United States v. State of Texas

Monitoring Team Report

Lufkin State Supported Living Center

Dates of Onsite Review: October 18-22, 2010

Date of Report: December 14, 2010

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Table of Contents

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 or her every six months, and detailing his or 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 were considered baseline reviews. Compliance reviews began in July 2010, and are intended to inform the parties of the Facilities' status of compliance with the SA. This report provides the results of a compliance review of the State Supported Living Center.

In order to conduct reviews of each of the areas of the Settlement Agreement and Health Care Guidelines, each Monitor has engaged an expert team. These teams generally include consultants with expertise in psychiatry, 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 the 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 the report for a section for which another team member had primary responsibility. For this review, the following Monitoring Team members had primary responsibility for reviewing the following areas: Teri Towe reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, integrated protections, services, treatments and supports, at-risk procedures, and consent; Carolyn Smith

reviewed nursing care; Helen Badie reviewed medical services, dental services, and pharmacy and safe medication practices; Daphne Glindmeyer reviewed psychiatry services; Gary Pace reviewed psychological care and services, restraint, and habilitation, training, education, and skill acquisition programming; Carly Crawford reviewed minimum common elements of physical and nutritional supports as well as physical and occupational therapy, and communication supports; and Alan Harchik reviewed serving individuals in the most integrated setting, record keeping, and quality assurance. 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, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review.

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. 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 review. The Monitoring Team made additional requests for documents while onsite.

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 discharge plans (CLDPs), 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 onsite, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. 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.

III. Organization of Report – The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement.

The report 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, the report includes the following sub-sections:

(a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
(b) **Facility Self-Assessment:** No later than 14 calendar days prior to each visit, the facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the SA. This section describes the self-assessment steps the Facility took to assess compliance, and the results, thereof;
(c) **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;
(d) **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 noncompliance, steps that have been taken by the facility to move toward compliance, obstacles that appear to be impeding the facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;
(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; and
(f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. 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. It is in the State's discretion, however, to adopt a recommendation or use 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, as Individual #45, Individual #101, and so on). 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

First, the monitoring team wishes to again acknowledge and thank the individuals, staff, clinicians, managers, and administrators at LSSLC for their openness and responsiveness to the many activities, requests, and schedule disruptions caused by the onsite monitoring review. Moreover, the facility made a number of staff members available to the monitoring team in order to facilitate the many activities of the monitoring team, including setting up appointments and meetings, obtaining documents, and answering many questions regarding facility operations.

The facility director, Gale Wasson, set the tone for the week of the onsite review. She was readily available, ensured that all requested information was obtained, and directed all of the staff to work cooperatively and openly with the monitoring team. The monitoring team was especially appreciative of the efforts of the Settlement Agreement Coordinators, Nikki Yost and Sherry Roark. They worked tirelessly during the week of the onsite review (as well as during the weeks immediately proceeding and following the onsite review) to ensure that the monitoring team members were able to obtain the information they needed to conduct this review.

As a result, a great deal of information was obtained, as evidenced by this lengthy and detailed report. Numerous records were reviewed, observations were conducted, and interviews were held. Specific information regarding many individuals is included in this report. It is the hope of the monitoring team that the information and recommendations contained in this report are both credible and helpful to the facility.

Second, the monitoring team found management, clinical, and direct care professionals eager to learn and to improve upon what they did each day to support the individuals at LSSLC. Many positive interactions occurred between staff and monitoring team members during the weeklong onsite review. All monitoring team members had numerous opportunities to provide observations, comments, feedback, and suggestions to managers. It is hoped that some of these ideas and suggestions, as well as those in this report, will assist LSSLC in meeting the many requirements of the Settlement Agreement.

Third, this was the first post-baseline review of LSSLC. These reviews are called compliance reviews and this is a report of the compliance review, that is, of the facility's status in complying with the requirements of the Settlement Agreement.

