alignment and support as his seatbelt was loose and was over the top of his thighs. He was not repositioned before his medication was administered. Per report of the RN case manager, he was at high risk for skin breakdown.<br>▪ Individual #275 was presented fluid in a paper cup with significant loss of fluid. The RN Case Manager cued the agency nurse to place the fluid in a sippy cup. His recommended adaptive equipment for fluid was a vacuum cup.<br>▪ Individual #225 was presented fluids in a paper cup. His dining plan prescribed a nosey cup.<br>▪ Individual #162 Dining Plan, dated 05/21/09, prescribed a nosey cup, but Ensure was presented in a paper cup. The entire cup of Ensure was presented without allowing her time to take a breath. She was in poor alignment and support during medication administration.<br><br>There should be collaboration between Nursing and Habilitation Therapies to ensure that individual PNMP content is integrated into medication administration records (MAR), as well as nursing/health care plans.<br><br>Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP. This indicator will receive further review during the next onsite review. | |

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| 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. | Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff. LBSSLC New Employee Orientation, updated 01/05/10, documented the following training that was provided by Habilitation Therapies:<br>▪ Lifting People/Video; for a duration of two hours;<br>▪ Alternate Means of Communication, Orientation, Mobility, Audiology, Physical Management, Handling and Positioning, for a duration of four hours;<br>▪ Bracing and Positioning Return Demonstration, for a duration of 30 minutes; and<br>▪ Mealtime Assistance, for 30 minutes.<br><br>In addition to this orientation training, the Training Program Outline for Feeding In-service, revised 4/26/09, documented the following content for the in-service: oral-motor development, aspiration, Thick-It/Thick It Check Off, adaptive feeding equipment, meal cards with diet texture and adaptive feeding equipment, re-evaluation of diet or adaptive feeding equipment, and repair-replacement of adaptive feeding equipment. The duration of this in-service was 30 to 40 minutes. There was a written test, and a Thick-It check off.<br><br>Mealtime observations did not support that staff had acquired the foundational knowledge and skills to follow dining plans to support safety at mealtimes. This was evidenced further by findings of non-compliance documented on Mealtime Observation (Monitoring) forms for the months of November 2009, December 2009 and January 2010. It did not appear that the time allotment for mealtime foundational training was sufficient for new employees, or that the ongoing in-service training was having the desired effect.<br><br>Foundational competency-based training for mealtimes should encompass mealtime position and alignment, diet texture and fluid consistency, presentation techniques to enhance nutritional intake and hydration, care and use of adaptive equipment, aspiration and choking precautions, strategies to minimize the risk of aspiration and choking, presentation of the Facility choking policy, and techniques to promote optimal levels of independence and skill acquisition during mealtimes. This training should also address the importance of implementing appropriate person-specific dining plan strategies that should be followed during oral hygiene and medication administration. Staff should be required to successfully complete a skill performance check-off to document staff competency with learning objectives.<br><br>The Training Program Outline for PNMP, Assistive Equipment and Wheelchairs, revised 10/28/02, indicated that the content of the course was instruction of PNMPs (with handouts), demonstration of application/removal of assistive equipment, and | |

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| | | demonstration of parts/use of wheelchair. The PNMP Return Demonstration training, not dated, indicated that staff had to demonstrate sitting in a wheelchair, and completion of a check-off on skills of positioning. There were no training curriculum/materials presented for the Lifting People/Video presentation.<br><br>Competency-based physical support training should identify learner objectives to support the acquisition of specific basic knowledge and skills-based competencies required of direct support professionals for the implementation of physical assistance support plans. The instructional curriculum should address techniques for safe and efficient lifting (body mechanics); safe handling; alignment and support before, during and after a transfer; physical assistance strategies for use in seating systems, mobility devices, and orthotics; and strategies for position and alignment in seating systems, alternate positions and mobility devices.<br><br>The content for new employee orientation in the area of physical and nutritional supports needs to be reviewed. The current time allotment should be reassessed, as well as the course content to ensure staff receive the foundational knowledge and skills to implement physical and nutritional support plans safely.<br><br>Job descriptions for direct support professionals should incorporate these training requirements, as well as their performance evaluations.<br><br><u>Competency-based training focuses on the acquisition of skills or knowledge and is represented by return demonstration of skills or by pre/post test, which may also include return demonstration as applicable.</u> PNMP Return Demonstration and Thick-It Check Off were the competency-based component of the New Hire Orientation curriculum. Additional areas of staff performance check-offs should include demonstration of an understanding of position and alignment in wheelchairs, alternate positions and mobility systems; safe body mechanics; mechanical lift and two-person transfer; position and alignment at mealtimes; identification of food textures and fluid consistency; and safe presentation techniques for food and fluid.<br><br><u>All foundational trainings are updated annually.</u> Physical Nutritional Management Program Policy (PNMP), revised 2/22/10, in Section II. On Staff Training stated: "LLSLC will ensure that staff training occurs on the content, activities, equipment, staff expectations, and documentation requirements of the Physical Nutritional Management Program in new employee orientation and will re-train staff as changes in plans or procedures occur. All training will be competency-based. All direct contact staff will successfully complete PNMP and lifting/transfer refresher and training will occur annually." This indicator will receive further review at the next on-site review. | |

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| | | Staff are provided person-specific training of the PNMP by the appropriate trained personnel. Physical Nutritional Management Program Policy (PNMP), revised 02/22/10, stated: "unit supervisory staff will ensure that substitute direct contact staff receives training on PNMPs of assigned individuals prior to working with these individuals. Documentation of training will include signature of both parties to acknowledge training occurred and direct contact staff will be retrained whenever supervisor or other staff identifies a need." It was unclear if unit supervisory staff had successfully completed person-specific competency-based training for PNMPs to provide appropriate training to direct support professionals. This will be reviewed in further detail during the next review.<br><br>PNM supports for individuals who are determined to be at an increased level of risk are only provided by staff who have successfully completed competency-based training specific to the individual. This indicator will receive further review during the next onsite review. | |
| 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. | A System is in place that monitors staff implementation of the PNMPs. The Habilitation Therapy Meal Observation Monitoring form, revised 11/09, included the following areas with indicators to be monitored for each:<br>▪ Dining Plans;<br>▪ Positioning;<br>▪ Food texture;<br>▪ Liquid consistency;<br>▪ Equipment present;<br>▪ Instructions posted/on table;<br>▪ Communication Alternative or Augmentative Communication (AAC)/Alternative Technology (AT);<br>▪ Reported to nursing<br><br>The Habilitation Therapies PNMP Observation Sheet, not dated, identified the following areas of potential concern, with related indicators to be monitored under each area of potential concern:<br>▪ Positioning;<br>▪ PNMP;<br>▪ Equipment;<br>▪ Communication AAC/AT; and<br>▪ Transfers.<br><br>A review of three months of monitoring for meals and PNMPs showed recurring errors from home to home without resolution. The monitoring indicators these tools addressed were appropriate to monitor staff competency for meals and PNMPs, but the forms were | |

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| | | generic and not person-specific. It was unclear if the monitor was to review every individual in a dining room for compliance with each indicator. Individual indicators would be marked "no" with no explanation. It was unclear if the "no" meant that every individual in the dining room, for example, did not have the correct diet texture. It was unclear what determined a "partial" score. These inconsistencies would make data analysis difficult to identify individual-specific as well as systemic concerns.<br><br><u>On a regular basis (at least monthly), all staff will be monitored for their continued competence in implementing the PNMPs.</u> The Physical Nutritional Management Program (PNMP) Policy, revised 2/22/10, in Section VIII on Monitoring did not address a monthly monitoring schedule. The policy stated that PNMPs should be monitored as scheduled and as needed by Residential Supervisors, Nursing, Specialized Therapy and other professional staff to assess effectiveness of plans, to ensure ongoing implementation, and to recommend changes as necessary. The policy did not identify established procedures for staff to be routinely monitored (at least monthly) to ensure their ongoing competency in the implementation of person-specific PNMPs.<br><br><u>A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.</u> The policy did not provide clear direction for the implementation of the monitoring process, criteria for and identification of PNMP monitors, definition of the PNMP monitoring tool with description of each performance indicator, definition of the competency-based training process for PNMP monitors to support confidence in monitoring results, definition of staff re-training thresholds, explanation of validation and inter-rater reliability process for PNMP monitors, definition of the analysis process of PNMP monitoring results to assist in the formulation of corrective strategies to address systemic areas of deficiency for specific indicators, and integration of the PNMP monitoring system into the Facility Risk Management and Quality Improvement systems.<br><br>Guidelines for Meal Monitors, dated 5/16/08, identified what "items" professional staff, who were not defined, were to observe, and indicated that monitors were to support both staff and individuals served "however needed." Any additions or concerns were to be addressed on the spot and noted on the Monitor's Observation Sheet, including what the monitor did to address the issues or concerns. These guidelines were not identified on the Habilitation Therapy Meal Observation (Monitoring) form.<br><br>The Dining Room Protocol, revised 10/02/07, indicated that the Home Team Leader or designee was responsible for the overall operation of the dining room. Direct support professionals' responsibilities prior to and during meals were described. Mealtime observations did not support that direct support professionals were consistently aware of the duties to be performed prior to and during a meal. | |

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| | | Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities). The PNMP Observation Sheet Areas of Concern did not address monitoring for oral care, bathing/showering and/or medication administration. The implementation of these daily activities has the potential to place an individual with identified health risk indicators (i.e., aspiration pneumonia) at risk.<br><br>All members of the PNM team conduct monitoring. The Nutritional Management Team (NMT) Policy, revised 02/22/10, stated: "a schedule for review is established and follow-up services are provided as needed: the NMT risk level is reviewed and reassigned as appropriate and the schedule for review is established." This review process was completed during the NMT meeting. NMT meeting minutes did not discuss person-specific monitoring.<br><br>Mechanism is in place that ensures that timely information is provided to the PNM team so that data may be aggregated, trended and assessed by the PNM team. This indicator will receive further review at the next onsite visit.<br><br>The PNM team identified trends, and addresses such trends, for example, to enhance and focus the training agenda. This indicator will receive further review during the next onsite visit.<br><br>Immediate intervention is provided if the person is determined to be at risk of harm. In order to review the Facility's response to an individual's need for immediate intervention, response to choking incidents were reviewed. During future reviews, other indicators of such need will be reviewed as well. Nutritional Management Risk Rating Guidelines, dated 3/08/09, documented NMT Health Risk Event Ratings for choking incidents to be assigned to individuals who experienced a choking incident as follows:<br>▪ High Risk-Level 1 will be seen/reviewed within 30 days for choking incidents requiring abdominal thrusts procedure to clear the airway;<br>▪ Medium Risk-Level 2 will be seen/reviewed in 30 days to one year for choking incidents requiring abdominal thrust procedure to clear the airway within the last year; and<br>▪ Low Risk-Level 3 will be followed by Health Status Team for individuals with stable health within the past year with history of choking incident requiring abdominal thrust procedure to clear the airway.<br><br>It was unclear why the NMT would not review an individual who experienced a choking incident requiring the abdominal thrust procedure for up to 30 days after the incident. A choking incident should have been a signal that the individual had the potential to be at immediate risk of ongoing harm. The following provides an example: | |

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| | | ▪ Individual #135 had two reported choking incidents on 10/30/09. His NMT Report documented the NMT did not review him at the next scheduled NMT meeting after the choking incidents, which was the protocol identified in the Nutritional Management Screening Tool. The NMT reviewed him on 11/20/09, and identified him as risk level of 2 – Medium Risk, which was in conflict with the Nutritional Management Screening Tool that identified choking incidents as Risk Level 1-High, indicating a need for review at the next scheduled Nutritional Management Committee meeting. There were timeline conflicts between these two documents (NMT Risk Screening Tool and Nutritional Management Risk Rating Guidelines, dated 3/08/09.<br><br>The Facility did not have a policy/procedures for choking incidents. A choking policy/procedure should be developed to include criterion for referrals to a mealtime incident response team based on operational definitions for choking, partial airway obstruction and aspiration/dysphagia risk. These procedures should define team membership, functional roles and responsibilities, action response timeframes, documentation requirements, follow-up and review guidelines, and ensure operational linkage to LBSSLC Risk Management and Quality Improvement.<br><br>This policy/procedure should be incorporated into new employee orientation and annual refresher training as well as conducting intermittent drills with staff to ensure staff awareness of the choking policy/procedure.<br><br><u>Other deficiencies noted during monitoring are corrected within an appropriate period of time based on the level of risk that they pose.</u> The policies entitled Nutritional Management Team, and Physical Nutritional Management Program did not define which individual monitoring indicators based on an identified level of risk would be corrected within a specified time period to minimize harm to an individual.<br><br><u>System exists through which results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor.</u> A formal monitoring reporting process to support appropriate follow-up for identified areas of non-compliance was not defined in the policies entitled Nutritional Management Team, and/or Physical Nutritional Management Program.<br><br>A review of Mealtime Observation (Monitoring) forms for three months November 2009, December 2009 and January 2009 documented ongoing individual-specific concerns and systemic concerns without resolution. Examples of repetitive mealtime errors were:<br>▪ Instructions not posted on table for Thick-IT;<br>▪ Individuals without dining cards;<br>▪ Staff not in-serviced for dining plan strategies; | |

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| | | ▪ Liquids not served with meal;<br>▪ No condiments offered;<br>▪ No seconds offered;<br>▪ Dining plan instructions not followed;<br>▪ Individuals not positioned correcting in wheelchair;<br>▪ Staff presented incorrect fluid consistency;<br>▪ Staff using incorrect adaptive equipment;<br>▪ Dining card instructions were face down on table;<br>▪ Food service staff serving incorrect diet texture;<br>▪ Thick-IT not being used;<br>▪ Communication AAC/AT devices not being used;<br>▪ Individuals were not transferred to dining chairs;<br>▪ Individuals experiencing excessive coughing;<br>▪ Individuals without shoes, so feet were not supported by footplates;<br>▪ Staff not providing supervision as instructed on dining plan;<br>▪ Dining rooms not clean; and<br>▪ Individuals receiving enteral nutrition were not positioned correctly.<br><br>These ongoing mealtime errors have the potential to place individuals at risk of harm. There did not appear to be a defined system for analyzing meal observation monitoring reports to identify individual-specific and systemic issues. Monitoring without a defined administrative feedback loop to ensure resolution of identified issues and/or concerns likely will not result in mealtime environments improving. This was evidenced by the three months of mealtime monitoring reports that were reviewed.<br><br>The policies/procedures submitted for monitoring did not define mealtime monitoring. A Mealtime Monitoring policy/procedure should define the system to include, but not be limited to: criteria for and identification of monitors; competency-based training for monitors; mealtime monitoring tool with description of each individual indicator; definition of staff re-training thresholds; explanation of a validation process to support inter-rater reliability; the monitoring schedule, with individuals who are at the highest risk during mealtimes being prioritized for more frequent monitoring; the analysis of monitoring reports to assist in the formulation of corrective strategies to address systemic and person-specific areas of deficiency for individual indicators; and integration of mealtime monitoring reporting system into the Facility Risk Management and Quality Improvement systems.<br><br>A review of the Habilitation Therapies PNMP Observation Sheet(s) for the months of November 2009, December 2009 and January 2010, documented ongoing individual-specific concerns and systemic concerns without resolution. Examples of repetitive non-compliance with PNMPs were: | |

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| | | ▪ Communication AAC/AT devices not being used and not clean;<br>▪ Individuals not positioned correctly in wheelchair and footrests not being used;<br>▪ PNMP documentation not completed;<br>▪ Individuals not positioned correctly in bed;<br>▪ Individuals not in correct position when receiving enteral nutrition;<br>▪ Individuals not wearing correct footwear;<br>▪ Wheelchairs not clean;<br>▪ Equipment not used correctly;<br>▪ Staff not in-serviced on PNMPs; and<br>▪ All About Me books not accessible to staff.<br><br>Multiple monitoring sheets documented that transfers were not observed, which should be an integral component of PNMP monitoring. The ongoing PNMP non-compliance with key indicators has the potential to place individuals at risk of harm.<br><br>A physical support monitoring system should ensure continued staff competency in the knowledge and skills acquired in foundational training, as well as with the implementation of individual-specific PNMPs. This system should be systematic and routine with consistent use of performance indicators that provide reliable data for system-wide analysis of monitoring reports. Individuals who are at most risk for aspiration, skin breakdown and fractures should be prioritized for more frequent monitoring. For example, individuals who were identified by the NMT at High Risk-Level 1 would be candidates for increased monitoring. Monitors should receive competency-based training and complete a performance check-off to achieve accurate scoring and ensure inter-rater reliability. Monitoring thresholds should be established which would require re-training for staff. Compliance thresholds for PNMP monitoring should be established. Scores falling below the threshold would require the development of an action plan to address identified systemic concerns and a timeframe for staff re-training for individual-specific PNMPs.<br><br><u>Process includes intermittent internal validation checks to ensure accuracy.</u> A validation process of PNMP monitors was not presented in the policies Nutritional Management Team, and Physical Nutritional Management Program. | |
| 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 | <u>A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.</u> As discussed in further detail above with regard to Sections O.1 and O.2 of the SA, the NMT met frequently, but there were concerns related to the process used to identify individuals at risk. The assignment of risk levels was not congruent with the Nutritional Management Screening Tool. Individuals with high risk | |

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| | difficulties, and revise interventions as appropriate. | health risk indicators (i.e., aspiration pneumonia, obesity) were assigned risk levels of Medium Risk-2 and/or Low Risk-3. The NMT will need to identify entrance criteria (standardized process for identifying people at risk) for referral to the NMT, as well as exit criteria (achievement of functional outcomes) to discharge a person from the NMT.<br><br>In addition, the extensive universe of people reviewed by the NMT within the Medium Risk-2 and Low Risk-3 categories did not allow time for the NMT to focus on individuals with the most complex physical and nutritional support needs. The NMT should provide the following supports to individuals at high risk: comprehensive assessments with measurable, functional outcomes; development and implementation of interventions based on outcomes; individual-specific monitoring of interventions to ensure efficacy; and modifications of interventions if they are not successful.<br><br>Issues noted during monitoring are followed by the PNM team and will remain open until all issues have been resolved and appropriate trainings conducted. This indicator will receive further review at the next on-site review.<br><br>Immediate interventions are provided when the individual is determined to be at an increased risk of harm. As stated above, staff non-compliance documented through monitoring with dining plans and PNMPs have the potential to place individuals at an increased risk of harm. | |
| 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. | All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status (HCG VI.C.3.c.1.d), and the need for continued enteral nutrition is integrated into the PSP. PSPs were reviewed for the following individuals receiving enteral nutrition: Individual #104, Individual #122, Individual #16, Individual #56, Individual #21, Individual #136, and Individual #323. For these seven individuals, none of their PSPs (0%) addressed the appropriateness of receiving enteral nutrition, justification to continue receiving enteral nutrition, and/or strategies that had been developed to transition an individual to oral intake.<br><br>When it is determined that it is appropriate for an individual to return to oral feeding, a plan is in place that addresses the process to be used. Activity Plans for Individual #283, dated 3/2/09; Individual #56, dated 5/1/09; and Individual #246, dated 8/6/09, documented recommendations/purpose to provide oral therapeutic feedings, plan strategies, and method of review. A Master Level Speech Language Pathologist (MS, CCC-SLP) developed these plans. This indicator will receive further review at the next on-site visit.<br><br>A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, | |

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| | | SLP or OT). Per policies submitted, there were no policies that defined the frequency and depth of evaluations related to enteral nutrition to be completed by the following disciplines: nursing, physician, Speech/language pathologist, and occupational therapist.<br><br>Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake. This indicator will receive further review during the next on-site visit. | |

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

1. The PNMT membership should include the expertise of a physical therapist.
2. Additional opportunities should be provided for continuing education for PNMT members to support their responsibilities in working with individuals with complex physical and nutritional supports needs.
3. The State and/or LBSSLC should establish guidelines to define further the categories of high, moderate and low levels of risk for physical and nutritional health risk indicators. Such guidelines also should establish thresholds to trigger initial and further evaluation, and the intervals of review based on the degree of an individual's identified level of risk. These guidelines should define the entrance criteria for review by the PNMT to ensure the individualized physical and nutritional support needs of a person are addressed. Furthermore, exit criteria should be defined as meeting the measurable, functional outcomes established by the PNMT for each individual. In developing these guidelines, the PNMT should review the Health Care Guidelines, Section VI, on Nutritional Management Planning, which provides criteria for risk categories. Additional health risk indicators such as decubitus ulcers, obesity, fecal impactions, recurrent hospitalizations, fractures, mobility-related falls should be considered as high-risk categories for review by the PNMT.
4. The NMT should focus on providing supports to individuals at highest risk and with the most complex needs by completing a comprehensive assessment for each with recommendations leading to the development of measurable, functional outcomes. Strategies will need to be developed and implemented for each individual to minimize and/or remediate identified health concerns. Individual-specific monitoring also needs to be implemented for those individuals at highest risk.
5. The NMT must have the support of administrative and programmatic staff to ensure all strategies are implemented consistently for those individuals at highest risk to minimize and/or remediate identified health concerns.
6. PNMPs should incorporate strategies for individuals for oral intake for mealtime, snacks, medication administration, oral hygiene, as well as any other activities that present potential risks such as bathing, or water activities. More than one PNMP may need to be in place for an individual. For example, it might be appropriate for a PNMP to be designed and implemented just for nursing staff who are responsible for the administration of medication.
7. Collaboration between Nursing and Habilitation Therapies is needed to ensure that individual PNMP content is integrated into medication administration records (MARs), as well as nursing/health care plans.
8. There is a need for Facility administration, in collaboration with Habilitation Therapies, to analyze dining plans within each home to determine the appropriate staffing ratio to ensure dining plans are implemented.
9. Mealtime oversight is needed during mealtimes to support individuals and staff, and provide a safe mealtime environment.
10. Foundational competency-based training for mealtimes should encompass mealtime position and alignment, diet texture and fluid consistency, presentation techniques to enhance nutritional intake and hydration, care and use of adaptive equipment, aspiration and choking precautions, strategies to minimize the risk of aspiration and choking, presentation of the facility choking policy, and techniques to promote optimal levels of independence and skill acquisition during mealtimes. This training should also address the importance of implementing appropriate person-specific dining plan strategies that should be followed during oral hygiene and medication administration.