In addition, the Settlement Agreement requires the facility to complete a self-assessment, and to submit it to the Monitor 14 days prior to the onsite review. In the monitoring report, the Monitor is to describe and comment upon the self-assessment steps the facility undertook to assess compliance and the results of this self-assessment. At LSSLC, the self-assessment consisted of two documents called the Plan of Improvement (POI) and Supplemental Plan of Improvement (SPOI). These were submitted to the Monitor within the required timeframes. The POI described the many actions the facility had taken, or planned to take regarding each provision of the Settlement Agreement. The SPOI described the facility's response to each of the recommendations in the baseline report. The Monitoring Panel and the parties have had a number of discussions regarding the POI and SPOI. As a result, a number of revisions and additions are going to be put in place for future POIs and SPOIs because in its current version, the documents did not provide the Monitor with sufficient detail regarding the facility's actions (e.g., number of cases reviewed, criterion used). A draft version of a new POI was circulated and it appeared that the revised format would allow the facility to describe its

progress specific to each provision and provision item, detail the actions it planned to take, and respond to recommendations and suggestions from the monitoring team.

Fourth, a brief summary regarding each of the Settlement Agreement provisions is provided below. Details, examples, and a full understanding of the context of the monitoring of each of these provisions can only be more fully understood with a reading of the corresponding report section in its entirety.

Restraints

- LSSLC's restraint trend analysis indicated that there had been 322 restraints at the facility from January 2010 through August 2010. There had been 95 total restraint incidents at the facility during the quarter prior to the monitoring visit (FY10 4th quarter). This was a decrease of 32% when compared with the previous quarter. Of the 95 restraints for the last quarter, 73% were medical restraints (69), 13% were emergency restraints (12), 9% were programmatic restraints (9), and 5% protective restraints (5). Trending of data indicated that there had been an overall reduction in the use of restraints at the facility since last year. The facility was still struggling with the classification of restraint types and data were not clear on what types of restraints were being used for what purpose, particularly in regards to self-injurious behavior. Observation during the monitoring visit indicated that many individuals restrained to prevent self-injurious behaviors spent a large portion of the day not engaged in activity, even though staffing levels had been increased for those individuals. The increased staffing levels appeared to be in place to intervene when the behavior occurred rather than to offer additional interaction for replacement behaviors. There were many meetings frequently held at the facility to address restraint incidents, including PST meetings for individuals involved in restraints, Restraint Reduction Committee meetings, daily incident management meetings, morning unit meetings, and Human Rights Committee (HRC) meetings. Most of these meetings were attended by an appropriate interdisciplinary team. The facility did not have a fully developed Human Rights Committee. This did not allow for informed discussion around rights and restrictions for each individual. Restraint data and trend information were not being used at the facility to develop specific strategies for reducing restraints. While there was considerable focus by the facility on tracking and trending restraints used for crisis intervention, there was less information and data available on the use of protective and medical restraints.

Abuse, Neglect, and Incident Management

- According to a log of investigations provided to the monitoring team, 105 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility from 1/1/10 through 9/21/10. Of these 105 allegations, seven (7%) were confirmed by DFPS. This included three confirmed allegations of physical abuse, two confirmed allegations of neglect, and two confirmed allegations of verbal or emotional abuse. Fifteen additional investigations were found to be inconclusive, indicating that there was not enough evidence available to

determine whether or not abuse or neglect had occurred. There were 3,016 injuries reported at the facility from January 2010 through August 2010 (1,073 occurred in the 4th quarter). This was a decrease of 8% from the 4th quarter in FY09 and a decrease of 16% from the 3rd quarter of FY10. The top three causes of injuries were bumping into something (189), scratches (160), and slips/trips/falls (132), and there had been 24 serious injuries. The facility needs to trend injuries by cause and implement injury prevention strategies, when possible. When trends are identified, such as the 33 injuries attributed to lifting/transfers, the facility should address these injuries with a plan of correction. Video surveillance cameras had been installed in common areas throughout the facility since the baseline monitoring visit. A review of incident investigations indicated evidence from the surveillance cameras was being used in only few investigations. It was a concern that the facility director was the only staff person at the facility allowed to review video evidence. According to the Risk Manager and Facility Investigator, investigators completing reports were not able to view evidence first hand to confirm or deny witness statements or gather additional information. The video was reviewed by the Facility Director and the investigator was given a written statement of findings.