11. Competency-based physical support training should identify learner objectives to support the acquisition of specific basic knowledge and skills-based competencies required of direct support professionals for the implementation of physical assistance support plans. The instructional curriculum should address techniques for safe and efficient lifting (body mechanics); safe handling; alignment and support before, during and after a transfer; physical assistance strategies for use in seating systems, mobility devices, and orthotics; and strategies for position and alignment in seating systems, alternate positions and mobility devices.
12. The content for new employee orientation in the area of physical and nutritional supports needs to be reviewed to reassess the time allotment as well as course content to ensure staff receive the foundational knowledge and skills to implement physical and nutritional support plans safely.
13. In addition to PNMP Return Demonstration and Thick-It Check Off, additional areas of staff performance check-offs should include demonstration of an understanding of position and alignment in wheelchairs, alternate positions and mobility systems; safe body mechanics; mechanical lift and two-person transfer; position and alignment at mealtimes; identification of food textures and fluid consistency; and safe presentation techniques for food and fluid.
14. Staff should be required to successfully complete a skill performance check-off to document staff competency with learning objectives. Job descriptions for direct support professionals should incorporate these training requirements, as well as their performance evaluations.
15. The Facility Mealtime Monitoring policy/procedure should define the system to include, but not be limited to: criteria for and identification of monitors; competency-based training for monitors; mealtime monitoring tool with description of each individual indicator; definition of staff re-training thresholds; explanation of a validation process to support inter-rater reliability; the monitoring schedule, with individuals who are at the highest risk during mealtimes being prioritized for more frequent monitoring; the analysis of monitoring reports to assist in the formulation of corrective strategies to address systemic and person-specific areas of deficiency for individual indicators; and integration of mealtime monitoring reporting system into the Facility Risk Management and Quality Improvement systems.
16. Facility monitoring policies did not provide clear direction for the implementation of the monitoring process, criteria for and identification of PNMP monitors, definition of the PNMP monitoring tool with description of each performance indicator, definition of the competency-based training process for PNMP monitors to support confidence in monitoring results and inter-rater reliability, definition of staff re-training thresholds, explanation of validation process for PNMP monitors, definition of the analysis process of PNMP monitoring results to assist in the formulation of corrective strategies to address systemic areas of deficiency for specific indicators and integration, of the PNMP monitoring system into the Facility Risk Management and Quality Improvement systems.
17. The Facility did not have a policy/procedures for choking incidents. A choking policy/procedure should be developed to include criterion for referrals to a mealtime incident response team based on operational definitions for choking, partial airway obstruction and aspiration/dysphagia risk. These procedures should define team membership, functional roles and responsibilities, action response timeframes, documentation requirements, follow-up and review guidelines, and ensure operational linkage to LBSSLC Risk Management and Quality Improvement. This policy/procedure should be incorporated into new employee orientation and annual refresher training as well as conducting intermittent drills with staff to ensure staff awareness of the choking policy/procedure.
18. Documented interdisciplinary, comprehensive assessments need to be completed for each individual receiving enteral nutrition on an annual basis. These assessments need to involve at least the following disciplines: nursing, physician, Speech/language pathologist, and occupational therapist. The interdisciplinary discussion regarding the results of the assessments, and the team's recommendations need to be clearly documented in the PSP of each individual receiving enteral nutrition.

| **SECTION P: Physical and Occupational Therapy** | |
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| 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:<br>▪ **Review of Following Documents**:<br>o OT/PT Service Assessments, dated 2/16/10;<br>o PNMP and Program Development, dated 2/16/10 (TX-LB-1003-XIII.1);<br>o Master HTPNMP Wheelchair.xls, dated 3/3/10 (TX-LB-1003-XIII.2.a);<br>o PNMP, Wheelchair, note dated (TX-LB-1003-XIII.2.b);<br>o Master HTPNMP data.xls, dated 3/10/10 (TX-LB-1003-XIII.2.c);<br>o Master HTPNMP data.xls-Lower Extremity Orthotics, dated 3/10/10 (TX-LB-1003-XIII.2.d);<br>o Impaired Skin Integrity Log, dated 1/15/09 through 11/2/09 (TX-LB-1003-XIII.2.e);<br>o List of Injury Causes and Types of Injuries, various dates in 2009-2010 (TX-LB-1003-XIII.2.f);<br>o PNM Wheelchair Maintenance Log/Schedule, various dates in 2009-2010 (TX-LB-1003-XIII.3);<br>o PNMP, various dates in 2009-2010 (TX-LB-1003-XIII.4);<br>o Blank Forms: Consultation Reports, OT/PT Evaluation, OT Assessment, OT/PT-PNMP Review, not dated (TX-LB-1003-XIII.5);<br>o OT/PT Updates-various dates, 11/09 through 01/10; PSPs, various dates in 2009-2010 (TX-LB-1003-XIII.6);<br>o Protocol to Identify and Track Wheelchair Needs, not dated;<br>o OT/PT Assessment, Update and Consultation Process, dated 2/22/10;<br>o Criteria for Creating a PNMP/Dining Plan and Guidelines for PNMP/Wheelchair/AAC Clinic Documentation, dated 3/10/10 (TX-LB-1003-XIII.7);<br>o OT/PT Therapy Updates, 11/09 through 1/10;<br>o PNMP and PNMP/Wheelchair Clinic Notes, various dates in 2009-2010 (TX-LB-1003-XIII.8);<br>o Wheelchair/PNMP Clinic notes from 5/09 through 9/09 and NMT List form, dated 2/22/10 (TX-LB-1003-XIII.9);<br>o PNMP Coordinator Schedule, not dated (TX-LB-1003-NW.4.0); and<br>o PNMP Coordinator Schedule (TX-LB-1003-NW.4.N)<br>▪ **Interviews with**:<br>o Linda Thomas, OTR/L, Director of Habilitation Therapies;<br>o Occupational Therapists and Certified Occupational Therapy Assistant (COTA) (all); and<br>o Physical Therapists and Physical Therapy Aides (PTAs) (all)<br>▪ **Observations of**:<br>o PNMP Coordinator In-Service, on 3/17/10;<br>o Seating Assessment with Prairie Simulator;<br>o Wheelchair Clinic, on 3/15/10;<br>o Transfers in Iris, on 3/17/10;<br>o PNMP Clinic, on 3/16/10;<br>o Large Workshop, on 3/16/10; |

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| | o Swallowing Therapy for Individual #119 in Canna, on 3/18/10;<br>o Birch, on 3/18/10; and<br>o Elm on 3/18/10 |
| | **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| | **Summary of Monitor's Assessment:** The current staffing ratio did not appear to be sufficient to support OTs and PTs being able to meet the requirements of the SA, provide appropriate supports to individuals with physical and nutritional support needs as well as be active members of individuals' Personal Support Teams. These staffing ratios should be reevaluated to determine the adequate number of therapists, OTs and PTs, and assistants, Certified Occupational Therapy Assistants and Physical Therapy Assistants, needed to meet the physical and nutritional supports of the individuals living at LBSSLC.<br><br>The dual supervision of PNMP coordinators will make it necessary to coordinate their schedules, and clearly define their roles and responsibilities with Unit Administration and Habilitation Therapies to eliminate confusion for these new positions.<br><br>The OT/PT Services, Assessment, Update and Consultation Process, and Physical Nutritional Management Program (PNMP) policies did not define a monitoring timeframe. The Mealtime Observation Monitoring and PNMP Observation Sheet were the current monitoring protocols used to determine staff competence. A review of three months of monitoring results did not support staff competency in foundational skills and knowledge.<br><br>OT/PT assessment submitted for review did not discuss medical issues and health risk indicators with an appropriate analysis to establish the rationale for recommendations/therapeutic interventions.<br><br>Competency-based training for individual-specific PNMPs for those individuals at increased risk was not completed, because they appeared to require verbal descriptions of procedures as opposed to a demonstration of the actual skill. There were no formal policies to address training for pulled and relief staff. |

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| P1 | By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with | <u>The facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.</u><br>There were six budgeted positions for Occupational Therapists. There were four Occupational Therapists currently on staff. There were two unfilled Occupational Therapists positions. The OT vacant positions significantly impacted the caseload of the remaining staff OTs. It appeared that these vacancies will hinder the Facility in achieving compliance with the SA. | |

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| | 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. | There were four budgeted positions for Physical Therapists. There were three Physical Therapists, and one Physical Therapy Assistant on staff. The total LBSSLC Staffing List, dated 2/5/10, documented there were no Physical Therapist vacancies. It was unclear why this document stated there were no PT vacancies, because one budgeted position was not filled.<br><br>The current staffing ratio will not be sufficient to support OTs and PTs being able to meet the requirements of the SA, provide appropriate supports to individuals with physical and nutritional support needs as well as be active members of individuals' Personal Support Teams. These staffing ratios should be reevaluated to determine the adequate number of therapists, OTs and PTs, and assistants, Certified Occupational Therapy Assistants, and Physical Therapy Assistants, needed to meet the physical and nutritional supports of the individuals living at LBSSLC.<br><br>Eight PNMP Coordinators had been hired. The PNMP Coordinator Position Description (HR0702 01/05) documented that this position worked under the general supervision of Unit Administration, and were stationed in residential and program areas. Habilitation Therapies provided training and supervision for technical duties, clinical applications, documentation, and training issues. The dual supervision of PNMP coordinators will make it necessary to coordinate their schedules and clearly define their roles and responsibilities with Unit Administration and Habilitation Therapies to eliminate confusion for these new positions.<br><br>The PNMP Coordinator provided services to individuals in the areas of physical and nutritional management, oral and enteral eating, positioning, mobility, communication, and other related PNMP services. Job duties included conducting competency-based training of staff; monitoring programs; monitoring availability, condition and proper use of assistive equipment; and ensuring appropriate availability and condition of PNMP instructions and illustrations.<br><br>PNMP Coordinators were to work one of two identified shifts, although the shift times submitted appeared to not be correct:<br>▪ 7:00 a.m. to 3:30 p.m.; and<br>▪ 10:30 p.m. – 7:00 p.m.<br><br>Due to the amount of documentation that will be required to achieve compliance with the SA, Habitation Therapies, in collaboration with Facility administration, should reevaluate current administrative support positions and explore the addition of skilled technology staff.<br><br><u>All individuals have received an OT and PT screening. If newly admitted, this occurred</u> | |

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| | | within 30 days of admission. Per interview, Habilitation Therapies did not implement OT and PT screenings, but rather completed OT/PT assessments.<br>▪ Individual #134 was admitted to LBSSLC in early 2010. His OT/PT Evaluation assessment was completed within 30 days of admission. The assessment included the following sections: active problems, medications, communication, behavioral considerations, range of motion, hand assessment, gait/mobility/transfer, foot assessments, posture, activities of daily living, nutritional management, dining/oral motor, strengths and recommendations. Nutritional Management Team Report in February 2010 reviewed Individual #134 for a baseline review as a new admission. His Risk Level was identified as 1 – High Risk. He was diagnosed with aspiration pneumonia in July 2009.<br><br>All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification. The OT/PT Services, Assessment, Update and Consultation Process, revised 2/16/10, in Section II on Occupational and Physical Therapy Procedures/Steps stated:<br>▪ Individuals will be screened/assessed for occupational and physical therapy needs within 30 days of admission by occupational and physical therapy staff;<br>▪ Individuals identified with therapy needs must receive a comprehensive integrated occupational and physical therapy assessment, and it will be completed within 30 days of identification of the needs;<br>▪ Comprehensive assessment/updates will be completed according to staffing schedule set forth by the Facility, and as indicated by need;<br>▪ Assessments must include evaluation of functional and wheelchair mobility, as needed;<br>▪ Assessments will consider significant medical issues and health risk indicators in a clinically justified manner; and<br>▪ Clinical data or information contained in the assessment will be analyzed and interpreted in the assessment report.<br><br>Assessment formats submitted were:<br>▪ Occupational/Physical Therapy Evaluation;<br>▪ Occupational Therapy Assessment;<br>▪ Occupational/Physical Therapy Update;<br>▪ Occupational/Physical Therapy PNMP Review;<br>▪ Physical Therapy Assessment; and<br>▪ Consultation Report.<br><br>The formats presented assessment domains, but there were no content descriptions under the assessment domains. A review of submitted Occupational/Physical Therapy Update assessments documented the assessment content did not consistently follow the | |

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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>assessment format domains. For example:<br>▪ Individual #37's OT/PT Update, dated 11/9/09 and 12/01/09, did not include the following assessment domains: behavioral considerations, sensory, or dining plan/oral motor.<br>▪ Individual #29's OT/PT Update, dated 11/9/09 and 12/01/09, did not include behavioral considerations, dining plans/oral motor, or sensory.<br><br><u>If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT assessment every 3 years, with annual interim updates or as indicated by a change in status.</u> Thirty-three (33) PSPs OT/PT assessment dates were reviewed for the following individuals: Individual #26, Individual #23, Individual # 270, Individual #303, Individual #118, Individual # 78, Individual #282, Individual #318, Individual #38, Individual #6, Individual #204, Individual # 59, Individual #104, Individual #122, Individual #16, Individual #56, Individual #21, Individual 136, Individual #323, Individual #192, Individual #53, Individual #52, Individual #245, Individual #3, Individual #116, Individual #66, Individual #45, Individual #316, Individual #172, Individual #37, Individual #225, Individual #130, and Individual #228. The following chart shows the results of this analysis, which showed that most individuals had had assessments within the last year, and all in the sample had had them within the last three years.<br><br>
<table>
<tr><th>Assessment Year</th><th>Number of Assessments Completed</th><th>Completion Percentage (Most Recent Year)</th></tr>
<tr><td>2006</td><td>1</td><td>3%</td></tr>
<tr><td>2008</td><td>2</td><td>6%</td></tr>
<tr><td>2009</td><td>30</td><td>91%</td></tr>
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<br><u>Individuals determined via comprehensive assessment to not require direct or indirect OT and/or PT services receive subsequent comprehensive assessments as indicated by change in status or PST referral.</u> OT/PT Assessment, Update and Consultation Process, dated 2/22/10, stated: "any changes in major health risk indicators/medical issues will warrant a new comprehensive OT/PT assessment. A PSPA will be requested to discuss needs of the person served and plans will be implemented accordingly." This indicator will receive further review during the next on-site visit.<br><br><u>Findings of comprehensive assessment drive the need for further assessment such a wheelchair/ seating assessment.</u> The Occupational/Physical Therapy Update format included assessment of the seating system domain including the following:<br>▪ Goal;<br>▪ Current wheelchair;</td><td></td></tr>
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| | | ▪ Mat assessment; and<br>▪ Clinical impressions.<br><br>This indicator will receive further review during the next on-site visit.<br><br>Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions. The Occupational/Physical Therapy Update assessment format included the domain "active problems." A review of submitted Occupational/Physical Therapy Updates showed the content of this section to be a listing of medical diagnoses and conditions. The assessment format did not provide an explanation of what the expectations were for the content to be provided within this section.<br><br>The OT/PT Services, Assessment, Update and Consultation Process policy stated: "assessment will consider significant medical issues and health risk indicators in a clinically justified manner." OT/PT Assessments reviewed included a section for Nutritional Management (Team), but the submitted assessments did not discuss medical issues and health risk indicators with an appropriate analysis to establish rationale for recommendations/therapeutic interventions.<br><br>Evidence of communication and or collaboration is present in the OT/PT assessments. Occupational Therapists and Physical Therapists completed a collaborative assessment. | |
| P2 | Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices | Within 30 days of a comprehensive assessment, or sooner as required for health or safety, a plan has been developed as part of the PSP. A review of OT/PT Update current assessments for Individual #113, Individual #162, Individual #14, and Individual #29, indicated they had PNMPs, but did not have an updated Personal Support Plan. For individuals with a PSP, their PNMP was referenced into the PSP under the OT/PT section.<br><br>Within 30 days of development of the plan, it was implemented. The Physical Nutritional Management Program (PNMP) policy did not document a timeframe for the development and implementation of a PNMP.<br><br>Appropriate intervention plans are:<br>▪ Integrated into the PSP;<br>▪ Individualized;<br>▪ Based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies; and<br>▪ Contain objective, measurable and functional outcomes.<br>As referenced above, individuals did not have PSPs to allow for integration of | |

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| | and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression. | appropriate intervention plans. Due to the absence of individual PSPs, this indicator was not met.<br><br>Interventions are present to enhance:<br>▪ Movement;<br>▪ Mobility;<br>▪ Range of motion;<br>▪ Independence; and<br>▪ As needed to minimize regression.<br>The plan addresses use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment to be used.<br>Physical Nutritional Management Program (PNMP) policy identified PNMP Critical Elements as:<br>▪ Shall identify specific positioning regimens as appropriate, including positioning for enteral eating, prevention of aspiration pneumonia and complications of gastroesophageal reflux disease (GERD);<br>▪ Shall identify any assistive equipment used in implementation of program, its purpose and schedule for use as appropriate; and<br>▪ Shall define lifting/transfer, mobility and movement techniques to be used.<br><br>For the sample reviewed, Facility PNMPs incorporated this information.<br><br>Therapists provide verbal justification and functional rationale for recommended interventions. This indicator will receive further review during the next onsite review.<br><br>On at least a monthly basis or more often as needed, the individual's OT/PT status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results. Physical Nutritional Management Program (PNMP) and OT/PT Services, Assessment, Update and Consultation Process policies discussed monitoring. They did not provide a timeframe, though, to review an individual's OT/PT status and PNMPs to determine if change was warranted by the individual's condition, transition (change in setting), and/or as dictated by monitoring results.<br><br>During the next onsite review, a sample of individual records will be reviewed to determine if monthly review is occurring, and changes are being made, as appropriate. | |
| P3 | Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that | Staff implements recommendations identified by OT/PT. As noted above in the Section that addresses O.4 of the SA, staff were not consistently implementing PNMPs.<br><br>Staff successfully complete general and person-specific competency-based training | |

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| | staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans. | related to the implementation of OT/PT recommendations. As was discussed in further detail above with regard to Section O.4 and O.6 of the SA, the foundational training provided to staff was not sufficient.<br><br>Staff verbalizes rationale for interventions. This indicator will receive further review during the next on-site visit. | |
| 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. | System exists to routinely evaluate:<br>▪ Fit;<br>▪ Availability;<br>▪ Function; and<br>▪ Condition of all adaptive equipment/assistive technology.<br>A quarterly routine wheelchair maintenance schedule for each home, not dated, was submitted. The Routine WC Maintenance 2010 form documented the date an individual's wheelchair was seen, and the date maintenance was completed. Protocol to Identify and Track Wheelchair Needs, no date, described the following processes:<br>▪ All people served with mobility, seating, positioning, or other PNMP needs will be evaluated in the PNMP clinic at least annually or as indicated by need;<br>▪ Participation in the PNMP clinic will include the person served, Habilitation Therapies disciplines, direct care staff, medical, health services, PST members, NMT representation fabrication and others as needed;<br>▪ Clinic activities include (but not limited to) evaluation, fabrication, review, fitting, and/or follow-up of assistive equipment mast assessment, integration of therapeutic services, review/revision of PNMP and need for additional services;<br>▪ All people served who have positioning /mobility devices will be prioritized by need and scheduled for provision of services based on the following criteria:<br>o **Priority 1**- includes people served with complex physical or medical problems/issues that are impacted by the seating/positioning system. Will be assessed in 30 days of identification with immediate repairs or modifications made on site when possible.<br>o **Priority 2**-refers to people served with moderate physical or medical problems/issues that impact health, comfort or function. Will be addressed within 60 to 180 days of identification; and<br>o **Priority 3**-refers to people served with minor physical/medical problems or minor functional issues. The current equipment continues to be appropriate but may need minor or cosmetic adjustments. Will be addressed within 180 to 360 days of identification.<br><br>This indicator will receive further review during the next on-site visit.<br><br>A policy/protocol addresses the monitoring process and provides clear direction | |

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| | | regarding its implementation and action steps to take should issues be noted. The OT/PT Services, Assessment, Update and Consultation Process policy, in Section V on Monitoring identified the following indicators for monitoring:<br>▪ The status of individuals with identified skilled occupational and physical therapy needs and PNMPs;<br>▪ The effectiveness of treatment interventions that address skilled occupational therapy, physical therapy plans, and physical and nutritional management plans; and<br>▪ PNMP implementation, assessment effectiveness, appropriateness, availability, and condition of supportive equipment.<br><br>The policy did not define how and when individual treatment(s) and PNMPs would be monitored, or provide clear direction for actions steps to be taken when issues/concerns and/or a lack of progress was documented.<br><br>On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs. The OT/PT Services, Assessment, Update and Consultation Process and Physical Nutritional Management Program (PNMP) policies did not define a monitoring timeframe. Mealtime Observation Monitoring, and PNMP Observation Sheet were the current monitoring system for staff competence. The section of this report above that addresses Section O.6 of the SA provides more information regarding these monitoring tools.<br><br>For individuals at increased risk, staff responsible for positioning and transferring them receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff. Competency-based training for individual-specific PNMPs for those individuals at increased risk was not completed. Training forms titled In-Service Due Date documented in-services were "competency-based and staff must be able to demonstrate competency before 'passing' in-service." However, staff were trained on Individual #199's PNMP on multiple dates, including 12/18 through 12/23/09, and 12/28/09. It was noted that staff "verbalized back" and passed the in-service. His PNMP documented two transfer options, instructions for movement, positioning for receiving enteral nutrition and repositioning. His PNMP documented he was at risk due to a history of pneumonia and aspiration pneumonia. To ensure the safety of Individual #199, verbal feedback would not be sufficient to determine that staff were competent to implement his PNMP instructions for transfers, movement, and repositioning. It also is important to note that there were no formal policies to address training for pulled and relief staff, whose use was frequent at LBSSLC at the time of the review. | |

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| | | Responses to monitoring findings are clearly documented from identification to resolution of any issues identified. As noted above with regard to Section O.6 of the SA, clear documentation was not found to address responses to monitoring findings and recommendations to ensure resolution of issues identified.<br><br>Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available. The Protocol to Identify and Track Wheelchair Needs identified strategies for prioritization by need. The timeframes for delivery ranged from immediate repairs or modifications made on site (when possible), to 30 days (Priority Group 1), to 60 to 180 days (Priority Group 2), to 180 to 365 days (Priority Group 3). These timeframes did not support individuals receiving equipment in a timely manner.<br><br>Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses the identified needs. Habilitation Therapies PNMP Observation Sheet that was being used to monitor positioning, equipment, transfers, components of PNMP and communication AAC/AT use was not person-specific. The form monitored the following categories:<br>▪ Positioning (position in wheelchair, footrests used, position in bed, head position, alignment, enteral eating position);<br>▪ PNMP (out and in use, pictures accurate, plans followed, documentation completed, correct supports used);<br>▪ Equipment (used correctly, in good repair, and clean);<br>▪ Communication AAC/AT (being used and in good repair/clean); and<br>▪ Transfers (correct transfer used, brakes locked, correct equipment used).<br><br>Person-specific monitoring needs to be completed. In order for this to occur, such monitoring needs to be defined both on a systemic level through policy, and on an individual level in individuals' PNMPs.<br><br>Data collection method is validated by the program's author(s). This indicator will be further reviewed during the next on-site visit. | |

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

1. The State should work with Lubbock State Supported Living Center to determine what barriers need to be removed to assist in the successful hiring of Occupational Therapists.
2. The current therapy staffing should be reviewed to determine if there are sufficient staff (OTs, COTAs, PTs, and PTAs) able to meet the requirements of the SA, provide appropriate supports to individuals with physical and nutritional support needs as well as be active members of individuals' Personal Support Teams.
3. The dual supervision of PNMP coordinators will make it necessary to coordinate their schedules and clearly define their roles and

responsibilities with Unit Administration and Habilitation Therapies to eliminate confusion.

4. As required by Facility policy, OT/PT assessments should "consider significant medical issues and health risk indicators in a clinically justified manner." Consideration should be given to modifying the format to prompt more than a list of medical diagnoses, but rather an appropriate analysis to establish rationale for recommendations/therapeutic interventions.
5. The OT/PT Services, Assessment, Update and Consultation Process and Physical Nutritional Management Program (PNMP) policies should define a monitoring timeframe.
6. The Mealtime Observation Monitoring and PNMP Observation Sheet should be reviewed to ensure that they support monitoring of staff competency in foundational skills and knowledge.
7. Habilitation Therapies should review the timeframes in the Protocol to Identify and Track Wheelchair Needs, because the current timeframes appear too long to ensure that individuals receive equipment in a timely manner.
8. The Habilitation Therapies PNMP Observation Sheet was generic and not individual-specific. This form should to be reviewed, and revised, as appropriate, to include indicators for generic as well as individual-specific monitoring.
9. The competency-based measures used to determine staff's competence with regard to the implementation of PNMPs need to require actual demonstration of the basic, and individual-specific skills and knowledge. A system also needs to be implemented to ensure that "pulled" or agency staff have the necessary competencies to implement the PNMPs with integrity.
10. Person-specific monitoring needs to be completed. In order for this to occur, such monitoring needs to be defined both on a systemic level through policy, and on an individual level in individuals' PNMPs. Please refer to additional recommendations above in Section O of this report related to monitoring.

| SECTION Q: Dental Services | |
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| | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o Daily Dental Schedule Logs;<br>o Dental Treatment Refusal list;<br>o LBSSLC's Dental Manual;<br>o Medical records for the following individuals: Individual #317, Individual #240, Individual #90, Individual #10, Individual #51, Individual #8, Individual #19, Individual #178, Individual #280, Individual #37, Individual #65, Individual #171, Individual #86, Individual #223, Individual #82, Individual #180, Individual #290, Individual #218, Individual #107, Individual #251, Individual #303, Individual #70, Individual #185, Individual #79, Individual #44, Individual #38, Individual #154, Individual #214, Individual #135, Individual #84, Individual #204, Individual #43, Individual #16, Individual #147, Individual #270, Individual #111, Individual #259, Individual #55, Individual #253, and Individual #241<br>▪ **Interviews with**:<br>o Russell W. Reddell, DDS, MBA, Director of Dental Services |
| | **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| | **Summary of Monitor's Assessment:** From the records reviewed, it appeared that individuals at LBSSLC generally were being seen at least every six months, and more frequently for restorative/preventative care. A system needs to be developed and implemented to accurately identify individuals who refuse dental care, so that the teams can address this issue.<br><br>At the time of the review, there were a number of desensitization programs that had been developed for individuals. However, psychology had just started collaborating with dental regarding dental refusals. In addition, other disciplines need to collaborate with dental such as the Physical Nutritional Management Team regarding individuals who are at risk for aspiration/choking.<br><br>LBSSLC's Dental Director did not support the use of restraints for dental procedures, unless the dentist was in the process of completing a procedure and an individual's behavior necessitated restraint in order for the procedure to be completed safely, or in an emergency situation, when less restrictive procedures could not be attempted first. The Facility should be commended for this philosophy and practice, and should be used as a model for the reduction of restraints for this purpose at the other SSLCs. |

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| Q1 | Commencing within six months of | At the time of the review, the Dental Department at LBSSLC had one full-time dentist, two | |

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| | 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. | Dental Assistants (one full-time and one part-time), and one Dental Hygienist. In addition, the Facility has secured a dental anesthesiologist for the past two years who came monthly to the Facility to provide sedation for dental procedures.<br><br>A review was conducted of 25 individuals' dental progress notes, including those for: Individual #317, Individual #240, Individual #90, Individual #10, Individual #51, Individual #8, Individual #19, Individual #178, Individual #280, Individual #37, Individual #65, Individual #171, Individual #86, Individual #223, Individual #82, Individual #180, Individual #290, Individual #218, Individual #107, Individual #251, Individual #303, Individual #70, Individual #185, Individual #79, Individual #44. All were seen and provided dental care at least every six months, and most of the individuals were seen much more frequently for restorative care. The dental notes reviewed were very comprehensive and descriptive regarding the findings of the exam, treatment plans, and the treatment provided. In addition, the notes clearly indicated the individual's oral hygiene status and condition of the teeth. Also, the dental notes included the individual's response to the examination, and all but one (Individual #51) included the medication, dose and route of any pre-sedation given prior to the appointment.<br>▪ The dental note for Individual # 51 indicated that the individual was "apparently sedated for behavior, falling asleep in chair. Unknown what sedated with." It was concerning that the dentist was not able to determine what medication was used for sedation indicating that either the medical record was not brought to the appointment, that there was no documentation regarding behaviors and medication, or that there was no communication between the physician and the dentist regarding this individual's extreme sedation.<br><br>Based on an interview with the Dentist, medical records were not consistently brought to the dental appointments. The Facility needs to develop and implement a system to ensure that medical records are brought for all dental appointments and that there is communication between the physicians and dentist.<br><br>Based on the medical record reviews and interview with the Dental Director, the dentist did a significant amount of duplication of his documentation. For one appointment, the dentist documented his note in the individual's dental clinical record, the medical record in the dental section, a referral form, and in the integrated progress notes. The Facility needs to find ways to consolidate this duplication of documentation, such as the use of a dental software program, so that a single note is completed, and placed in the appropriate records.<br><br>Data reviewed from the Dental Department indicated that the Dentist monitored the number of dental procedures done, number of annual exams conducted, scheduled visits, number of individuals that were rescheduled, "no shows," extractions performed, and | |

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| | | oral hygiene ratings. The Dental Director used the Daily Dental Schedule Log to document and track "no shows," and refusals for dental appointments. However, he reported that because there was no formal system in place to notify the individual that they have an appointment, accurately identifying refusals versus no shows was difficult. In addition, he reported that often the unit staff was not aware that an individual had a dental appointment. Thus, data provided regarding dental refusal was not reliable. The Facility needs to implement a system to ensure that staff and individuals are informed of dental appointments. Once this is accomplished, a system for tracking actual refusals should be implemented, and information gained from this system provided to individuals' teams, so that they can address such refusals in an integrated team fashion.<br><br>At the time of the review, the Facility QE Nurse had begun to monitor some dental items. This process needs to continue to develop to ensure that dental notes and practices are being implemented in alignment with generally accepted standards of practice, as defined in the SA. | |
| Q2 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints. | Based on a review of the Facility's Dental Manual, the department needs to review all of its policies, procedures and protocols to ensure that they are in alignment with current practices and requirements, as defined by the SA and Health Care Guidelines. For example, the policy addressing Dental Desensitization did not include collaboration with psychology.<br><br>In addition, a monitoring system needed to be developed and implemented to ensure that these policies are consistently being implemented. There also needed to be collaboration between the disciplines such as nursing and psychology and the Dental Department regarding the monitoring of certain policies/procedures. This is necessary because other disciplines have shared responsibilities addressing certain issues such as missed and refused appointments, and individuals with physical and nutritional challenges that impact the provision of dental care. At the time of the review, there had been no collaboration with the PNMT regarding individuals at risk for aspiration/choking. In addition, there was no indication that polices had been reviewed annually and some were missing specific criteria, such as timeframes for completing annual and emergency evaluations. A statewide Dental Manual would be beneficial.<br><br>Based on a review of 15 individuals' dental desensitization programs (Individual #38, Individual #154, Individual #214, Individual #135, Individual #84, Individual #204, Individual #43, Individual #16, Individual #147, Individual #270, Individual #111, Individual #259, Individual #55, Individual #253, and Individual #241), it was impossible to determine who actually developed the programs since none of the 15 contained a signature. Some of the programs appeared to have been implemented in | |

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| | | 2007, 2009, and 2010. Although there was no data provided to indicate if the programs were being conducted, and if the individuals were making progress. Eight of the 15 programs (53%) focused on desensitizing and improving oral care and tooth brushing at the unit level, not just on desensitization at the Dental Clinic. From interview with the Director of Behavioral Services, psychology had just started collaborating with dental regarding dental refusals. The disciplines in the Facility need to collaborate to develop desensitization programs/strategies to assist in decreasing refusals, as well as the use of pre-sedation and restraints for dental and medical procedures.<br><br>Documents were provided by the Facility for a number of individuals that received pre-sedation for dental procedures. However, there was no documentation included demonstrating that nursing was monitoring the individuals after the appointment was completed. Only the dental notes were included in the requested medical records. The Facility needs to develop and implement a policy/procedure to ensure that individuals are monitored after receiving pre-sedation for dental/medical procedures.<br><br>LBSSLC's Dental Director did not support the use of restraints for dental, unless the dentist was in the process of completing a procedure and an individual's behavior necessitated restraint in order for the procedure to be completed safely, or in an emergency situation, when less restrictive procedures could not be attempted first. The Facility should be commended for this philosophy and practice and should be used as a model for the reduction of restraints at the other SSLCs. | |

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

1. Dental policies, procedures and protocols should be reviewed/revised to ensure that they are in alignment with current practices, as defined by the requirements of the SA and Health Care Guidelines. Consideration should be given to developing and implementing a statewide Dental Manual.
2. Monitoring systems should be developed and implemented to ensure that dental practices are in alignment with generally accepted standards of practice, as defined by the requirements of the SA and Health Care Guidelines.
3. A formal system should to be developed and implemented addressing refusals or missed dental appointments, so that the PSTs can develop strategies to help the individual tolerate dental care.
4. Dentistry should continue to collaborate with other disciplines such as nursing, psychology, and habilitation therapies regarding the implementation of certain policies/procedures that have shared responsibilities regarding dental issues, such as the development of plans to reduce the need for pre-sedation medications, and the implementation of individuals physical and nutritional management plans to ensure their safety during dental work.
5. The Facility needs to develop and implement a system to ensure that medical records are brought for all dental appointments, and that there is communication between the physicians and dentist.
6. The Facility needs to implement a system to ensure that staff and individuals are informed of dental appointments.
7. Dentistry should collaborate with nursing regarding the development and implementation of a monitoring system to ensure that individuals

are appropriately monitored when receiving pre-sedation medication for medical/dental procedures.

8. The Facility should consider ways to consolidate the dental documentation to avoid the duplication of documentation, such as the use of a dental software program so that a single note is completed, and placed in the appropriate records.

| SECTION R: Communication | |
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| 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:<br>▪ **Review of Following Documents**:<br>o State Supported Living Center Policy, dated 10/7/09;<br>o Speech/Communication Assessment Process, dated 2/16/10 (TX-LB-1003-XV.1);<br>o List of individuals with AAC devices (TX-LB-1003-XV.2);<br>o Speech/Language Update and Evaluation formats, not dated (TX-LB-1003-XV.3);<br>o Speech Evaluation format, not dated (TX-LB-1003-XV.4);<br>o PSPs, various dates in 2009;<br>o SL Evaluation/Updates, various dates in 2009 (TX-LB-1003-XV.5);<br>o AAC Home Monitoring Form, dated 2/3/10;<br>o AAC Individual Equipment Monitoring Form, not dated;<br>o Habilitation Therapy Meal Observation (Monitoring) Form, dated 11/09;<br>o PNMP Observation Sheet, dated 11/09;<br>o Communication Questionnaire, not dated (TX-LB-1003-XV.6);<br>o PNMP Dining Plan, dated 1/10;<br>o HT/NMT/PNMP Health Status Meeting, dated 1/10;<br>o AAC Home Monitoring, dated 1/10;<br>o AAC Individual Equipment Monitoring, various dates from 12/09 through 2/10 (TX-LB-1003-XV.7);<br>o Communication Questionnaire, dated 8/09 through 2/10 (TX-LB-1003-XV.8);<br>o Communication Dictionary, revised 6/1/06 (TX-LB-1003-XV.9);<br>o AAC/AT Systems, various dates 2008 thru 2010 (TX-LB-1003-XV.10); and<br>o Updated list, dated 3/9/10, of communication devices by individual and home (TX-LB-1003-NW.4<br>▪ **Interviews with**:<br>o Debbie M. Jones, MS, CCC-SLP, Chairperson of NMT; and<br>o Speech Pathologists (all)<br>▪ **Observations of**:<br>o Generic communication systems in Iris, Rose, Zinna, Oak, Aspen, Rose, Birch, and Elm; and<br>o New Employee Orientation Communication Training session |
| | **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| | **Summary of Monitor's Assessment:** There were four budgeted positions for Speech Therapy. There were four Speech Language Pathologists on staff with no vacancies. The current staffing ratios for SLPs did not appear to be sufficient to support SLPs being able to meet the requirements of the SA, provide appropriate supports to individuals with physical and nutritional support needs, provide supports in the area of |

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| | functional communication, as well as be active members of individual's Personal Support Team (PST).<br><br>At the time of the review, per report, twenty-six (26) percent of the individuals living at LBSSLC had an augmentative device (low tech or high tech). Based on observation, there were a significant number of individuals who needed communication systems, but did not have a system. The number of individuals who had communication systems was low given the population supported by the Facility. The low percentage of individuals with communication systems appeared to be driven by the insufficient number of speech language pathologists available to develop and implement communication programs, provide competency-based staff training, and provide monitoring oversight to determine progress and efficacy of the systems.<br><br>The Speech Language Pathologists submitted a listing of multiple generic communication systems that were available in individual's homes, and throughout the Facility. Monitoring staff observed these generic, and potentially valuable systems. Unfortunately, staff and individuals were not engaged using these systems.<br><br>A review of AAC Individual Monitoring Forms documented unresolved issues that were not resolved on the repeated individual monitoring forms. The current monitoring system did not review the utilization of individual systems throughout the Facility, or in the community. |

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| R1 | Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs. | <u>The Facility provides an adequate number of speech language pathologists or other professionals with specialized training or experience.</u> Speech/Communication Assessment Process, revised 2/16/10, in Section I on Assurances stated: "LBSSLC will provide an adequate number of speech language pathologists with specialized training or demonstrated competency in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training and monitor for the implementation of programs."<br><br>There were four budgeted positions for Speech Therapy. There were four Speech Language Pathologists on staff with no vacancies. It did not appear that the current staffing ratios for SLPs were sufficient to support SLPs being able to meet the requirements of the SA, provide appropriate supports to individuals with physical and nutritional support needs, provided needed supports within the area of functional communication, as well as be active members of individual's Personal Support Teams. These staffing should be reevaluated by analyzing the universe of unmet individual functional communication needs, and current caseloads. A determination should be made regarding the adequate number of therapists (SLP) and assistants required to meet the nutritional and communication needs of the individuals living at LBSSLC.<br><br>As stated above, PNMP Coordinators' job descriptions documented these positions would | |

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| | | provide services/supports to individuals in the area of physical and nutritional supports as well as communication. It will be important to ensure the PNMP coordinators are available to provide assistance to the SLPs, because there were no assistants/technicians working with the SLPs.<br><br><u>Supports are provided to individuals based on need and not staff availability.</u> A list was submitted, dated 3/9/10, listing alternative and augmentative communication devices (low tech and high tech) currently in use, and identifying individual(s), their homes and the type(s) of devices. The following summarizes this information: | |

| Home | Number of Individuals with AAC Devices and/or ECU |
|---|---|
| 504 E. Mesquite | 4 |
| 504 W. Mesquite | 7 |
| 517 S. Cedar | 3 |
| 527 N. Cedar | 5 |
| 528 N. Cedar | 5 |
| 516 S. Cedar | 3 |
| 523 N. Cedar | 7 |
| 525 N. Cedar | 3 |
| 521 N. Cedar | 2 |
| 513 S. Cedar | 8 |
| 514 S. Cedar | 2 |
| 515 S. Cedar | 8 |
| 518 S. Cedar | 3 |
| **Total** | 60/231= 26% |

At the time of the review, per report, twenty-six (26) percent of the individuals living at LBSSLC had an augmentative device (low tech or high tech). Based on observation, there were a significant number of individuals who needed communication systems, but did not have a system. The number of individuals who had communication systems was low given the population supported by the Facility. The low percentage of individuals with communication systems appeared to be driven by the insufficient number of speech language pathologists available to develop and implement communication programs, provide competency-based staff training, and provide monitoring oversight to determine progress and efficacy of the systems.