Quality Assurance

- Little activity had occurred since the baseline monitoring review. There were plans to revise the overall QA program at the facility and across the state. This included the creation of a Quality Assurance and Quality Improvement Committee (to replace the PIC) and the contracting with an outside vendor to develop a QA program at each facility. An adequate, comprehensive quality assurance plan did not exist. Facility-wide data were not directed to the QA department. Regular reports were not completed by the QA department for use by senior management. Even so, a number of QA-related activities continued to occur at LSSLC, including the observation and monitoring of various areas by department staff across the facility. The data, however, were not organized under a QA plan as to what data should be collected by QA staff, what data should be submitted by facility departments to the QA department, and how those data should be handled once submitted. QA staff had engaged in many activities to integrate their work into the overall operation of the facility and to have the QA department become known to staff and to be seen in a positive light. This included the distribution of Thank You notes to staff observed doing a good job, a weekly drawing for a small prize, a monthly one-page newsletter, and a weekly meeting of QA staff to discuss the prior week's activities and successes. Initial attempts at CAPs were seen at the facility. There appeared to be confusion, however, between CAPs, PETs, and PITs. This will require some attention from facility management and, perhaps, DADS central office. Self-advocacy activities remained weak. Little had occurred since the baseline monitoring review. A new rights protection officer had recently been assigned at the facility.

Integrated Protections, Services, Treatment, and Support

- A new DADS policy for this section had been revised and approved 7/10/10, though QMRPs had only recently completed training on the new procedure. Most of the PSPs reviewed for compliance with this provision were dated prior to the approved policy revision and subsequent changes in PSP format, therefore, the monitoring team was unable to fully assess implementation of the new policies and procedures for compliance with this provision. QMRPs had attended training on developing these new style person centered plans. They were just beginning to implement the new process at annual PSP meetings. Four PSP meetings were observed the week of the monitoring visit. For all QMRPs facilitating the meetings, it was only their first or second time to facilitate PST meetings using the new format. As expected, the meeting format was noticeably uncomfortable for the QMRPs and the other team members. On the other hand, a family member at one of the meetings stated at the end of the meeting that this was the best team meeting she had ever attended. She felt that she was more involved in the discussion around the needs of her brother and less time was spent reviewing information. In two of the meetings observed, it was noted that the QMRP attempted to facilitate open discussion around the individual's likes, dislikes, and preferences. Team members contributed to the discussion and, in both meetings, a fairly comprehensive list of what the individual wanted in his or her life was developed, however, it was not clear that this led to person centered outcome development. After much discussion around the interest and needed supports for Individual #140, the meeting ended with no discussion specific to what outcomes would be worked on during the upcoming year. The PSPs reviewed included a list of "What's most important to the person?" For the majority of plans reviewed, this list was individualized, fairly comprehensive, and offered a good starting point for plan development. It was not evident that this list was always the central focus in planning for the person.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- State policies were not developed or implemented at the time of the onsite review to address this provision of the Settlement Agreement. Even so, some activities were occurring at LSSLC. Medical and clinical staff were beginning to work towards meeting what they considered to be the criteria of this provision further highlighting the need for state policy to provide guidance and direction to the facility. The facility had identified the medical director and the chief nurse executive as the lead managers for these provisions of the Settlement Agreement, and a number of activities had occurred regarding this provision item since the baseline review. Clinicians across the facility were becoming familiar with this provision. A number of examples of ways in which LSSLC was working towards a greater integration of clinical services, as well as examples of areas in which integration was not occurring, are presented below in sections G and H. It is likely that a specific focus to ensure that all areas of clinical service provision as specified in both provisions are included in the facility's provision of integrated clinical services. It is recommended that the facility's QA play a role in addressing this provision.

At-Risk Individuals

- LSSLC's rating forms allowed individuals who were at risk to be rated low if plans were in place to address specific risk. This practice did not alert staff that individuals at risk needed to be monitored more frequently for signs and symptoms of risk. Further, plans addressing risk were often not sufficient or were not monitored adequately placing the individual at risk, even with a plan in place. Risk levels often conflicted with information included in the PSP by specific disciplines. Comprehensive risk reviews that considered and analyzed influencing factors contributing to each risk area needed to be completed. All staff needed to be aware of and trained on identifying crisis indicators. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual. Revisions to the At Risk Individuals policy was under revision at the time of the review and changes to the system at LSSLC were reported to be on hold pending the final policy. LSSLC's Health Status Team (HST) Coordinator was scheduling and conducting meetings according to the policy. An HST meeting was observed. There was minimal discussion among team members regarding supports and services needed to address risk factors for individuals. Accurate risk levels were not being assigned through this process. The monitoring team provided input at the HST meeting to clarify the purpose of risk identification and assigning accurate ratings. The committee revised their assessment process on the spot and expanded discussion on risk ratings at the meeting.

Psychiatric Care and Services

- Four psychiatrists accounted for 2.25 full-time equivalents (FTE). They were qualified by virtue of their board eligibility/certification status to provide services at LSSLC. One physician had been designated as the director of psychiatry. A primary goal must be to recruit and retain psychiatrists, such that the psychiatric program can be expanded to provide clinical services that are integrated with other disciplines. The current psychiatric physicians had integrated themselves well with the primary care physicians. There was a morning meeting where all physicians met to review the cases of individuals who were currently admitted to the hospital or to the facility infirmary. Some duties that should fall in the realm of psychiatry were being provided by psychology (e.g., informed consent and risk/benefit analysis for psychotropic medications). Also, there were areas where psychology could be more integrated with psychiatry (e.g., identification of target symptoms, data collection, collaboration regarding case formulation). The staff from both disciplines were aware of the challenges and the need for increased structure and integration, however, they were also aware of the manpower shortage and history of a lack of clinical resources in psychiatry, which did not lend itself to close collaboration. What was most striking during the onsite review, was that staff overall were caring and invested in the treatment of the individual and had the desire to see the individual benefit from treatment. It was also apparent that the teams had been functioning for so long in the absence of psychiatry (due to the lack of clinical resources), that it was difficult for them to even consider psychiatry as a part of the team. This was evident in some clinical and team

observations. Over time, psychiatry staff will need to establish themselves as a viable department and establish themselves as a viable member of the individual's treatment team.

Psychological Care and Services

- Progress was observed in several of the provision items. For example, there was a substantial increase in the number of psychologists enrolled in coursework toward the Board Certified Behavior Analyst (BCBA) certification (K1) and the facility had hired a qualified director of psychology (K2) who had been working for about four months at the time of this onsite review. In addition, the facility had established an internal peer review (K3), added flexibility to the data system (K4), developed a new psychological evaluation format, and improved the overall quality of Positive Behavior Support Plans (K9). Some other areas had not shown progress and required more immediate attention. These included the need for a plan to be developed to ensure that those psychologists not enrolled in BCBA coursework, or eligible to sit for the exam, either receive the training and experience necessary to write effective positive behavior support plans, or are reassigned to duties that do not include the writing of PBSPs (K1). In addition, LSSLC needed to more closely manage peer review meetings to increase the number of individuals discussed at each meeting (K3), modify the current ABC data system (K4), and graph target and replacement behaviors at increments sufficient to make data-based treatment decisions (K4).