The Speech Language Pathologists submitted a listing of multiple generic communication systems, dated 3/09/10, in individual's homes and throughout the Facility. These included: pictured bathroom communication board, general sign language pictured

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| | | communication book, pictured community communication board, medical/bathroom communication board, medical communication book, Talking My Way object/symbol bathroom items communication board, Talking My Way object/symbol morning/evening routine communication board, Talking My Way object/symbol dining routine communication board, Talking My Way object/symbol nursing items communication board, Talking My Way object symbol leisure activities communication board, picture/sign take and talk common area communication board, dining room full size sign/word/communication placemats, dining room pictured communication condiments cards, home program communication signs (sick, thank you, no), sign language pictured communication book, recorded picture frames, picture/sign take and talk grooming area communication board, English/Spanish sign language communication book, dining social communication voice output communication aide, and meal choice boards. Monitoring Team members observed these generic systems in homes and day programs, but unfortunately, staff and individuals were not engaged in using these systems.<br><br>A request was made by the Monitoring Team for copies of all communication dictionaries being used at the Facility. Communication dictionaries for seven individuals identified as having decreased communication were submitted for: Individual #202, Individual #222, Individual #11, Individual #103, Individual #313, Individual #306, and Individual #107, which represented three percent of the individuals living at LBSSLC. It was unclear why additional communication dictionaries were not submitted, as a significant number of individuals living at LBSSLC did not verbally communicate. Communication dictionaries would be helpful tools, particularly given that "pulled" staff who are not always familiar with the individuals, and their communication styles frequently are in the homes and day programs. In addition, as individuals prepare to transition to the community, communication dictionaries will be an important component of the transition planning.<br><br>The Speech/Communication Assessment Process policy in Section VII on Collaboration with Psychology indicated that:<br>▪ Speech language pathologists and/or Habilitation Therapies designee will participate in Behavior Support assessments, as deemed appropriate;<br>▪ Speech therapists will collaborate and provide input to psychology to assist them in their development of communication strategies for behavioral support/interventions; and<br>▪ Speech language pathologists and/or Habilitation Therapies designee will attend the Behavior Support Committee (BSC) to collaborate and provide input to assist in the development of communication strategies for behavioral support interventions.<br><br>This indicator will receive further review during the next onsite visit. | |

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| R2 | Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions. | <u>All people have received a communication screening. If newly admitted, this occurred within 30 days of admission.</u> The Speech/Communication Assessment Process, revised 02/16/10, in Section II in the Steps/Assessments for Speech/Communication Department policy stated:<br>▪ Individuals will be screened/assessed for communication needs, including augmentative communication needs, within 30 days of admission.<br><br>Individual #134 was admitted to LBSSLC in early 2010. His Speech Language Evaluation was completed within 30 days of admission. The Speech Language Evaluation assessment domains included: significant information, behavioral considerations, hearing and vision, communication history, previous assessments, reports from significant others, observation, receptive/expressive language, articulation, voice fluency, oral mechanism, augmentative/alternative communication, clinical impressions, recommendations, communication equipment, and communication instructions.<br><br><u>All people identified with therapy needs have received a comprehensive communication assessment within 30 days of identification that addresses both verbal and nonverbal skills, expansion of current abilities, and development of new skills.</u> The Speech/Communication Assessment Process, revised 2/16/10, in Section II in the Steps/Assessments for Speech/Communication Department policy stated:<br>▪ Comprehensive communication assessments/updates will be completed according to staffing schedule set forth by the facility and/or as indicated by need;<br>▪ Assessments will include evaluation of need for augmentative and alternative communication, as appropriate;<br>▪ Assessments will consider behavioral issues and provide recommendations, including recommendations regarding communication systems involving behavioral supports or interventions, as indicated;<br>▪ Information contained in assessments will be analyzed and interpreted n a clinically justified manner to identify individuals who would benefit form alternative or augmentative communication;<br>▪ Individuals who have been provided an augmentative/alternative communication system or who have received direct speech/communication services will be provided an annual update. The update will address the augmentative/alternative communication system and any changes that occurred in the previous year including any consultations that were generated.<br><br>Speech/communication assessment formats did not present a section to address medical issues and risk indicators that may have an impact on therapy interventions. The format(s) presented assessment domains, but there were no content descriptions listed under the assessment domains. | |

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Addition information is provided below in the section that discusses individuals who had received a speech/communication assessment, but did not have a communication system.

<u>If receiving services, direct or indirect, the individual is provided a comprehensive Speech-language assessment every three years, with annual interim updates or as indicated by a change in status.</u> Thirty-three (33) individual PSPs were reviewed to determine the most recent SLP and Audiology assessment dates for the following individuals: Individual #26, Individual #23, Individual #270, Individual #303, Individual #118, Individual #78, Individual #282, Individual #318, Individual #38, Individual #6, Individual #204, Individual # 59, Individual #104, Individual #122, Individual #16, Individual #56, Individual #21, Individual 136, Individual 323, Individual #192, Individual #53, Individual #52, Individual #245, Individual #3, Individual #116, Individual #66, Individual #45, Individual #316, Individual #172, Individual #37, Individual #225, Individual #130, and Individual #228. For this sample of individuals, their PSPs showed the following data with regard to the completion of the assessments listed:

| Assessment Year | Number of SLP Assessments Completed | SLP Completion Percentage (Most Recent Year) | Number of Audiology Assessments Completed | Audiology Completion Percentage (Most Recent Year) |
|---|---|---|---|---|
| No Date | 1 | 3% | - | 0% |
| 2007 | 0 | - | 1 | 3% |
| 2008 | 10 | 30% | 13 | 39% |
| 2009 | 21 | 64% | 19 | 58% |
| 2010 | 1 | 3% | 0 | 0% |

Speech assessments had been completed for all individuals in the sample in a timely manner and followed the established format.

<u>For persons receiving behavioral supports or interventions, the Facility has a screening and assessment process designed to identify who would benefit from AAC. Note: This may be included in PBSP.</u> The Speech/Communication Assessment Process in Section VII on Collaboration with Psychology stated:

- Speech language pathologists and/or Habilitation Therapies designee will participate in Behavior Support assessments as deemed appropriate;
- Speech therapists will collaborate and provide input to psychology to assist

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| | | them in their development of communication strategies for behavioral support/interventions; and<br>▪ Speech language pathologists and/or Habilitation Therapies designee will attend the Behavior Support Committee (BSC) to collaborate, and provide input to assist in the development of communication strategies for behavioral support interventions.<br><br><u>The following provides an example for whom this coordination was not occurring:</u><br>▪ Individual #160's Positive Behavior Support Plan, dated3/30/09, and revised 06/21/09, indicated that he "will learn to communicate his needs in a PBSP acquisition program involving the training of sign language." His Speech-Language Update, dated 9/23/09, did not reference his PBSP, nor did the PBSP reference the Speech-Language Update.<br><br>This will be reviewed in further detail during the next monitoring visit.<br><br><u>Policy exists that outlines assessment schedule and staff responsibilities.</u><br>The Speech/Communication Assessment Process policy indicated that comprehensive communication assessments/updates would be completed according to staffing schedule set forth by the Facility and/or as indicated by need. The policy did not identify timeframes for the assessment schedule, or identify staff responsibilities for the assessment process. The following assessment formats were submitted:<br>▪ Speech-Language Evaluation;<br>▪ Speech-Language Update; and<br>▪ Speech Evaluation.<br><br>An extensive individual AAC Tracking database was submitted with the following fields: last and first name; case number, evaluation/update date; next evaluation date; consultations; AAC/AT Systems current; revised/replaced; Treatment trials; order/initial request/ received; AAC/AT monitor; AAC/AT follow up contact verbal, email response; outcome, PSPA, in-service/training; pieces; location; and AAC/AT discontinued date. This database provided valuable information to track the status of individual communication systems.<br><br><u>Findings of comprehensive assessment drive the need for further assessment in Augmentative Communication.</u> This indicator will receive further review during the next onsite visit. | |
| R3 | Commencing within six months of the Effective Date hereof and with full implementation within three | <u>Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the PSP and the PNMP. The PSP and PNMP contain information regarding how the person communicates and strategies staff may utilize to enhance</u> | |

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| | 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. | communication. Speech/communication assessments were reviewed for Individual #155, Individual #264, Individual #174, Individual #195, and Individual #60, but these individuals did not have PSPs.<br><br>AAC devices are portable and functional in a variety of settings and are meaningful to the individual. Observations in homes and throughout the facility documented that staff and individuals were not engaged in using generic, and/or individual-specific communication systems.<br><br>Staff are trained in the use of the AAC. Per interview, staff were trained in AAC generic and individual-specific programs, but multiple observations demonstrated that staff did not assist the individuals to use these systems.<br><br>Communication strategies/devices are integrated into the PSP and PNMP.<br>As stated above, there were individuals without PSPs therefore communication strategies and, therefore, PNMPs could not be integrated into the PSP.<br><br>General AAC devices are available in common areas. As discussed earlier, there were a multitude of generic communication devices in homes and throughout the Facility, but observations did not document staff and individuals engaged in using these systems. | |
| 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 is in place that:<br>▪ Tracks the presence of the ACC;<br>▪ Working condition of the AAC;<br>▪ The implementation of the device; and<br>▪ Effectiveness of the device.<br>The Speech/Communication Assessment Process in Section VI on the Monitoring policy stated: "Habilitation Therapies Department shall implement a system to monitor and address:<br>▪ "Condition, availability and appropriateness of Augmentative and Alternative communication (AAC) equipment;<br>▪ Implementation and effectiveness of home programs and enhancement of Speech recommendations are being provided by direct support staff;<br>▪ Identified communication systems are readily available to the individual/being used and its condition;<br>▪ Environmental devices are readily available, being used and their condition."<br><br>The AAC Home Monitoring Form, updated 2/3/10, documented the following fields: type of device, location, present, clean, working, replace battery, missing pieces, and refer to SLP, or Staff Comments. In addition, there was an AAC Individual Equipment Monitoring | |

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| | | Form. Neither the generic and/or individual form(s) addressed observation of the individual system being used by the individual, or staff engagement with the individual and the system. The following homes were monitored for generic and individual-specific communication systems in December 2009, January and February 2010: | |

| Month | Generic | Individual |
|---|---|---|
| December (12 homes) | 513 S. Cedar Ave.<br>514 S. Cedar Ave.<br>515 S. Cedar Ave.<br>517 S. Cedar Ave.<br>518 S. Cedar Ave.<br>520 S. Cedar Ave.<br>523 N. Cedar Ave.<br>525 N. Cedar Ave.<br>527 N. Cedar Ave.<br>528 N. Cedar Ave.<br>504 W. Mesquite<br>504 E. Mesquite | 513 S. Cedar Ave.<br>514 S. Cedar Ave.<br>515 S. Cedar Ave.<br>517 S. Cedar Ave.<br>517 S. Cedar Ave.<br>520 S. Cedar Ave.<br>523 N. Cedar Ave.<br>525 N. Cedar Ave.<br>527 N. Cedar Ave.<br>528 N. Cedar Ave.<br>504 W. Mesquite<br>504 E. Mesquite |
| January (11 homes) | 513 S. Cedar Ave.<br>514 S. Cedar Ave.<br>517. S. Cedar Ave.<br>518 S. Cedar Ave.<br>520 S. Cedar Ave.<br>521 N. Cedar Ave.<br>523 N. Cedar Ave.<br>525 N Cedar Ave.<br>527 N. Cedar Ave.<br>528 N. Cedar Ave.<br>504 E. Mesquite | 513 S. Cedar Ave.<br>514 S. Cedar Ave.<br>517. S. Cedar Ave.<br>518 S. Cedar Ave.<br>520 S. Cedar Ave.<br>521 N. Cedar Ave.<br>523 N Cedar Ave.<br>525 N. Cedar Ave.<br>525 N. Cedar Ave.<br>528 N. Cedar Ave.<br>504 E. Mesquite |
| February (13 homes) | 513 S. Cedar Ave.<br>514 S. Cedar<br>515 S. Cedar<br>517 S. Cedar<br>518 S. Cedar<br>520 S. Cedar<br>521 N. Cedar<br><br>525 N. Cedar<br>527 N. Cedar<br>528 N. Cedar | 513 S. Cedar Ave.<br>514 S. Cedar Ave.<br>515 S. Cedar Ave.<br>517 S. Cedar Ave.<br>518 S. Cedar Ave.<br>520 S. Cedar Ave.<br>521 N. Cedar Ave.<br>523 N, Cedar Ave<br>525 N. Cedar Ave.<br>527 N. Cedar Ave.<br>528 N. Cedar Ave. |

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| | 504 E. Mesquite<br>504 W. Mesquite | 504 E. Mesquite<br>504 W. Mesquite |

Home 516 S. Cedar, which had three individuals with communication systems, was not monitored. It was not clear why a different number of homes were monitored from month to month.

A review of AAC Individual Monitoring Forms documented unresolved issues that were not resolved over the course of repeated individual monitoring forms:

- The 12/8/09 monitoring form first identified that Individual #266's radio was destroyed, and he was buying a new one.
- In December, it was first identified that Individual #140 wanted more pages added to increase communication;
- On 12/22/09, it was noted that Individual #288's visual schedule board was ripped and the moveable pieces were getting worn, and "the paper is curling pretty bad."
- On 1/11/10, it was noted that Individual #48's voice output talking picture photo album had four pages not working, and social communication family picture puzzle "had not been seen for a long time."
- On 1/21/10, it was noted that Individual #313's small switch was missing, and did not make a sound. Staff stated he deleted messages.

Monitoring covers the use of the AAC during all aspects of the person's daily life in and out of the home. The AAC Individual Monitoring Form only reviewed communication systems in the home. The current monitoring system did not review system use throughout the Facility or in the community.

Validation Checks are built into the monitoring process and conducted by the plan's author. This indicator will receive further review during the next onsite review.

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

1. The current staffing levels for SLPs and related support staff should be re-evaluated to determine if these positions are sufficient to implement individual-specific functional communication systems for individuals at LBSSLC, as well as to provide supports to individuals with mealtime needs. If additional resources are needed, then requests should be made.
2. The Speech Language Therapy comprehensive assessment format should be revised to ensure it integrates strategies for specific health risk indicators to minimize or reduce the effects of identified health issues.
3. All individuals who do not have effective means of communication should be provided with training objectives to address their needs. If augmentative devices are recommended, these should be individualized. All systems should provide the individual with a "voice" so that

he/she can at a minimum make his/her basic wants and needs known. The use of the Picture Exchange Communication System is strongly encouraged as its effectiveness, and resulting benefits have been well documented in the literature.