Medical Care

- The medical department had made little progress since the baseline review. The medical director reported that the facility had been waiting on guidance from state office. Since the DADS policy on medical was released in July 2010, the facility had greater clarity on how to proceed. The medical department was in the process of implementing the Health Care Guidelines. The most notable need for improvement was seen in physician assessments, follow-up of acute and chronic medical problems, and post-hospital evaluations. No external review of medical services had been completed and there was no formal medical quality program in place. The medical director had developed some audit tools to assess compliance with standards of care. He provided a copy of the diabetes audit tool that assessed compliance with the American Diabetes Associations guidelines for care. No aggregate data resulting from these audits were available. Policies and procedures based on state issued medical policy and the Health Care Guidelines had not been developed. The medical director reported that the medical manual was outdated. The medical director was confident that, with a recent reduction in his caseload, he would have time to devote to addressing the provisions of the Settlement Agreement.

Nursing Care

- During the conduct of this review, 20 individuals were visited, and their records were reviewed. In general, recordkeeping practices were improved from the baseline monitoring review. Physicians were generally

notified of significant changes in their health status and needs, and/or when they needed to be seen, usually within less than 24 hours, by their physician or nurse practitioner. During medication administration observations, nurses properly washed and disinfected their hands, identified the individuals receiving medications, appropriately thickened liquids, and they did not initial medications on the MAR prior to the individuals' receipt of the medications. There were several areas of medication administration practice, however, that did not meet acceptable professional standards, such as timely administration and appropriate follow-up for response to treatment with PRN medications. During the week of this review, a new distribution system was initiated. The effectiveness of these changes to a system that was identified as highly flawed at the time of the baseline review will require further review and evaluation. Nurses continued to check each individual order against the week's supply and handwrite any variance onto the physician's order on the MAR. All 20 individuals reviewed had annual and quarterly nursing assessments filed in their records. Problems, however, were noted with the conduct of nursing assessment, diagnosis, planning, implementation of planned interventions, and evaluation of plans. Comprehensive documentation in the individuals' records of their significant changes in health status from identification to resolution was inconsistent and incomplete. The 20 individuals reviewed had some or all of their health needs and risks referenced by Health Management Plans (HMPs) and Acute Health Care Plans (ACPs). The plans were generally generic and more appropriate for acute episodes than for individualized long term management of a health risk or problem. A number of monitoring and training efforts were underway, including a new Program Compliance Coordinator position in the nursing department to address monitoring and follow-up for targeted areas addressed in the Texas Health Monitoring Tools that were related to nursing services. Adequate nursing staffing to meet the needs of an aging population of individuals with more frequent and severe chronic health problems and associated acute episodes remained a significant issue.

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

- The facility demonstrated progress in several areas. Drug regimen reviews had been completed in a timely manner as well as the MOSES and DISCUS scales. Work was needed to improve the actual content of these tools in order for them to become even more clinically relevant. Primary care providers were not responding appropriately to information contained in these documents. The adverse drug reporting system was lacking tools to provide an objective determination of the occurrence of an adverse drug reaction. Only two reports were submitted over the span of a year and the system had not been fully developed. The pharmacy department appeared to complete all required components in the process of filling medication orders, but had no documentary evidence to support compliance. Medication errors were being reported and corrective actions were documented. The focus on the causes of errors was individual employees. Little attention had been given to how the current systems contribute to employee error. This resulted in multiple employees having similar types of errors.

Physical and Nutritional Management

- The process used to establish health risks continued to be inconsistent across the HST and NMT. A new system for risk assessment had been developed, but was not yet in place. Current assessment was not specifically driven by level of health risks. These were discipline-specific assessments with the exception of the OT/PT assessments, and little collaboration at the time of assessment was noted among professional staff for any individual, and especially for those at highest risk. PNMPs and Dining Plans were developed by the QMRPs in most of the homes at LSSLC based on findings documented in the OT/PT and communication assessments. Based on observations of individuals during meals across a variety of homes, there continued to be concerns for staff implementation of interventions and recommendations outlined in the mealtime plan portion of the PNMP. Primary concerns for positioning and alignment were also noted and related to staff not positioning the pelvis back in the seat, posterior tilt of pelvis, and inadequate foot support. There was no mechanism to ensure that staff training occurred as outlined in the training plans when not conducted by Habilitation Therapies staff. The training for supervisors and home managers will be critical as it was observed that these staff did not consistently provide oversight and coaching for the direct support staff they were responsible for. Monitoring was conducted to address mealtimes, as well as communication, transfers, and positioning in the homes. No monitoring was completed related to bathing, medication administration, or oral hygiene. The NMT did not specifically review aggregated findings across homes for trend analysis to drive system change and training. There was no system in place to conduct trend analysis to consistently review if interventions had a positive outcome on an individual's health status. They also did not review overall incidence of health concerns such as aspiration pneumonia, use of bowel management aides, weight loss/gain, falls, fractures, and so forth over time to address system outcomes as a result of interventions and supports.