4. A system of oversight and monitoring should be developed and implemented to ensure that all individuals are consistently using their communication skills. Included should be a schedule of regular visits by speech therapy staff to all settings in which the individual resides, works, and recreates. The monitoring system should include competency-based training and validation process for monitors, a description of the monitoring tool (generic and individual-specific), strategies for monitoring each indicator, a process for staff to be trained if monitoring score falls below established thresholds, guidelines for the analysis of monitoring results, the formulation of corrective strategies to address systemic and individual-specific areas of deficiency, and integration of the monitoring system in the Facility Quality Enhancement system.
5. AAC Individual Monitoring Forms need to document resolution of all unresolved issues for generic and individual-specific AAC systems.
6. Individuals' communication strategies should be consistently integrated into their PNMPs and PSPs.
7. It is essential that there be a focus on ensuring that individuals who have communication devices are supported regularly to use them.

| **SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs** | |
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| 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:<br>▪ **Review of Following Documents**:<br>o Personal Support Plans (PSPs), including Monthly and/or Quarterly Reports, when available, for: Individual #264, Individual #276, Individual #286, Individual #77, Individual #23, Individual #232, Individual #135, Individual #288, Individual #214, Individual #202, Individual #240, and, Individual #33;<br>o PSP Monthly and/or Quarterly reviews for individuals where PSP was unavailable: Individual #82, Individual #34, Individual #237, Individual #94, Individual #50, and, Individual #106;<br>o Individualized Education Plans (IEPs) for: Individual #264, Individual #276, and Individual #288; and<br>o Personal Support Plan Specific Performance Objectives (SPOs) and/or requested recent SPO data sheets (last three months), when available, for: Individual #264, Individual #276, Individual #213, Individual #77, Individual #107, Individual #126, Individual #82, Individual #218, Individual #23, Individual #237, Individual #94, Individual #232, Individual #60, Individual #125, Individual, #28, Individual #288, Individual #106, Individual #135, Individual #214, Individual #202, Individual #240, Individual #116, and, Individual #33;<br>o Active Treatment Team Meeting minutes, dated 2/16/10, 2/17/10, 2/18/10, 2/22/10, 2/26/10, and 2/24/10; and<br>o LSS - IDT Process – Program Development, Person Directed Planning Assessment Process, dated 4/2/09 (R)<br>▪ **Interviews with**:<br>o Jim Forbes, Director of Behavioral Services, on 3/15/10 and 3/18/10;<br>o Trent Lewis, Marisol Gonazales, and Lola Walker, on 3/15/10;<br>o Psychology Assistants, including Adam Crawford, Nicole Johnson, Amber Flores, Cheryl Gambles, and R. Jamie Trevino, on 3/17/10;<br>o Speech Language Pathologists, on 3/17/10;<br>o Associate Psychologists, including Teresa Balawejder, Beckie Robbins, Christina Sosa, Lamecca Abduljaami, Phillip Kite, Krista Leubner, Carolyn Milton, Joanna Mollica, and Ron Flint, on 3/17/10;<br>o Thirteen QMRPs and Active Treatment Coordinators, on 3/18/10; and<br>o Residence Coordinators, including Rodshadi Moore, Renate Ruiz, Felicia Cooper, Tiffany Lattimore, Danette Mitchell, Pat Moore, Ladonna Pendgraft, Stefani Williams, Rachel Anderson, Jessica Alcorta, Earnice Coppage, Courtney Ashton, and Tajuana Mam, on 3/19/10<br>▪ **Observations Conducted**:<br>o Annual Personal Support Plan (PSP) meeting for Individual #301, on 3/16/10; |

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| | o Human Rights Committee (HRC) Meeting, on 3/17/10;<br>o Behavior Support Committee (BSC) Peer Review Meeting, on 3/18/10;<br>o Onsite direct observation, including interaction with direct care staff and other professionals, occurred throughout the morning, day and/or early evening hours at the following residential and day programming sites:<br>▪ 526 N. Cedar Avenue (Tulip), on 3/15/10;<br>▪ 504 E. Mesquite Drive (Quail), on 3/16/10;<br>▪ 514 S. Cedar Avenue (Birch), on 3/16/10;<br>▪ 516 S. Cedar Avenue (Fir), on 3/16/10;<br>▪ 517 S. Cedar Avenue (Maple), on 3/16/10;<br>▪ 518 S. Cedar Avenue (Oak), on 3/16/10;<br>▪ 519 S. Cedar Avenue (Pine), on 3/16/10;<br>▪ 515 S. Cedar Avenue (Elm), on 3/17/10;<br>▪ 536 Magnolia Drive (EIWS; 'Big Workshop'), on 3/17/10;<br>▪ 531 Chestnut (Hearts and Hands) – brief visit with staff, on 3/17/10;<br>▪ 521 N. Cedar Avenue (Canna), on 3/17/10;<br>▪ 525 N. Cedar Avenue (Rose), on 3/17/10;<br>▪ 528 N. Cedar Avenue (Zinnia), on 3/18/10; and<br>▪ Day program at 540 Lark Street (residential services building), on 3/19/10 |
| | **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| | **Summary of Monitor's Assessment:** Based on verbal reports from staff, the Personal Focus Worksheet: Individualized Assessment Screening Tool (PFW), as well as the Positive Assessment of Living Skills (PALS) were completed annually to assist with the development of the PSP. However, record review showed the implementation of these assessments to be inconsistent. In addition, psychological assessments did not consistently result in recommendations for prioritized training on skills.<br><br>In general, Specific Program Objectives (SPOs) followed a prescribed format. They all typically included basic elements such as an objective; baseline data; a plan for implementation, including setting, schedule, materials, reinforcement, and teaching procedures; and evaluation criteria. However, the detail and comprehensiveness of the plans varied greatly. Many of these elements, as written, were relatively vague and did not provide enough specificity for their consistent and complete application across staff. For example, some behavioral objectives did not provide enough detail to ensure consistent identification and reliable measurement of the target response. Also, at times, the objective of the SPO did not match the steps specified to teach the skill. More importantly, many of the sampled SPOs did not include an operational definition of the target behavior (i.e., what is being taught), specific detailed steps based on a task analysis, use of differential reinforcement, a plan regarding maintenance and generalization, and/or sufficient trials per day (or week) to promote acquisition. |

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| S1 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint. | Based on the review of 12 Personal Support Plans (PSPs), it appeared that all individuals sampled had identified objectives and goals, based on assessments and recommendations as conducted and determined through the PSP process, and outlined in skill acquisition plans, referred to as Specific Program Objectives (SPOs). Brief review of the SPOs provided for 22 sampled individuals indicated that each SPO followed a specific format, primarily sections identifying the objective, baseline data, the plan (procedures and method for teaching the skill), and evaluative criteria. Each sampled individual had many skill acquisition programs with an approximate average of five SPOs per individual. Although the SPOs generally adhered to the typical format, SPOs differed across individuals in the number of targeted goals and objectives, level of specification of the teaching methodology and procedures, and the specific evaluative criteria utilized to determine success. According to verbal reports of QMRPs, the format of the PSP had recently changed, in fact, had been changed repeatedly, and was reported to likely change again. It was unclear, however, if this upcoming change would have implications for how SPOs were identified, written, and/or implemented.<br><br>At the time of the review, QMRPs facilitated the collection, summary and integration of assessment findings, as well as subsequent recommendations from the Personal Support Team. These results were identified in Action Plans that were the basis for programming, services and supports. Residence Coordinators utilized these action plans to develop appropriate SPOs and are, ultimately, responsible for training staff to implement SPOs, as well as document their ongoing performance.<br><br>In general, according to reviewed documentation, it appeared that SPOs were developed to address a variety of needs, including those identified by psychological assessments, SFBAs, language and communication assessments, medical assessments, and/or other assessments described in PSPs. It was unclear how, given the many needs identified by assessments, an individual need was selected for inclusion as an SPO, or how needs were prioritized.<br><br>As presented above, SPOs followed a prescribed format. All of the SPOs reviewed across 20 sampled individuals included basic elements such as an objective; description of baseline performance; a plan for implementation- including the setting, schedule, materials, reinforcement, and teaching procedures; and evaluation criteria. However, the detail and comprehensiveness of the plans varied greatly. Many of these elements, when described, were relatively vague and did not provide enough specificity for their consistent and complete application across staff. For example, some behavioral objectives did not provide enough detail to ensure consistent identification and reliable measurement of the target response. For example, an objective stated that an individual "… will slow his eating pace…" (i.e., Individual #267), "… participate in activities emphasizing attention span …" (i.e., Individual #264), or "… shave one area with an | |

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| | | electric razor …" (i.e., Individual #202). Also, at times, the objective of the SPO did not match the steps specified to teach the skill. For example, an objective aimed at encouraging an individual to discuss his day at school was followed by instructional steps designed to prepare for school the following day (i.e., Individual #288).<br><br>In addition, some of the sampled SPOs did not include an operational definition of the target behavior (i.e., what is being taught), a specific instruction (discriminative stimulus), detailed steps based on a comprehensive task analysis, use of differential reinforcement,, a plan regarding maintenance and generalization, and/or sufficient trials per day (or week) to promote acquisition.<br><br>There were many SPOs, however, that included relatively solid instructional elements. For example, steps involved in hand washing and tooth brushing appeared to approximate a comprehensive task analysis for Individual #23 and Individual #116, respectively, a clear objective for tooth brushing for Individual #286, or operational definition of targeted response of "agitation" for Individual #214.<br><br>Record review indicated that some SPOs promoted active engagement at home as well as integration into the community. Although some SPOs contained objectives aimed at community integration, it appeared that these typically targeted participation in recreation or leisure activities rather than structured skill building. In addition, review of sampled documentation reflected that the SPOs of several individuals included goals related to engagement or work skills within vocational or day service settings.<br><br>Informal assessment of staff and individual interactions, as well as individual engagement was completed during brief site visits. Direct observation of staff and individual interactions, across all residential and day program sites, appeared to be very positive. Direct care staff as well as professional staff members were very respectful toward the individuals they were supporting. In general, many of the individuals appeared to enjoy these interactions as well. Engagement levels of individuals within programs varied greatly. That is, there were some settings were engagement appeared to be very high for the majority of individuals present. These settings usually included staff members that were enthusiastic about finding and offering activities or items of interest. Multiple observations including staff and individuals sharing interest in a specific activity were observed. At these times, recreational or leisure activities (e.g., crafts, puzzles, games, etc.) appeared readily available. Day program and vocational sites, especially Estacado Industries Workshop (EIWS) and Estacado Industries Residential Services (EIRS) also appeared to have very high levels of engagement. However, there were other settings in which engagement appeared more passive than active. That is, several observations evidenced limited interactions between staff and individuals, despite sufficient staffing ratios, and included only passive forms (e.g., | |

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| | | watching television or listening to music) of engagement.<br><br>Efforts to enhance individual engagement at LBSSLC have the potential to be facilitated by the presence of the Active Treatment Coordinators. At the time of the review, there were three of these professionals working across the three units, although, it appeared that their responsibilities were not equally distributed across all programs. Verbal reports from staff suggested that these positions had great promise in supporting higher levels of active and meaningful programming. However, reports across disciplines also reflected confusion about the role(s) of these professionals, suggesting that these supports were likely not utilized to their full potential, and were likely underappreciated.<br><br>Documentation suggested that active treatment team meetings occurred on a monthly basis at various residential programs. Meeting minutes indicated that attendees reviewed schedules for residential activities, community activities and various on-campus special events, as well as discussed the integration of teaching and engagement strategies. It was unclear if these meetings occurred monthly at each program. Review of documentation also indicated that Weekly Active Treatment Schedules also had been developed for residential programs.<br><br>In addition, it appeared that structured active treatment observations occurred within the residential programs. These observations estimated engagement for several individuals over time, as well monitored the nature of staff interactions with individuals, including tone of voice, choice-making opportunities, prompting and promotion of independence, redirection of maladaptive behavior, use of verbal praise, and availability of functional materials. It was unclear how these observations were scheduled or how often they were completed.<br><br>Staff report, document review and observation reflected active efforts at providing meaningful day/vocational engagement as well as skill building opportunities within settings both on and off the LBSSLC campus. For example, a substantial number of individuals were engaged in work associated with several contracts (e.g., meal kits, document shredding, gravel bags, cable television materials, etc.). These activities were completed both on-site (i.e., EIWS, EIRS, and Pine workshop), and off-site (i.e., two supported enclaves in the community). Many individuals were also involved in designing, making and selling items at the Heart and Hands store. Programs had also been developed, for example, the spa, nature walks, multi-sensory, art and crafts, visually impaired training, functional living, and cooking classes (or classrooms), to provide structured activities within day settings (Pine, Lily, and Educational Building). | |
| S2 | Within two years of the Effective Date hereof, each Facility shall | Based on verbal reports from staff, the Personal Focus Worksheet: Individualized Assessment Screening Tool (PFW), as well as the Positive Assessment of Living Skills | |

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| | 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. | (PALS) were completed annually to assist with the development of the PSP. As described, the PWF was completed in an attempt to identify individual goals, interests, likes/dislikes, achievements, and lifestyle preferences. The PALS evaluated a number of skills areas, and would offer additional information on an individual's preferences, strengths, and needs. Of the 12 individuals sampled, only two PFWs (i.e., for Individual #77 and Individual #288), and three PALs (i.e., for Individual #77, Individual #23, and Individual # 202) were included within the requested documentation. This lack of available documentation was surprising given that verbal reports from QMRPs and RCs indicated that the PFW and PALs were the foundation for the development of the PSP. A third assessment, that was not described during staff interviews or meetings, called the Personal Adaptive Skills Essential for Privacy and Independence, was completed for six of the sampled individuals (i.e., for Individual #264, Individual #232, Individual #135, Individual #288, Individual #214, and Individual #240 . This assessment appeared to be completed independent of and, at times, concurrent with the PFW and/or PALS. Subsequently, based on the available sampled documentation, there did not appear to be consistency across individuals as to which assessment(s) were completed as part of the PSP process. However, as presented above with regard to Section K of the SA, the sampled ICAP assessments appeared to be completed within, at least, the previous three years. Other than reporting and monitoring of more global scores, it was unclear if scores on individual or groups of items were utilized to monitor an individual's progress, or identify areas for skill acquisition.<br><br>In reviewing the summary information regarding the completion of discipline specific assessments, it was discovered that, for at least three PSP reports (i.e., for Individual #135, Individual #214, and Individual #288), Physical/Medical assessment reports were not available prior to or at the PSP meeting. The absence of this important information would appear to be a significant barrier to the provision of necessary supports and services, as well as limit the overall comprehensiveness of the PSP process. This finding within sampled documentation may likely reflect a larger trend across all PSPs. However, there did not appear to be a similar trend of missing assessment data from other disciplines.<br><br>Although preferences and reinforcers were described in detail, often in SFBAs, PBSPs, and/or SPOs, it was unclear how these were identified. That is, it is unknown if structured preference assessments were completed and, if they were, how regularly they were conducted. Standard practice suggests that formal preference assessments should be conducted at least annually. In addition, it was not readily apparent during observations that reinforcers, other than verbal praise, were used to promote adaptive responding.<br><br>One consistent theme encountered across staff meetings and interactions with direct | |

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| | | support professionals was how the challenging behaviors of many individuals limited their integration into the community. This appeared to include staff's perception of their ability to obtain supported employment within the community, as well as move into residential placements outside of LBSSLC. This perception may also limit an individual's opportunities to work on functional skills in community settings. It is essential to note that not everyone interviewed supported this view. PSP teams should actively consider whether or not held beliefs regarding an individual's behavior and how it limits their inclusion into community settings is based on actual observations of these behaviors within the community, and, if so, whether or not behavioral supports and services could support the individual to be more successfully included in integrated settings. | |
| 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: | Review of sampled psychological assessments indicated that general recommendations were often made regarding behavioral programming and medications. Goals related to these recommendations were often found in Action Plans of PSPs, and monitored though PSP Quarterly Reports. However, it was not typical to find, in sampled documentation, specific recommendations from psychological assessments that were then represented in SPOs. Some of the more general recommendations regarding, for example, maintaining quality of life or promoting skill development, was at times reflected in some identified SPOs. Specific recommendations regarding, for example, prioritization of skill training based on assessments of adaptive living skills generally were not found.<br><br>As previously presented, it is clear that SPOs contained strategies that identified the setting, implementation schedule, necessary materials and reinforcers, as well as how to prompt appropriate responding using a general prompt hierarchy, and to reinforce active responding. However, specific evidenced-based teaching strategies, including task analysis, chaining procedures, and error correction procedures were not generally apparent. Plans often included steps that approximated a task analysis, but it was unclear, for example, if procedures emphasized forward, backward, or whole task chaining. In addition, differential reinforcement procedures, as related to individual accuracy or performance, were not typically described. In addition, most SPOs only prescribed a limited number of trials per day, usually only one. Lastly, data associated with skill acquisition programs was not typically graphed.<br><br>Record review, discussions with professional staff across disciplines, and direct observation throughout the residential settings reflected an emphasis on functional communication training. Indeed, the availability of visual cues (i.e., signs, pictures, icons, etc.) was obvious across multiple settings. Many replacement behaviors identified in PBSPs, and objectives in SPOs targeted the training and promotion of alternative, more adaptive communicative responses in an attempt to replace more maladaptive behavior. Given this comprehensive effort and obvious emphasis, it was surprising that not a single observation included the demonstration of function communication training, and/or the active use of these provided assisted communicative materials. Overall, little formal or | |

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| | | incidental teaching was observed at the residential program during brief visits. | |
| | (a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and | As presented above, review of documentation reflected SPOs that addressed a variety of needs identified on Action Plans developed by QMRPs. Objectives identified on these action plans appeared to result from assessment completed as part of the annual PSP process (e.g., psychological assessments, SFBAs, language and communication assessments, medical assessments, and/or other assessments described in the PSP). It was unclear how, given the many needs identified by assessments and listed on Action Plans, an specific need was selected for inclusion as an SPO, or how needs were prioritized. In addition, it was unclear when or how these SPOs were revised or discontinued.<br><br>It was difficult, given the method in which data on SPOs was tracked, to determine performance of individuals over time. The following issues were identified:<br>▪ Data on these skill acquisition programs was not displayed in tables or graphs, similarly to the target or replacement behaviors found in PBSPs. Interpretation of progress, subsequently, was challenging.<br>▪ Interpretation was even more difficult because, on some SPOs staff simply crossed out dates, steps or other information on the document and provided more recent dates or other information (e.g., new steps).<br>▪ It was also challenging to assess progress on SPOs based on monthly and/or quarterly PSP reports due to the lack of specification on individual performance, primarily the absence of quantitative data, with the exception of target or replacement behaviors from PBSPs. More specifically, monthly reports rarely commented specifically on performance on SPOs, and the majority of quarterly reports utilized terms such as "progressing," "regression," or "maintenance." More difficult to interpret were the SPO quarterly reports that indicated that data was "missing," "misplaced," or the "wrong data" had been collected, or as found in many reports, "no data" or "data unavailable" was reported. These terms were found across SPOs and, unfortunately at times, observed over the course of two to three consecutive months across multiple SPOs.<br>▪ In addition, brief record review during a visit at the Pine day program, for example, evidenced limited data collection as well.<br><br>Given these challenges, it would be difficult to judge whether or not skill acquisition programs were currently promoting growth, development, and independence across most individuals. | |
| | (b) Include to the degree practicable training | As presented earlier, some SPOs that detailed training or participation in the community were identified (e.g., Individual #28, Individual #286 and Individual #232) during record | |

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| | opportunities in community settings. | review of sampled documentation. However, not all individuals appeared to have SPOs targeting community inclusion, or have skill acquisition training in the community. It was promising to observe some sampled SPOs targeting skill training within on-campus work settings (e.g., Individual #116, Individual #276, Individual #202).<br><br>Community Integration Reports appeared to be completed monthly for each of LBSSLC's three units. These reports reflected data on the nature of community inclusion for each individual, including where they went, the date, skills trained and reinforced, and individual response. Brief review of documentation from August 2009 through January 2010, reflected that for the homes for which data was available, most individuals had at least one community outing per month. Indeed, many individuals from various programs appeared to experience multiple outings per month. However, data was incomplete as monthly reports from some residential programs were not available.<br><br>Staff reports indicated that only one individual at LBSSLC currently had obtained competitive employment with only five others working in community-based enclaves with the support of job coaches. Although not primarily based within the community, the 26 individuals working at 'Hearts and Hands' experience an integrated experience both on and off-site. Additional work needs to be done in this area. | |

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

1. Currently, not all skill acquisition objectives are written in a manner that provides a clear understanding of the expected outcome. It is recommended that all training objectives be written to include the following: a) specific conditions under which the behavior will occur; b) a definition of the behavior in observable and measurable terms; c) identification of the criteria that will be used to indicate mastery of the skill; and d) a plan for the maintenance and generalization of the skill. Additionally, specific guidelines for teaching the skill must be provided. This should include relevant discriminative stimuli, prompting strategies, shaping guidelines, and steps for teaching behavioral chains.
2. Initial intensive and on-going training on the development, implementation, and monitoring of skill acquisition plans should be provided to QMRPs, RCs, Active Treatment Coordinators and others that are likely to develop, implement, and/or monitor these teaching plans (SPOs). Training should address writing operational definitions and behavioral goals as well as evidenced-based teaching strategies, including task analysis, chaining procedures, error correction procedures, differential reinforcement, and/or prompting hierarchies and fading.
3. Behavioral services staff, including Associate Psychologists and Psychology Assistants, should be more intensely involved in the development, implementation and monitoring of SPOs. When this occurs, they should receive similar intensive and on-going training as mentioned above in Recommendation #2.
4. Efforts to expand meaningful day and vocational programs should continue.
5. Consideration should be given to surveying staff members, including behavioral services staff as well as QMRPs and RCs, and identifying potential areas for further staff training. For example, it appears that staff members are likely to benefit from additional training on autism, including evidenced-based assessment and intervention strategies, or providing supports to individuals with autism.
6. Assessment of adaptive behavior should occur at least annually. The ICAP is limited in the range of domains assessed. Therefore, the supplemental use of the PALS or some other more comprehensive assessment is recommended. Preference assessments should also be

completed on a regular basis to ensure that potentially effective reinforcers are applied for all desirable behavior.

7. If not already in place, a tracking grid should be developed to allow monitoring of completion of assessments (e.g., PFW, PALS, medical/nursing, etc.) required as part of the PSP.
8. The results of these assessments should be used to identify a prioritized list of skill acquisition needs, and these list should be utilized by PSTs to determine the annual goals and objectives for individuals.
9. Consideration should be given to graphing progress on skill acquisition programs in addition to challenging behaviors. This process should include monthly summary and graphing of data as well as review by an Associate Psychologist.
10. A more effective system of data collection and monitoring of data collection should be developed to prevent or reduce the amount of data that is misplaced, or not collected as written. This should include simplifying and systematizing how goals are written, how data is summarized and displayed, and how/when performance will be regularly assessed.
11. Observations of engagement and staff interactions should continue, and be broadened. Such observations should result in feedback to staff regarding positive interactions and engagement, as well as areas in need of improvement.
12. A system of monitoring of treatment fidelity of SPOs should be developed and implemented.
13. During PSP meetings, attempts should be made to identify community settings in which SPOs could be implemented to enhance the goal's meaning and function.
14. Integration and active consultation (beyond providing training materials) of behavioral services staff should occur within day service settings, including support of job coaches and individuals in supported employment.

| SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs | |
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| | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o List of Individuals Assessed for Placement since 7/1/09, and resulting recommendations;<br>o List of Individuals Referred for Placement from 7/1/09 through 1/31/10;<br>o List of Individuals who Have Requested Placement since 7/1/09;<br>o List of Community Living Discharge Plans between 7/1/09 and 1/31/10;<br>o List of Individuals who Have Been Transferred to a Community Setting from 7/1/09 through 1/31/10;<br>o List of Individuals Discharged Pursuant to an Alternate Discharge since 7/1/09;<br>o List of Alleged Offenders at LBSSLC, not dated;<br>o Community Placement Report, from 7/1/09 through 1/31/10;<br>o Updated List of Individuals who Requested Community Placement, Transitioned to the Community, Had a Community Living Discharge Plan (CLDP) Developed, and Were Referred for Placement, dated 3/15/10;<br>o DADS Policy Number 018, entitled "Most Integrated Setting Practices", dated 10/30/09;<br>o LSS - Continuity of Services: Community Placement;<br>o Section T. Serving Institutionalized Person in the Most Integrated Setting Appropriate to Their Needs monitoring form, revised 10/16/09;<br>o Identified Obstacles to Placement, document #POI-O-1.7.3;<br>o Transfer, Discharge Reassignment Summary, dated 6/30/04;<br>o Job descriptions for: QMRP III – Post-Move Monitor, and Admissions/Transfer/Placement Coordinator;<br>o Annual Provider Fair on 3/14/10 flier;<br>o Staff Record of Community Interaction, from 6/30/09 through 2/25/10;<br>o Announcement and Sign-in Sheets for 10/22/09 Mental Retardation Authority (MRA) Living Options Training, with PowerPoint presentation;<br>o Agenda and Handouts from Admission Placement/Post-Move Monitor 3/18/10 Scan Call;<br>o LBSSLC Monitoring Summaries for Section T, for November 2009, December 2009, and January 2010;<br>o LBSSLC Quarterly Summary of Monitoring for the Months of October through December 2009;<br>o PSPs for Individual #161, Individual #52, and Individual #172;<br>o PSPs and related assessments for the following individuals: Individual #110, Individual # 16, Individual #56, Individual #303, Individual #177, Individual #195, Individual #196, Individual #159, Individual #12, Individual #122, Individual #15, Individual #168, Individual #268, Individual #269, Individual #97, Individual #79, Individual #264, Individual #153, Individual #69, Individual #49, and Individual #279;<br>o Community Living Discharge Plans, PSPs, related assessments, and Post-Move Monitoring |

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| | checklists for the following individuals: Individual #49, Individual # 153, Individual #177, Individual #279, Individual #69, and Individual #110.<br>▪ **Interviews with**:<br>o Carla Prell, Admissions/Placement Coordinator;<br>o Annette Webster, Post-Move Monitor and Guardianship Coordinator<br>o Trent Lewis, Director of Active Treatment, on 3/15/10;<br>o Marisol Gonazales, ISP Coordinator, on 3/15/10<br>o Lola Walker, QMRP Coordinator, on 3/15/10; and<br>o Thirteen (13) Qualified Mental Retardation Professionals (QMRPs), on 3/18/10<br>▪ **Observations of**:<br>o PSP meeting for Individual #309 |
| | **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| | **Summary of Monitor's Assessment:** Individuals' PSPs did not consistently identify all of the protections, services and supports that needed to be provided to ensure safety, and the provision of adequate habilitation. It is essential as teams plan for individuals to move to community settings that PSPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services.<br><br>PSPs also did not clearly identify barriers to individuals moving to the most integrated setting appropriate to meet their needs. As a result, action plans to address such barriers had not been identified.<br><br>At the outset, it is important to note that the CLDPs at LBSSLC were some of the most extensive seen by this Monitoring Team. Clearly, much thought and effort had gone into the development of the plans. Efforts appeared to have been made to include as full a complement of team members at the CLDP meetings as possible. As reported, some of the efforts made even prior to the CLDP meeting were assisting individuals to safely transition to the community. As is described below, though, the CLDPs continue to need to be further enhanced because they are the documents that define what is provided to the individual by the new provider agency, and are used by Post-move Monitors and MRAs to ensure the provision of protections, supports and services once the individual leaves LBSSLC.<br><br>The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility was still refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways.<br><br>Some level of post-move monitoring had been completed for all of the individuals who had transitioned to the community. However, according to the documentation provided, 50 percent of the required visits had not been completed. |

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| | With regard to the content of the checklists, the checklists all utilized the format attached to the SA as Appendix C. Each of the items on the checklists had been addressed. It would be helpful, however, if additional information was provided with regard to the methodology used to conduct the reviews and the information gathered with regard to each indicator.<br><br>The post-move monitoring identified some issues with regard to the provision of services at the community sites. The follow-up to rectify issues identified was not clearly documented, and generally consisted of a due date for the support or service to be initiated. |

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| **T1** | **Planning for Movement, Transition, and Discharge** | | |
| T1a | Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. | On 10/30/09, DADS issued a policy entitled "Most Integrated Setting Practices." This State policy accurately reflected the provisions contained in Section T of the Settlement Agreement. The policy's stated purpose was to "prescribe procedures for encouraging and assisting individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the Untied States Supreme Court's decision in Olmstead v. L.C.; identification of needed supports and services to ensure successful transition in the new living environment; identification of obstacles for movement to a more integrated setting; and, post-move monitoring." The policy included components to ensure that any move of an individual to the most integrated setting was consistent with the determinations of professionals that community placement was appropriate, that the transfer was not opposed by the individual or the individual's LAR, and that the transfer was consistent with the individual's PSP. During future reviews, the Monitoring Team will continue to evaluate the State and the Facility's implementation of this policy.<br><br>With regard to the availability for funding for community transition of individuals from LBSSLC, funding availability was not cited as a barrier to individuals moving to the community. No one appeared to be on a waiting list, and transitions were occurring at a reasonable pace. In fact, the State's expectation was that once a referral was made, the transition to the community should occur within 180 days. Permission needed to be sought for any transitions that were anticipated to take longer than the 180-day timeframe. | |
| T1b | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, | LBSSLC's Continuity of Care: Community Placement policy had not been revised since 3/6/08. As a result, some of the information was not wholly consistent with the Settlement Agreement or the State policy. For example, it did not define monitoring activities after an individual moved to the community in the same way as the SA. | |

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| | revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that: | Generally, though, the policy described the procedures outlined in the SA and State policy. A couple of concerns were as follows:<br>▪ In a couple of places, the document stated the following: "The decision of the individual, with the ability to give legally adequate consent, or the LAR is final." It would be important to note in the context in which these sentences were included that at any time the individual or LAR could modify his/her decision.<br>▪ The document also referred to "discharge criteria." It was unclear what this meant. Based on interview with the Admissions/Placement Coordinator, this might refer to criteria that were being set out during the CLDP process for formal discharge from commitment to the Facility. Within the context of this policy, though, it would be important to distinguish this from criteria that individuals must meet before they are allowed to transition to a community setting. | |
| | 1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles. | The two major requirements of this section of the SA are discussed separately below:<br><br><u>Identification in PSP of needed protections, services and supports</u>: As is further discussed in the section of this report that addresses Section F of the SA, as well as throughout other sections of the report, PSPs generally did not identify the comprehensive array of protections, services, and supports that individuals needed to ensure their safety and the provision of adequate habilitation. In all of the PSPs reviewed, concerns were noted with regard to their completeness. Some of these issues related to timely, thorough and adequate assessments not being completed (e.g., medical, nursing, physical and nutritional management, and communication); services and supports not being adequately integrated with one another (e.g., psychology and dental/medical, nursing and dental, and medical and habilitation therapies); protections, services, and supports not being adequately defined, such as a lack of specificity about the supports that direct support professionals need to provide to protect and support individuals with regard to behavioral, therapeutic, or healthcare issues; and/or adequate plans not being developed to address individuals' preferences, strengths and needs (e.g., nursing, psychology and habilitation, physical and nutritional supports, and communication).<br><br>A Living Options Discussion Record (LODR) was included as part of individuals' PSPs. This portion of the PSP had various sections, including an optimistic vision for the person; discussion notes about the individual and LAR's awareness of community living options; preferences of the individual and LAR; the supports needed by the person served in various areas, including safety, mobility, medical, behavioral/psychiatric, work/day activities, and quality of life; MRA input and recommendations, permanency plans, as appropriate; and a determination of the most integrated setting. The quality of the LODRs varied widely. For example, the LODR for Individual #303 provided a | |

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| | | substantial amount of information about the optimistic vision of the individual, and the supports he required, as opposed to the LODR for Individual #16 that provided minimal information. As is discussed in further detail below, these documents did not clearly identify barriers/obstacles, and/or plans to overcome them.<br><br>An additional concern about the LODRs was the lack of integration of these documents within the overall PSP. In a person-directed planning process, the discussion, for example, about the "Optimistic Vision" for the individual should lead the team's entire discussion about the protections, supports and services to be provided to the individual in no matter what setting the individual will be served. It should not only apply to the discussion about living options. Likewise, it was not clear why the LODR included a section that described the supports and services needed by the person. Again, the overall PSP should define these protections, supports, and services clearly.<br><br>It is essential as teams plan for individuals to move to community settings that PSPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports and services. This is important for two 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 the perspective provider agencies are able to support the individual appropriately; and 2) as the process progresses, the PSP will be the key document that is used to ensure that essential supports are identified and in place prior to an individual's move. If all of the necessary protections, supports and services are not outlined in the PSP, it will be much more difficult to ensure the individual's safe transition.<br><br><u>Identification of obstacles and strategies to overcome them</u>: In none of the PSPs reviewed, were obstacles to an individual's movement to the most integrated setting appropriate to his/her needs and preferences, and/or strategies to overcome such barriers clearly identified. In some plans, the Living Options Discussion Record section identified some obstacles, but no plans to overcome them were identified.<br><br>As part of the document request for review of this section of the SA, the Facility was asked to provide three recent PSPs. The Facility chose PSPs for Individual #161, Individual #52, and Individual #172. None of these PSPs clearly identified barriers, and none included plans to overcome the barriers that were implied in the narrative sections of the Living Options Discussion Record. Specifically:<br>▪ For two of these individuals, their families and/or guardian had reservations about them moving from LBSSLC. No plans were found to address these reservations.<br>▪ For Individual #161, the barriers appeared to be due to her increased need for | |

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| | | nursing and medical care. She had lived in the community until early 2009, when due to her provider's inability to provide for her increased medical needs, as a result of a diagnosis of Alzheimer's Disease, she moved first to a nursing home, and then to LBSSLC. Her team did not specifically identify the supports or services that were lacking in the community that she needed, or develop plans to assist her in overcoming such barriers.<br><br>Even in some of the most recently developed plans, barriers/obstacles were not clearly stated in the LODRs, and no concrete plans for overcoming barriers were developed by individuals' teams. For example, the LODRs included no such delineation of obstacles or plans to overcome them for Individual #16 in his PSP, dated 1/7/10; for Individual #56 in his PSP dated 1/5/10; or for Individual #303 in his PSP, dated 1/5/10. More specifically:<br>▪ In the LODR, Individual #16's team identified the optimistic vision for him as living at home with his family. The team indicated that he "requires 24 hour nursing care and his mother fees she is unable to care for him in the home, therefore, LSSLS is the most optimistic vision for [Individual #16]." The discussion in the LODR of the supports the individual would need in the community was minimal. The team identified no specific barriers/obstacles to movement to the community, although some are implied. No plan(s) were identified to overcome the barriers, even the implied barriers. It did not appear that the team identified with any specificity the concerns that the guardian had with regard to considering a community placement.<br>▪ Individual #303 was able to state what his optimistic vision was for himself. He clearly told his team he wanted to live in a group home. The optimistic vision in his LODR provided considerable detail about what he would like his day-to-day life to involve. In the LODR, the team discussed a number of supports that Individual #303 would need. These all appeared to be supports that could be provided in a community setting. The team did not specify any particular barriers to movement to the most integrated setting appropriate, but concluded that he would remain at LBSSLC, "since it is his mother/guardian's wish." Again, some potential barriers were alluded to in the discussion, but not specifically stated as barriers, with corresponding plans to overcome them. For example, the team identified that some of Individual #303's behaviors could result in "serious consequences should he exhibit these behaviors in the community." However, associated barriers were not identified, such as a possible lack of providers with the capacity to provide the necessary behavior supports, or lack of group homes in neighborhoods that would meet the individual's needs, etc. Likewise, it was not clear that the team identified his guardian's specific concerns to determine if these concerns could be addressed. | |

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| | 2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices. | LBSSLC had engaged in a number of activities to provide education about community placements to individuals and their families or guardians to enable them to make informed decisions. This had taken a number of forms, including:<br>▪ On 3/14/10, a provider fair was held. According to the Admissions/Placement Coordinator (APC), all families were sent an invitation. This event had been held each March in conjunction with a meeting of the Family Association.<br>▪ Visits to community group homes and day programs were occurring on the last Tuesday of every month. Such visits offered individuals and Facility staff the opportunity to obtain first-hand knowledge of what community supports were available, to meet provider staff, and potentially other people with whom they could have the opportunity to live or work. In late June 2009, formal tracking had begun with regard to which staff attended these visits, as well as when staff interacted with community providers in other ways such as accompanying an individual on a pre-move visit. LBSSLC is encouraged to continue offering regular visits to community homes and day programs.<br>▪ Individuals and their guardians also were provided information through the Mental Retardation Authority (MRA) Community Living Options Information Plan (CLOIP) process. This was occurring regularly as part of the individual planning process.<br>▪ In addition, MRAs also had met with PST members in meetings designed specifically to provide information about services and supports that were available in the community. For example, this occurred on 10/22/09.<br><br>The Facility is encouraged to continue offering a variety of educational options to individuals and families, and to expand these options to creatively meet the needs of various individuals and guardians. For example, as individuals successfully transition to community settings, with their and their guardians' permission, newsletter articles could highlight such success stories. At times, it might be helpful to match individuals and/or guardians who have gone through the process with individuals and/or guardians who are considering a placement referral. This would allow someone with first-hand knowledge about the process, including the challenges as well as the successes to share information and provide support. | |
| | 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 | In response to a request for a list of individuals who had been assessed for placement since July 1, 2009, LBSSLC provided a list of individuals who had been assessed for placement within that timeframe. The list contained 139 names of which seven (5%) had been referred for community placement.<br><br>In reviewing a sample of PSPs, teams had completed the Living Options Discussion record including a section in which teams documented their decision with regard to the "most appropriate living option for the individual at the current time." At times, it was | |

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| | transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices. | unclear what criteria teams were using to make their decisions. This was complicated by the fact that barriers to placement were not consistently identified. The following provides an example of this issue:<br>▪ Individual #159's 8/7/09 PSP included discussion about her community living options. There was contradictory information in this section about Individual #159's wishes with regard to her preference. At one point, the document indicated that she did not want to move, and in another stated that she "was adamant that she did not want to stay here at the Lubbock State Supported Living Center and wants to live in a group home." The team identified that all of Individual #159's needs could be met in a community setting. Due to concerns about self-sabotage, Individual #159's guardian stated that Individual #159 "needs very intensive one to one (sic) counseling before she can reconsider letting [Individual #159] move back to the community." It was unclear if the team agreed with this statement. However, the "PST and Contract MRA agreed to not initiate the referral for [Individual #159] to return to the community at this time." The team indicated that this would be revisited after Individual #159 completed outside counseling. No action plan was found showing that counseling had been initiated. The monthly plan reviews submitted did not indicate that counseling was occurring.<br><br>During upcoming monitoring visits, the Monitoring Team will continue to review the Facility's progress in this regard, including the process being used by team to assess individuals for placement. | |
| 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: | Community Living Discharge Plans were reviewed for six individuals. This sample was drawn from the list of eight individuals whom the Facility identified as having had a CLDP developed since July 1, 2009.<br><br>At the outset, it is important to note that the CLDPs at LBSSLC were some of the most extensive seen by this Monitoring Team. Clearly, much thought and effort had gone into the development of the plans. Efforts appeared to have been made to include as full a complement of team members at the CLDP meetings as possible. As reported, some of the efforts made even prior to the CLDP meeting were assisting individuals to safely transition to the community. As is described below, though, the CLDPs continue to need to be further enhanced because they are the documents that define what is provided to the individual by the new provider agency, and are used by Post-move Monitors and MRAs to ensure the provision of protections, supports and services once the individual leaves LBSSLC.<br><br>With regard to the timeliness of the Community Living Discharge Plans, it appeared that many were developed only a few weeks prior to the individual's transition date, making | |

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| | | adequate transition planning difficult. Particularly because the Facility was attempting to define essential and non-essential supports during the CLDP meeting, as opposed, for example, to identifying them for each as part of the annual PSP meeting, such a short window between the CLDP and transition date made it difficult to ensure that all essential supports were identified, and that provider and Facility responsibilities with regard to discharge were both identified and implemented. | |
| | 1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff. | The Community Living Discharge Plans reviewed included a number of action steps related to the transition of the individuals to the community. However, many of the CLDPs did not clearly identify the specific steps that the Facility would take to ensure a smooth and safe transition, and were not sufficiently detailed or measurable. As is described in further detail in the section of this report that addresses Section T.1.e of the SA, the CLDPs also did not consistently identify the essential supports required by the individuals.<br><br>The monitoring activities were identified in the CLDPs, including the role of the MRA, as well as the role of Facility staff in the post-move monitoring and follow-up process.<br><br>The following provide examples of some of the concerns noted with regard to the CLDPs reviewed with respect to defining the role of the Facility staff in the transition process:<br>▪ Generally, all of the individuals who were transitioned had some plans being implemented at the Facility such as Behavior Support Plans, Physical and Nutritional Management Plans, and Nursing Care Plans. Four out of six CLDPs did not define the Facility staff's role in assisting community provider staff to learn about these plans and their implementation. The two that did defined it in limited fashion. For example:<br>o Individual #279's CLDP included an action step for the LBSSLC staff psychologist to provide in-service training to provider staff. The plan did not specify which provider staff would be responsible for attending the training session, or specifically what would be covered.<br>▪ Although from interview, it appeared that LBSSLC staff were assisting in the transition by accompanying individuals to their new homes, and attending portions of pre-move visits, this was not formalized in the CLDPs reviewed. Sometimes this was mentioned in the narrative regarding activities that had occurred before the meeting. But again, because the CLDPs were being developed sometimes days before a transition, these activities were not defined as measurable action steps. | |
| | 2. Specify the Facility staff responsible for these actions, and the timeframes in which | Based on the sample reviewed, teams generally identified target dates for the completion of actions steps included in CLDPs, as well as the person responsible by name. This was evident in five out of six of the plans reviewed. The timeframes and persons responsible | |