Physical and Occupational Therapy

- Staffing levels had increased since the previous review with the addition of a PT and a new PTA. There were 15 therapy technicians who were assigned to assist in the wheelchair shop, take pictures for plans, implement therapy programs, assist the audiologist, and provide staff training. There were nine PNMPCs who provided monitoring and staff training. The training programs for these staff were under revision to identify specific competencies for PNM-related areas such as mealtime, alignment and positioning. All of the assessments reviewed described individuals with movement disorders and limitations in self-care and/or functional skills. There were 322 individuals identified with PNM needs by the department, however, it was noted that only four individuals received direct physical therapy treatment and five who received OT services. Others participated in range of movement-based interventions provided by therapy technicians. Many others received only indirect supports via annual assessments, PNMPs, or dining plans. There was no data system used to track completion of assessments submitted. These assessments were not generally comprehensive and did not address specific risk

issues or provide adequate analysis or rationale for interventions and recommendations. Though equipment generally was available, implementation of plans by staff was not consistent as intended per the PNMP. A number of individuals were observed sitting with a posterior tilt, loose seatbelt, or pelvis not well back into the seat of their wheelchair. In a number of cases, the plans did not provide staff with visual cues regarding the appropriate position and alignment for individuals. Measureable goals were uncommon in the design of most of the plans and, as a result, there was little in the documentation to quantify progress or regression. There was no policy or guidelines to address the monitoring process completed by therapists or PNMPCs. There was no tracking system to analyze and report findings to drive needed staff training and to ensure system change as indicated.

Dental Services

- Record reviews indicated the individuals received a variety of services in the dental clinic. Problems were identified in the areas of missed appointments and refusals, but there was no comprehensive strategy in place to address the issue of missed appointments. Oral hygiene care in the homes was problematic as individuals were frequently seen in clinic with heavy calculus accumulation. The facility had a substantial number of individuals with poor oral hygiene ratings, but no systemic interventions were implemented. Desensitization plans were being written by the dental hygienist without meaningful input from the psychology department. Individuals appeared to receive HRC approval to undergo general anesthesia for routine exams and cleanings.

Communication

- The major focus of the department in the last six months had been to prioritize and organize clinician caseloads. The level of professional staffing had essentially remained unchanged since the baseline review. The clinicians had begun work on their Master Plan to appropriately prioritize individuals for assessment. This plan had not, however, considered those with behavioral concerns as required by the Settlement Agreement. Based on review of communication assessments submitted for 32 individuals, at least 82% of these assessments identified individuals with significant expressive and/or receptive language deficits. Per the AAC database submitted, there were approximately 63 individuals listed with some type of AAC system, though over 50% were limited to a community poster only. Another 67 individuals were recommended for some type of equipment per the database, but these had not been issued. Approximately 40 of these were recommended for an environmental switch rather than a communication based system. The speech clinicians had initiated some pilot groups with a focus on the development of communication skills and social interaction, including a coffee group and a music group. Based on review of the PNMP monitoring sheets submitted, it appeared that at times, the monitors were marking the sheets without regard to the actual communication supports and programs provided to the individual and as such was ineffective to assess the consistency of implementation of those AAC systems currently issued to individuals.

Habilitation, Training, Education, and Skill Acquisition Programs

- This provision incorporates a wide variety of aspects of programming including skill acquisition, engagement in activities, and staff training. To assess compliance with this provision, the monitoring team looked at the entire process of habilitation and engagement. The facility was awaiting the development and distribution of a new policy in this area. It is expected that the policy will provide direction and guidance to the facility. Although no items of this provision were found to be in substantial compliance, the facility was making progress in several areas, including the addition of graphing of skill acquisition plans (SAPs), increasing the number of SAPs for dental desensitization and replacement behaviors, and the development of an engagement tool. Many of these improvements were too new to be fully evaluated by the monitoring team and will be reviewed in future reviews. Some improvements were also seen in the amount of educational services provided to individuals though a number of concerns remained.

Most Integrated Setting Practices

- More individuals (eight) had been placed in the community and more individuals (25) were on the referral list compared to six months prior to this review. Nevertheless, the number of individuals placed in the community was a relatively small percentage of the LSSLC population, that is, only 2.5% of the individuals over the past 12 months. The 25 individuals on the current list represented more than 6% of the population. Little progress had been made in areas, such as the determination of needed supports, the identification of obstacles, and the identification and definition of essential and nonessential supports. Some progress, however, was noted in the describing of evidence required to indicate the presence of a support. Four new-style annual PSP meetings were observed by the monitoring team. The new process appeared to have the potential to improve the depth and breadth of discussion regarding optimistic optimal living characteristics for each individual, however, they were not yet accomplishing this goal. QMRPs need to become more fluent with this new process and would benefit from training in how to facilitate and lead these types of meetings. The facility had engaged in each of the five educational activities listed in the DADS policy. LSSLC should consider ways of making the provider fair more effective and more work should be done on the system of community tours (though there had been progress made since the baseline review), and self-advocacy groups should be used as an opportunity to educate individuals about community placement. The CLDP process was also being revised. Comments are provided in section T below. A continuing problem was the inclusion of individualized and meaningful essential and nonessential supports within the CLDP. Post move monitoring was occurring as per the required schedule. There continued to be a need for more detailed descriptions of essential and nonessential supports, so that they could be observed and so that the post-move monitor would know what was required to indicate evidence of the presence of the support. A visit by the monitoring team to a home where post-move monitoring had occurred resulted in the identification of serious concerns about the placement. This led to state and facility involvement

and a change in provider and placement. Specific quality assurance procedures were not in place (see section E above), however, admissions and placement staff, as well as one QA staff member, had recently begun to complete monitoring tools regarding some of their work.

Consent

- Although the facility had made minimal progress on prioritizing a list of individuals who needed guardians, there had been some activity around recruiting guardians at the facility. Since the baseline review, LSSLC had conducted Parent Association Meetings to educate parents on the guardianship process. A judge presented information to parents at a meeting on 7/31/10 on the responsibilities, process, and cost of obtaining guardianship. Additionally, a letter had gone out to all families encouraging them to pursue guardianship. The letter provided contact information for social workers at the facility that could assist them with guardianship issues. According to the Director of Individual and Family Relations, there were 14 families activity pursuing guardianship at the time of the monitoring visit. Five individuals at the facility had acquired guardians since 4/18/10.

Recordkeeping and General Plan Implementation

- The new policy and record keeping practices were implemented across the facility. The unified record for every individual was created, including a reformatted active record and a brand new individual notebook. The unified records consisted of a multi-volume active record, an individual notebook, a master record of historical and legal documents, and an overflow record of thinned and purged materials that were stored for future use if needed. The new records followed the state's policy. The active records and individual notebooks were organized according to the required format. A master record existed for each individual, but it appeared to contain a lot of information that was not, and should not be, in a master record, such as numerous PSPs and assessments. Other recommendations for modifications to the records include addressing inconsistencies across individual's active records, such as by determining what should be in the record sections for consent, habilitation, and skills assessments, as well as assessing the individual notebooks for duplication (e.g., PNMPs) and unnecessary components (e.g., activity schedules). Comments from staff at all levels indicated an overall satisfaction with the new recordkeeping practices. Many staff liked the new individual notebooks and found them to be useful and easier to use than the previous systems. Medical staff, however, noted that sometimes needed information had been purged from the active record and that, at other times, important information was with the individual in his or her individual notebook and not available to them when needed, such as to review the most current seizure information. Thirteen record audits had been completed. Useful information was obtained during these audits. A system, however, was needed to ensure that corrections were made to the records based on the audits. Further, an additional audit tool was needed to ensure that all contents of all components of the record were audited. LSSLC should ensure that record keeping is tied into the facility's quality assurance program and that