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| | such actions are to be completed. | were not identified for Individual #69, whose CLDP was developed in September 2009. It appeared that at some time after that, the format for the CLDP changed. | |
| | 3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting. | From the sign-in sheets provided with the CLDPs that were reviewed, it appeared that teams consistently reviewed CLDPs with the individuals and their guardians prior to discharge. For only one of the six plans reviewed was neither Individual #69 nor the correspondent noted to be present. Community provider staff also participated in the meetings. As noted above, it appeared that efforts were made to include as many team members as possible in the CLDP meetings. | |
| 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. | Based on the documented dates of assessments reviewed at the CLDP meetings, it appeared that many of the assessments had been updated within 45 days. However, for all five CLDPs for which dates could be determined, each had some assessments that were older than the 45 days. | |
| T1e | Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility. | The six CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility was still refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways. Moreover, the plans did not consistently identify preferences of the individuals that might affect the success of the transition. This made it difficult for thorough and meaningful monitoring to occur prior to and after the individual's transfer to the community. The following provides only a few examples of issues identified with regard to the identification of measurable essential and non-essential supports:<br>▪ For Individual #153, no essential supports were identified. In reviewing his PSP, Individual #153 had many supports that appeared would be essential to his safety. Just to name a few, he had a BSP in place, and was seen by the psychiatrist for prescription and oversight of psychotropic medications. He also had a PNMP that required him to have a ground diet.<br>▪ Individual #279 had some essential supports listed, but there were others that appeared to be missing. For example, he had a BSP, but there was no mention in the essential supports that the plan needed to be implemented by trained staff, or that oversight of this plan needed to be provided by a psychologist or qualified staff person. He also had a chopped diet to address safety issues, but this was not identified as essential. He also had eyeglasses, but these were not mentioned as essential or non-essential.<br>▪ Individual #49 had some essential supports listed as well, but an example of a support that appeared essential, but was not mentioned, included a positioning | |

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| | | plan that was included in her LBSSLC PSP.<br>▪ Most of the CLDPs reviewed listed 24 hour staffing as an essential support. But none of them defined the level of supervision that needed to be provided by staff to the individual.<br>▪ Most of the essential supports were listed as just a phrase, such as "24 hour staffing," or "adaptive equipment," or "PNMP." This did not result in a measurable description of the protections, services or supports that needed to be provided to the individual.<br><br>With regard to monitoring by the MRA or other means to ensure essential supports were in place prior to an individual's transition, this will be reviewed at the next monitoring visit. The documentation to confirm this was not provided as part of the CLDP or post-move monitoring paperwork, likely because the Monitoring Team did not specifically request it. | |
| 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. | Based on documentation provided, the QE Department was implementing checklists to evaluate the Facility's compliance with Section T of the SA. These checklists generally tracked the requirements of the SA. They also generally appeared to include a number of valuable indicators that would provide information about both processes and outcomes on an individual, and, at times, systemic level. Information generally could be aggregated to provide a systems picture of the integrated planning process.<br><br>One aggregate report was provided showing poor scores in many areas. However, interpretation of the data was somewhat difficult, because a significant issue identified as a result of the reviews was that documentation was not filed timely. When a document, such as the CLDP, was not filed or sent in a timely manner to the QE Department, indicators were scored as "No." Although there is validity to the concept that "if it is not documented, it did not happen," interpretation of the data with regard to the actual quality of the CLDPs, for example, was hindered. In order to provide a clear picture of the quality of the documents, consideration may want to be given to distinguishing between missing documentation, a serious issue that should not be ignored, and documentation that did not meet the identified standard.<br><br>It was not clear from the documentation provided what the expectations were with regard to the frequency of review, the sample size, the criteria used to determine acceptable levels of performance, or the follow-up activities that were expected to occur. Moreover, as is discussed with regard to Section E of the SA that addresses Quality Assurance, it was not clear that information being collected through monitoring processes was consistently being analyzed, and, as appropriate, plans being developed to address identified areas of need. | |

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| 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. | Based on a review of PSPs and interviews with staff, LBSSLC was at the very initial stages of identifying obstacles to placement on an individual basis. As a result, the Facility had not yet collected sufficient data for analysis and submission of a report to the State. The Monitoring Team looks forward to reviewing such reports as part of future reviews. | |
| 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 | In response to a document request, the Facility submitted to the Monitoring Team a Community Living Placement Report. The report listed individuals who had been referred by their teams for community placement between 7/1/09 and 1/31/10, including the individual's name, the date of referral, and, if applicable, the date the referral had been rescinded. The list included six names of individuals referred, including one who had her referral rescinded due to "LAR choice." The second page of the document listed five individuals who had been transitioned to the community during this time period. | |

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| | individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I. | | |
| **T2** | **Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs** | | |
| T2a | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool | Timeliness of Checklists: The SA anticipated that post-move monitoring would commence by December 26, 2009, for individuals transferred to community settings. To obtain a baseline measurement with regard to this activity, the Monitoring Team requested a sample of the post-move monitoring checklists for six individuals.<br><br>All of the individuals in the sample (100%) had had some post-move monitoring visits conducted. Based on the documentation provided, of the 12 required visits, six (50%) had been documented as having been completed. Individual for whom some of the required visits had not been conducted included Individual #49 (seven day), Individual #279 (seven day), Individual #153 (45 day and 90 day), and Individual #69 (seven day and 45 day).<br><br>Content of Checklists: With regard to the content of the checklists, the checklists all utilized the format attached to the SA as Appendix C. Each of the items on the checklists had been addressed. It would be helpful, however, if additional information was | |

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| | 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. | provided with regard to the methodology used to conduct the reviews, and the information gathered with regard to each indicator. For example, it was unclear from the monitoring checklists if onsite visits were conducted, which documents were reviewed, and if staff and/or the individual was interviewed. Other than a "yes" or "no" response, no additional information was provided to substantiate that essential and non-essential supports were in place.<br><br>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. Generally, it appeared that issues were being identified. These notes related to follow-up were minimal. They generally indicated that a due date had been set for completion of the activity. | |
| T2b | The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date. | This could not be assessed as no post-move monitoring visits were scheduled during the week of the review. | |
| **T3** | **Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do | | |

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| | apply to individuals committed to the Facility following the court-ordered evaluations. | | |
| **T4** | **Alternate Discharges -** | | |
| | Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals:<br>(a) individuals who move out of state;<br>(b) individuals discharged at the expiration of an emergency admission;<br>(c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe;<br>(d) individuals receiving respite services at the Facility for a maximum period of 60 days;<br>(e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission;<br>(f) individuals discharged pursuant to a court order vacating the commitment order. | Since 7/1/09 and the time of the review, there had been no alternate discharges of individuals served by the Facility. | |

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

1. LBSSLC's Continuity of Care: Community Placement policy should be reviewed, and revised, as appropriate to be consistent with the SA and State policy.

2. The Facility is encouraged to continue to offer a variety of educational opportunities with regard to community options to ensure that individuals and their guardians make informed decisions regarding movement to the community. Consideration should be given to developing a written plan that identifies the actions that will be taken, persons responsible and timeframes for completion.
3. Consideration should be given to beginning the process of developing the CLDP much sooner in the transition process to ensure that a comprehensive plan is developed, and that there is time to implement an adequate transition process.
4. Consideration should be given to identifying essential and non-essential supports as a standard part of developing annual PSPs. In addition to the resulting documents being helpful to direct support professionals and others at LBSSLC, it would begin this process much earlier for individuals who eventually transition to the community.
5. Essential and non-essential supports need to be better defined in Community Living Discharge Plans. Likewise, the role of the Facility staff in the transition and discharge process needs to be better defined.
6. Teams should be provided with additional competency-based training on the identification of obstacles to movement of individuals to the most integrated setting appropriate to their needs and preferences. Such obstacles should be defined in terms of protections, services, and supports that currently are lacking or not available in the community. Obstacles also should be defined with sufficient detail to allow the State to identify and address issues related to the current community system. For example, certain services or supports might be lacking in a particular area of the State where the individual or LAR wants the individual to live, the timeliness with which services can be accessed in the community (e.g., certain types of medical services) may be an issue, etc. Such detail is essential to ensuring that the State has the information necessary to make changes.
7. Likewise when an individual or LAR indicates that they do not want to consider transition to the community, it is important to document the specific reasons for this. For example, reasons could range from concerns about quality of community services, rates of turnover in community settings, concerns about the individual leaving comfortable surroundings, types of services that are not available, etc. Such information needs to be collected and analyzed by the State.
8. Teams should be provided with training on the development of action plans/strategies to overcome identified barriers. Such training should be competency-based.
9. With regard to Post-Move Monitoring, clear expectations should be established with regard to the process that needs to be used for monitoring, and the documentation that needs to be maintained.
10. Post-Move Monitoring Checklists should include: 1) a description of the monitoring methodology (e.g., documents reviewed, people interviewed, observations made); and 2) information to substantiate conclusions that essential and non-essential supports are in place, and/or steps being taken by the provider agency to ensure that such supports and services are provided.
11. Staff responsible for the completion of post-move monitoring activities should complete competency based training on the completion of monitoring reviews, including the methodology, proper documentation, and the development and implementation of action plans to address issues identified.
12. With regard to monitoring activities, the Facility should:
    a. If not already done, set expectations with regard to the frequency of review, the sample size, the criteria used to determine acceptable levels of performance, and the follow-up activities that are expected to occur;
    b. In order to provide a clear picture of the quality of the documents, consideration may want to be given to distinguishing between missing documentation, a serious issue that should not be ignored, and documentation that did not meet the identified standard; and
    c. 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.

| SECTION U: Consent | |
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| | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o Texas Guardianship Statute - Probate Code, Chapter XIII. Guardianship, Sections 601 through 700;<br>o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle D. Persons with Mental Retardation Act, Chapter 591. General Provisions, Subchapter A. General Provisions, Section 591.006. Consent;<br>o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle B. State Facilities, Chapter 551. General Provisions, Subchapter C. Powers and Duties Relating to Patient Care, Section 551.041. Medical and Dental Care;<br>o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle D. Persons with Mental Retardation Act, Chapter 592. Rights of Persons with Mental Retardation, Subchapter A. General Provisions, Section 592.054. Duties of Superintendent or Director;<br>o LBSSLC Final prioritized list of those persons needing guardians based on information obtained from the QMRPs, revised 3/15/10;<br>o Inventory for Client and Agency Planning (ICAP);<br>o List of New Guardians from 10/07 through 10/09;<br>o Agenda and handouts from LBSSLC Family Association Meeting on 9/13/09;<br>o Guardianship Tracking form (POI-O-1.7.3);<br>o Guardianship Tracking spreadsheet, updated 10/5/09;<br>o Description of Attempts to Obtain Guardians, not dated;<br>o Guardianship Tracking System; dated 7/6/09;<br>o LSS – Rights: Informed Consent for Treatment/Procedure, revised 11/30/06;<br>o LSS – Rights: Rights of Persons Served, revised 1/17/08;<br>o Guardianship Attorney List, dated 3/8/10;<br>o "Families Must Become Guardians" from the Parent Association for the Retarded of Texas, copyright 2007; and<br>o Texas Guardianship Association web page explaining the guardianship process<br>▪ **Interviews with**:<br>o Carla Prell, Admissions/Placement Coordinator; and<br>o Annette Webster, Post-Move Monitor and Guardianship Coordinator |
| | **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| | **Summary of Monitor's Assessment:** At the time of the review, DADS Central Office was still in the process of developing a policy on guardianship and consent that was expected to provide guidance to the Facilities with regard to the implementation of these SA requirements. LBSSLC did not have a specific guardianship policy, but had some policies related to the informed consent decision-making process. A document |

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| | entitled "Guardianship Tracking System" provided some minimal guidance on the process of prioritizing an individuals' need for guardianship.<br><br>LBSSLC had developed a prioritized list of individuals needing guardians based on information obtained from the QMRPs. This list included names of 114 individuals served by LBSSLC. At the time of the review, Lubbock supported approximately 230 individuals, of whom approximately half needed guardians. Although it was somewhat unclear how individuals had been prioritized, this was a good initial step.<br><br>LBSSLC had taken a number of steps to attempt to identify guardians for individuals whose teams had identified a need for a guardian. These included, but were not limited to contacting local groups to determine interest in assisting in identifying guardians, such as law schools and clinics and disability groups; providing information to individuals' family members or correspondents about the importance of guardianship; and sending a letter to guardians asking if they were interested in taking on guardianship for someone else. Despite these efforts, LBSSLC have had extremely limited success identifying guardians for people who need them. Based on the information provided, without additional resources, such as a funded guardianship program, it seemed unlikely that guardians would be identified for the 114 individuals whose teams have determined a need. |

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| U1 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with | Staff indicated that DADS Central Office was still in the process of developing a policy on guardianship and consent that is expected to provide guidance to the Facilities with regard to the implementation of these SA requirements.<br><br>LBSSLC did not have a specific guardianship policy, but had policies that referenced guardianship and/or consent, including: LSS – Rights: Informed Consent for Treatment/Procedure, revised 11/30/06; and LSS – Rights: Rights of Persons Served, revised 1/17/08. None of these provided a description of the processes to be used for: 1) determining an individual's capacity to make informed decisions; or 2) identifying an individual's level of priority for pursuing guardianship.<br><br>A document entitled Guardianship Tracking System, dated 7/6/09, and a corresponding form, identified characteristics that should be considered by teams in determining the priority need for an individual to obtain a guardian. These included factors consistent with the Settlement Agreement, including the use of a Safety Plan or PBSP, the use of psychoactive medication, as well as the individual's potential guardianship resources. Issues such as the frequency of the need for guardianship, or the individual's ability to make their wishes known, did not appear to be included.<br><br>LBSSLC had a prioritized list of individuals needing guardians based on information obtained from the QMRPs. This list had been revised several times, with the last revision, at the time of the review, being on 3/15/10. This list included names of 114 individuals | |

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| | potential guardianship resources. | served by LBSSLC. At the time of the review, Lubbock supported approximately 230 individuals, of whom approximately half needed guardians.<br><br>In reviewing the list, it was difficult to determine how individuals ended up in the order they did on the list. For example, individuals identified with "inactive guardians" came before those with PBSPs; and individuals with PBSPs were listed in priority slots numbered 23 through 79, without explanation of why one individual took priority over another. The Facility developed this list without the benefit of a State policy on this subject. Once the State policy is issued, the Facility may need to reconsider the prioritization of individuals on the list. The Facility should be commended, though, for the effort it undertook to identify individuals needing guardians, and attempting to prioritize the list. | |
| 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. | Based on staff interview as well as a document listing attempts that had been made to obtain guardians for individuals, a number of actions had been implemented to try to identify potential resources for guardians, and funding to pay for the guardianship process. Despite these significant efforts, Facility staff were experiencing extremely limited success.<br><br>The following provides some examples of efforts that staff had undertaken to identify new guardianship resources, as well as to maintain individuals' current guardians:<br>▪ When asked, Facility staff assisted current guardians in completing annual reports necessary for them to maintain guardianship;<br>▪ Attempts were made to pursue grant money to assist in obtaining guardians, but the county would have needed to match the funds, and such funding from the county could not be secured;<br>▪ Numerous groups and individuals had been approached to determine their interest in identifying people to become guardians. For example, those contacted included an attorney at Texas Tech School of Law, the Director of Special Education for the local school district, a local autism network, and a local law clinic. Unfortunately, for various reasons, these had not materialized.<br>▪ On an annual basis, and most recently on 9/13/09, Facility staff made a presentation at a Family Association Meeting. Materials regarding guardianship were provided. In addition, staff sent a letter to all current guardians and correspondents asking about interest in becoming a guardian for someone else living at LBSSLC. No interest was generated from this letter.<br><br>A couple of legal resources had been identified that could be used if a person was identified who wanted to become a guardian, but needed assistance with the cost of the initial legal process. These included private attorneys, and a local law clinic. | |

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| | | The Facility was maintaining a spreadsheet documenting any attempts made to identify a guardian for each individual on the prioritized list. At times, these attempts included trying to work with family members or correspondents to become the guardian for the individual, or being in touch with inactive guardians.<br><br>Based on staff interview, the Lubbock probate court had an Office of the Public Guardian, but did not have any resources in terms of public guardians, or a volunteer guardianship program. Unlike other areas of the state, there were no guardianship programs to which individuals could be referred. Without additional resources, such as a guardianship program, it seemed unlikely that guardians would be identified for the 114 individuals whose teams have determined a need.<br><br>One of the questions raised by staff was if or how information about an individual whom the team had determined was not able to make informed decisions could be shared with a potential guardian, while ensuring compliance with the Health Insurance Portability and Accountability Act, as well as other federal and state privacy laws. The State should provide LBSSLC, as well as the other SSLCs, with guidance regarding this question.<br><br>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.<br><br>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. A meeting is being scheduled with the Monitoring Panel and the State to further discuss the guardianship process. However, at this juncture, it is unclear what, if any, role the State views Facility staff as having with regard to guardianship proceedings. | |

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

1. The State should finalize the State policy on guardianship and consent, and implement it as soon as possible. In doing so, it should consider including in the policy the following:
    a. An assessment process that clearly identifies an individual's specific capacities as well as incapacities related to decision-making. Such a detailed assessment would potentially be helpful in a guardianship proceeding in which decisions need to be made regarding full versus limited guardianship;
    b. An assessment process that identifies alternatives to guardianship, including potential supports or resources that would either allow an individual to make informed decisions or increase his/her ability to make informed decisions over time (e.g., education, information provided in alternative formats, etc.);
    c. A standard tool/process for identifying priority with regard to the need for guardianship; and
    d. Definition of the role of State and Facility staff in the guardianship process, including potentially completing assessments for use in guardianship proceedings, participating in guardianship proceedings, and assisting in the identification of potential guardians for consideration by the Court.
2. The State should provide the Facility(ies) with guidance regarding if or how information about an individual whom the team has determined is not able to make informed decisions can be shared with a potential guardian, while ensuring compliance with the Health Insurance Portability and Accountability Act, as well as other federal and state privacy laws.
3. Once the State policy is finalized, the State should provide key Facility staff with training on its implementation.
4. Once the State policy is finalized, LBSSLC should develop/modify its policy on guardianship to reflect the State policy.
5. Based on any additional information provided in State policy regarding prioritization for guardianship, LBSSLC should review the list that identifies individuals who need the support of a guardian, and re-prioritize the list, as needed.
6. LBSSLC should continue its diligent efforts to identify potential resources for guardians, as well as funding for the guardianship process.
7. The State should consider seeking or providing funding for a guardianship program in the Lubbock area that would be responsible for the identification, training, and oversight of guardians, such as those programs that are available in other parts of the state.

| SECTION V: Recordkeeping and General Plan Implementation | |
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| | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o DADS policy #020 entitled "Recordkeeping", dated 9/28/09;<br>o LBSSLC Record Maintenance Guidelines, revised 1/22/10;<br>o LSS – Communication Process: Recordkeeping policy, revised 1/27/09;<br>o Recordkeeping and General Plan Implementation Monthly Analysis for November 2009, December 2009, and January 2010; and<br>o Analysis POI V.1, 2nd Quarter 2009, September to November 2009, on recordkeeping<br>▪ **Interviews with**:<br>o Sherry Thomas, Director of Auxiliary Client Support Services; and<br>o Martha Castillo, Lead File Clerk |
| | **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| | **Summary of Monitor's Assessment:** At the time of the monitoring visit, the State was in the process of finalizing the Table of Contents for the unified record. The Records Management Department at LBSSLC reported being aware of a new Table of Contents for the records, but did not yet have a plan for converting the records to the new format. Staff indicated that they had gone through many similar conversions of records over the past several years.<br><br>Based on a review of the Recordkeeping and General Plan Implementation Monthly Analyses for November 2009 through January 2010, and a summary report for the second quarter of 2009 (September through November), the Facility was completing five record audits per month for these months. The information provided through these reviews was helpful information that should have been used to correct issues identified. It was unclear if this information was further analyzed, and action plans developed and implemented.<br><br>During the review, issues were noted with regard to the availability and quality of the individual records. This had the potential to impact staff 's ability to utilize records in making medical treatment and training decisions. Interestingly, the Facility's QE staff had identified some similar issues. Again, though, it was unclear that the QE reports resulted in actions being implemented to correct existing problems. |

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| V1 | Commencing within six months of the Effective Date hereof and with full implementation within four | At the time of the monitoring visit, the State was in the process of finalizing the Table of Contents for the unified record. The Records Management Department at LBSSLC reported being aware of a new Table of Contents for the records, but did not yet have a | |

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| | years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D. | plan for converting the records to the new format. Staff indicated that they had gone through many similar conversions of records over the past several years.<br><br>A review of the LBSSLC policy on recordkeeping, revised in 1/09, revealed that it contained many of the requirements of Appendix D of the SA. Once the State issues the new format for records, LBSSLC will need to review its recordkeeping policy to ensure it is consistent.<br><br>While on site, the Monitoring Team identified some issues related to individuals' records. Some of these are discussed below with regard to Section V.4 of the SA. The following provide additional examples of practices that were potentially inconsistent with Appendix D of the Settlement Agreement:<br>▪ An allegation was made to the Monitoring Team that information regarding the treatment of an individual had been falsified to potentially hide a failure to provide appropriate treatment. The Monitoring Team reported the alleged falsification of documentation to State Office staff for further investigation. Members of the Monitoring Team reported the allegation of potential neglect to the Abuse Hotline.<br>▪ Legibility is one of the requirements of Appendix D. As is discussed below with regard to Section I of the Health Care Guidelines, a review of a number of individuals' medical records indicated that there were some problematic issues with the legibility of some of the nursing and physician notes rendering some of them impossible to read. Most progress notes reviewed included the complete date and time. However, there were several instances in which it was difficult to identify the professional title of the staff who wrote a progress note due to legibility issues. In addition, some signatures were difficult to decipher. | |
| V2 | Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement. | As is discussed throughout this report, policies and procedures necessary to implement the SA were in various stages of development.<br><br>In reviewing policies, it was noted that many had not been reviewed for over a year, and in some cases for years. As a result, as is discussed in other sections of this report, the Facility policies often did not reflect requirements of the SA and/or HCG. There did not appear to be an expectation, or at least one that was enforced, that policies would be reviewed regularly, and updated as appropriate. It also was unclear if any review and approval process was in place, for example, by executive staff and/or State office staff to ensure the adequacy of policies and their consistency with State policy. | |
| V3 | Commencing within six months of the Effective Date hereof and with full implementation within three | Based on a review of the Recordkeeping and General Plan Implementation Monthly Analyses for November 2009 through January 2010, and a summary report for the second quarter of 2009 (September through November), the Facility was completing five | |

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| | years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence. | record audits per month for these months. This is an area that requires further review during upcoming monitoring visits. However, it appeared that the tool used to conduct the monitoring was designed to evaluate the presence or absence of items/documents required to be present in the records, and whether these items were up-to-date. The information provided through these reviews was helpful information that should have been used to correct issues identified. It was unclear if this information was further analyzed, and action plans developed and implemented.<br><br>Interestingly, some of the issues identified by Facility QE staff who conducted these reviews were similar to those identified by the Monitoring Team, and that are discussed in further detail below with regard to Section V.4 of the SA. For example, the summary report for the second quarter of 2009 revealed that a number of pieces of information relevant to ensuring that adequate treatment was being provided were missing. For example, the following is a summary of some of the pieces of information that the Facility Monitors found to be missing:<br>▪ Eleven out of 15 progress notes;<br>▪ Four out of five menstrual records;<br>▪ Ten out of 15 Health Maintenance observations;<br>▪ Four out of 15 neurological check forms;<br>▪ Six out of 10 physicians' orders; and<br>▪ Fourteen out of 15 "Client Identifying Data."<br><br>What the monitoring tool did not appear to assess was some of the other requirements of Appendix D, including issues such as legibility, completeness, proper dating and signature of entries, and procedures to limit the possibility of the falsification of data. This will be reviewed in further detail during the upcoming monitoring reviews. | |
| 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. | During the review, the following issues were noted with regard to the availability and quality of the records, and the impact on the ability of staff to utilize records in making medical treatment and training decisions:<br>▪ As noted with regard to Section M.1 of the SA, during the review, it was noted that a number of documents were not in the medical records, and had to be located since they were not timely filed. This was a consistent problematic issue throughout the review process while onsite. The Medical Director, Chief Nurse Executive, and the QE Nurse verified that there were on-going problems with record keeping, due to the lack of adequate staff assigned to file documents in the records. For example, a number of chest x-rays were not found in the records for individuals who had positive PPDs. In addition, an abdominal x-ray for Individual #232 was noted to have been taken on 2/24/2010. However, it was not filed in the medical record, nor did the PA who read the x-ray results | |

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| | | alert the team that the x-ray showed a metallic coin was in the lower quadrant of the individual's intestines, until 3/17/10. Consequently, there had been no assessment or interventions put in place for this individual for nearly one month. This oversight was identified during the week the Monitoring Team's visit to the Facility. Nursing staff called the Abuse Hotline to report it as alleged neglect. The Facility needs to ensure that documents are timely filed in the medical records so that pertinent clinical information is readily available to clinicians needing this information, when making decisions regarding treatments and health care services.<br>▪ Recording of data is a key part of recordkeeping, and the integrity of such data collection is key to the clinical decision-making process. In reviewing the collection of data for Behavioral Support Plans and skill acquisition goals, it was determined that the records in which data was collected were not consistently available to staff. Verbal reports suggested that, at times, direct support professionals did not have access to the "All About Me" book and, therefore, data was not collected as it was intended to be. Direct observation confirmed this, because these books appeared to be readily available in some settings, but not in others.<br>▪ Based on an interview with the Dentist, medical records were not consistently brought to the dental appointments. As is noted with regard to Section Q.1 of the SA, the Facility needs to develop and implement a system to ensure that medical records are brought for all dental appointments. | |

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

1. Facility management should ensure that the Records Management Department has the support it needs to complete the conversion of records to the new format as expediently and accurately as possible, so as to reduce the impact on the delivery of supports and services.
2. Once the State issues final guidance with regard to the new format for records, the Facility should review its recordkeeping policy to ensure consistency with the State policies, procedures, and Appendix D of the SA.
3. The State and Facility should consider recommendations regarding policies and procedures that are offered throughout this report as they develop and/or finalize policies and procedures.
4. If the monitoring of records does not yet include all of the elements of Appendix D, such as legibility and completeness of records, then modifications should be made to the tool(s) being used to incorporate these items.
5. Monitoring of records should result in action steps/plans to address individual as well as systemic issues as they are identified.
6. If one does not already exist, a procedure should be established for Facility policies to be reviewed regularly, and updated, as appropriate, and formally approved at the Facility-level and/or State-level. Such a review should be completed to ensure compliance with the Settlement Agreement, as well as applicable laws and regulations.
7. The Facility should ensure that documents are timely filed in the medical and programmatic records, so that pertinent clinical information is readily available to clinicians and others needing this information when making decisions regarding treatments and health care services. The Facility should determine if adequate staff supports are currently available to ensure the timely filing of records.

8. Taking into consideration the need for to protect the privacy and security of records, staff who need to have access to records for documentation or service coordination reasons should have easy access to such records.
9. The Facility needs to develop and implement a system to ensure that medical records are brought for all dental appointments.

## Health Care Guidelines

| SECTION I: Documentation |
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| **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o Individuals' medical records as noted in previous sections |
| **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| **Summary of Monitor's Assessment:** A review of a number of individuals' medical records indicated that there were some problematic issues with the legibility of some of the nursing and physician notes rendering some of them impossible to read. Most progress notes reviewed included the complete date and time. However, there were several instances in which it was difficult to identify the professional title of the staff who wrote a progress note due to legibility issues. In addition, some signatures were difficult to decipher. Also, the format of the progress notes was inconsistent regarding the use of the SOAP (Subjective, Objective, Assessment, and Plan), or DAP (Data, Assessment, and Plan) format. No inappropriate late entries were found in the records reviewed. Although there were a number of comprehensive and clear progress notes written by different disciplines, the communication between disciplines was not readily apparent from most of the notes reviewed. |

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

1. The disciplines should ensure that all entries in the medical records are legible, accurate and clearly written to facilitate effective interdisciplinary communication, and to provide a means of assessing and evaluating individual care. The full signature and professional title of the writer also needs to be legible.
2. The disciplines should document communications with the interdisciplinary team members to include the content of discussions, and any health care decisions or recommendations that result.
3. The disciplines should consistently document the content of integrated progress notes concerning health problems in the appropriate format selected by the Facility (i.e., SOAP or DAP).

| SECTION II: Seizure Management |
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| **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o Medical records for the following individuals: Individual #243, Individual #265, Individual #54, Individual #322, Individual #106, Individual #143, Individual #76, Individual #199, Individual #282, Individual #313, and Individual #16, and Individual #314 |
| **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| **Summary of Monitor's Assessment:** A review of the medical records for 12 individuals with seizure disorders found that there were a number of Seizure Records for each individual that were incomplete. Several dates were left off of the forms as well as the signatures of the staff that were completing the forms. In addition, a significant number of nursing assessments, and vital sign sections were either left blank or inadequately completed. Also, there was no place on the Facility's seizure record to record any precipitating factors or pre-ictal signs or symptoms as required by the Healthcare Guidelines. Most records, 10 out of 12 (83%) did not contain a graph of monthly seizure activity or a cumulative record of seizures that |

occurred each year. In addition, most of the nurses' notes in the medical records did not include adequate descriptions of the seizure activity or assessments of the individuals at the time and/or after the seizure activity.

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

1. A system should be developed and implemented to monitor the documentation requirements regarding seizure activity.
2. Training needs to be provided to nurses regarding the documentation requirements and assessment process regarding seizure activity.
3. Statewide forms for seizure documentation should be considered that are in alignment with the Healthcare Guidelines.

**SECTION III: Psychotropics/Positive Behavior Support**

**Steps Taken to Assess Compliance:** Please see the portions of the report that address Psychiatric Care and Services (Section J), and Psychological Care and Services (Section K).

**Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports.

**Summary of Monitor's Assessment:** Please see the portions of the report that address Psychiatric Care and Services (Section J), and Psychological Care and Services (Section K) for information related to the use of psychotropic medication and Positive Behavioral Support Plans.

**Recommendations:** Please see the recommendations for Section J and Section K of the Settlement Agreement.

**SECTION IV: Management of Acute Illness and Injury**

**Steps Taken to Assess Compliance:** Please see sections above that address Sections L and M of the Settlement Agreement.

**Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports.

**Summary of Monitor's Assessment:** Please see sections above that address Sections L and M of the Settlement Agreement.

**Recommendations:** No additional specific recommendations are offered at this time.

**SECTION V: Prevention**

**Steps Taken to Assess Compliance:** Please see sections above that address Sections L and M of the Settlement Agreement.

**Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports.

**Summary of Monitor's Assessment:** Please see sections above that address Sections L and M of the Settlement Agreement.

**Recommendations:** No additional specific recommendations are offered at this time.

| SECTION VI: Nutritional Management Planning |
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| **Steps Taken to Assess Compliance:** Please see sections above that address Section O of the Settlement Agreement. |
| **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| **Summary of Monitor's Assessment:** Please see sections above that address Section O of the Settlement Agreement. |

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| **Recommendations:** No additional specific recommendations are offered at this time. |

| SECTION VII: Management of Chronic Conditions |
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| **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o Individuals' Nursing Care Plans as noted in previous sections |
| **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| **Summary of Monitor's Assessment:** A review of Nursing Care Plans for chronic conditions such as Hepatitis, Congestive Heart Failure, constipation, seizures, and issues with skin integrity found that there was a significant lack of interventions addressing the prevention of complications related to the chronic conditions. In addition, assessments listed in the Nursing Care Plans were only focused on the signs and symptoms of the illness, not activities or interventions designed to relieve the particular symptoms of the chronic condition. In essence, the Nursing Care plans focused on illness rather than health promotion. |

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| **Recommendations**: The following recommendations are offered for consideration by the State and the Facility:<br>1. Nursing Care Plans' focus should shift from assessing for only illness to health promotion and proactive, preventive healthcare. |

| SECTION VIII: Physical Management |
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| **Steps Taken to Assess Compliance:** Please see sections above that address Sections O and P of the Settlement Agreement. |
| **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| **Summary of Monitor's Assessment:** Please see sections above that address Sections O and P of the Settlement Agreement. |

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| **Recommendations:** No additional specific recommendations are offered at this time. |

| SECTION IX: Pain Management |
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| **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o Nursing Quarterlies and Annual Assessments and Nursing Treatment Plans noted with regard to Section M of the SA. |
| **Facility Self-Assessment:** This is not applicable during the baseline reviews. It will be assessed in future reports. |
| **Summary of Monitor's Assessment:** The current practice regarding pain assessments at LBSSLC was to conduct an assessment every quarter on the Nursing Quarterly Assessments. However, in most cases this assessment indicated that the individual was not experiencing pain at the time of the assessment. In order to assess if the Facility is appropriately assessing and managing the issue of pain, the Facility needs to develop and implement a system to track individuals who experience chronic and acute pain so that these individuals can be reviewed for compliance with the Healthcare Guidelines that address pain management. |

| **Recommendations:** The following recommendations are offered for consideration by the State and the Facility: |
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| 1. The Facility should consider developing and implementing a system to monitor and track individuals who experience both chronic and acute pain in order to assess clinical care and outcomes regarding pain management and compliance with the Healthcare Guidelines. |

**List of Acronyms**

| Acronym | Meaning |
|---|---|
| AAC | Alternative or Augmentative Communication |
| ABA | Applied Behavior Analysis |
| ABC | Antecedent-Behavior-Consequence |
| ADR | Adverse Drug Reaction |
| A/N/E | Abuse/Neglect/Exploitation |
| AP | Alleged Perpetrator |
| APC | Admissions/Placement Coordinator |
| APS | Adult Protective Services |
| ARNP | Advanced Registered Nurse Practitioner |
| AT | Alternative Technology |
| BCABA | Board Certified Assistant Behavior Analyst |
| BCBA | Board Certified Behavior Analyst |
| BID | Twice a Day |
| BM | Bowel Movement |
| BMI | Body Mass Index |
| BSC | Behavior Support Committee |
| BSP | Behavior Support Plan |
| cc | Cubic Centimeter |
| CCC | Certificate of Clinical Competence |
| CDC | Centers for Disease Control |
| CLDP | Community Living Discharge Plan |
| CLOIP | Community Living Options Information Process |
| CMS | Centers for Medicare and Medicaid |
| CNE | Chief Nursing Executive |
| COTA | Certified Occupational Therapy Assistant |
| CRIPA | Civil Rights of Institutionalized Persons Act |
| DADS | Texas Department of Aging and Disability Services |
| DAP | Data, Assessment, and Plan |
| DFPS | Department of Family and Protective Services |
| DISCUS | Dyskinesia Identification System: Condensed User Scale |
| DNR | Do Not Resuscitate |
| DOJ | United States Department of Justice |
| DRR | Drug Regimen Reviews |
| DSHS | Department of State Health Services |
| DSM | Diagnostic and Statistical Manual |
| DSP | Direct Support Professional |
| DUE | Drug Utilization Evaluation |
| DWR | Desired Weight Range |
| E.coli | Escherichia coli |

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|---|---|
| ECU | Environmental Control Unit |
| EEG | Electroencephalogram |
| EGDs | Esophagogaastroduodenoscopies |
| ENT | Ear, Nose and Throat |
| ER | Emergency Room |
| FA | Functional Analysis |
| FAST | Functional Analysis Screening Tool |
| FTE | Full-time Equivalent |
| GERD | Gastroesophageal Reflux Disease |
| GI | Gastrointestinal |
| G-tube | Gastrostomy Tube |
| HCG | Health Care Guidelines |
| HIV | Human Immunodeficiency Virus |
| HRC | Human Rights Committee |
| HSM | Health Status Meeting |
| HST | Health Status Team |
| IC | Infection Control |
| ICAP | Inventory for Client and Agency Planning |
| ICF/MR | Intermediate Care Facility for Persons with Mental Retardation |
| IDT | Interdisciplinary Team |
| IM | Intramuscular |
| IMC | Incident Management Coordinator |
| IMRT | Incident Management Review Team |
| IPN | Integrated Progress Notes |
| IV | Intravenous |
| J-tube | Jejunostomy Tube |
| LAR | Legally Authorized Representative |
| LBSSLC | Lubbock State Supported Living Center |
| LODR | Living Options Discussion Record |
| LRA | Labor Relations Alternatives |
| LSS | Lubbock State School |
| LVN | Licensed Vocational Nurse |
| MAR | Medication Administration Record |
| MAS | Motivation Assessment Tool |
| MBS(S) | Modified Barium Swallow Study |
| MD | Medical Doctor |
| mg | Milligram |
| MH | Mental Health |
| MHMR | Mental Health/Mental Retardation |
| MOSES | Monitoring of Side Effects Scale |
| MR | Mental Retardation |
| MRA | Mental Retardation Authority |

| | |
|---|---|
| MRSA | Methicillin-resistant Staphylococcus aureus |
| NM | Nutritional Management |
| NMT | Nutritional Management Team |
| NP | Nurse Practitioner |
| NPO | Nothing by Mouth |
| O&M | Orientation and Mobility |
| OIG | Office of Inspector General |
| OT(R) | Occupational Therapist |
| PA | Physician Assistant |
| PALS | Positive Adaptive Living Skills |
| PBSP | Positive Behavior Support Plan |
| PCP | Primary Care Provider |
| PEG | Percutaneous Endoscopic Gastrostomy |
| PFW | Personal Focus Worksheet |
| PMAB | Prevention and Management of Aggressive Behavior |
| PNMT | Physical Nutritional Management Team |
| PNM | Physical and Nutritional Management |
| PNMP | Physical and Nutritional Management Plan |
| PO | By mouth |
| PP | Permanency Plan |
| PPD | Purified Protein Derivative |
| PRN | Pro re nata (as needed) |
| PSP | Personal Support Plan |
| PSPA | Personal Support Plan Addendum |
| PST | Personal Support Team |
| PT | Physical Therapist |
| PTA | Physical Therapist Aide |
| PFW | Personal Focus Worksheet |
| QA | Quality Assurance |
| QAM | Every morning |
| QE | Quality Enhancement |
| QMRP | Qualified Mental Retardation Professional |
| RC | Residential Coordinator |
| RD | Registered Dietician |
| RN | Registered Nurse |
| RNP | Registered Nurse Practitioner |
| RWR | Recommended Weight Range |
| SA | Settlement Agreement in U.S. v. Texas |
| SAMS | Self-Administration of Medications |
| SFBA | Structural and Functional Behavior Assessment |
| SGA | Second-generation Antipsychotic |
| SIB | Self-Injurious Behavior |

| | |
|---|---|
| SLP | Speech and Language Pathologist |
| SOAP | Subjective, Objective, Assessment and Plan |
| SPCI | Safety Plans for Crisis Intervention |
| SPO | Specific Program Objective |
| SSLC | State Supported Living Center |
| SSO | Staff Service Objective |
| STAT | Immediately or Without Delay |
| STD | Sexually-transmitted disease |
| TID | Three times a day |
| TIMA | Texas Implementation of Medical Algorithms |
| TMAP | Texas Medical Algorithm Project |
| TST | Tuberculin Skin Test |
| UTI | Urinary Tract Infection |
| VNS | Vagus Nerve Stimulators |
| VRI | Viral Respiratory Infection |