quality assurance activities occur related to record keeping. Moreover, it will be important for LSSLC to obtain feedback and suggestions from those who use the records regularly in order to make relevant and useful changes to the record keeping system.

The comments in this executive summary were meant to highlight some of the more salient aspects of this status review of LSSLC. The monitoring team hopes that the comments throughout this report are useful to the facility as it works towards meeting the many requirements of the Settlement Agreement.

The monitoring team continues to look forward to continuing to work with DADS, DOJ, and LSSLC.
Thank you for the opportunity to present this report.

V. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints

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:

Documents Reviewed:

- DADS Use of Restraint Policy #001, dated 8/31/09
- DADS Administration of Chemical Restraint Consult Form
- DADS Restraint Checklist Form, numbered 06032010R
- DADS Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint
- LSSLC Dental/Medical Sedation and Restraint Procedure, dated 7/16/10
- LSSLC Restraint Implementation Procedures, dated 7/1/09
- LSSLC Restraint List 3/1/2010 – 9/7/2010
- FY10 3rd Quarter Restraint Trend Analysis
- Training Curriculum: Use of Restraint in a Behavioral Crisis dated 09/09
- Training transcripts for eight direct support staff and the following four restraint monitors:
  - Patricia Husband, Michael Thigpen, Lucy Logan, Brenda Vansickle
- List of all individuals with safety plans
- List of all medical and dental restraints since 3/1/10
- List of all chemical restraints used since 3/1/10
- Incident Management Team meeting minutes 6/1/10-8/30/10
- List of individuals with medical and/or dental desensitization plans
- The following individual documentation in regards to 48 restraint incidents over the past six months:

Individual	Date/Type	Restraint Checklist	QA Audit of Restraint	PSP Addendum(A)	PBSP	Safety Plan
#600	7/23/10 Physical	x		1/12/10 4/9/10(A) 4/14/10(A) 4/16/10(A) 4/28/10(A) 5/17/10(A) 5/25/10(A) 7/13/10(A) 7/23/10(A)	8/8/10	
	7/13/10 Physical	x				
	5/8/10 Physical	x				
	4/16/10 Physical	x	x			
	4/16/10 Physical	x				
	4/14/10 Physical	x	x			
	4/9/10 Physical	x				
	4/9/10 Physical	x	x			
#203	10/7/10 Chemical	x		10/20/09	1/31/10	10/6/10
	10/1/10 Chemical	x				

			8/8/10 Physical	x	x			
			8/5/10 Chemical	x				
			5/14/10 Physical	x				
			4/23/10 Physical	x	x			
			4/18/10 Chemical	x				
			4/18/10 Physical	x				
		#312	8/10/10 Physical	x	x	10/20/09 2/5/10 (A) 8/10/10(A) 9/16/10(A)	11/1/09	
			8/9/10 Physical	x	x			
		#269	4/16/10 Physical	x	x	7/2/09 3/9/10(A) 4/16/10(A)	6/3/09	
		#562	8/21/10 Chemical	x	x	7/2/09	Not dated	
			8/20/10 Chemical	x	x			
		#176	10/9/10 Physical	x		3/11/10 6/9/10(A) 8/4/10(A) 9/13/10(A) 10/12/10(A)	8/25/10	
			9/9/10 Physical	x				
			8/4/10 Physical	x	x			
			6/8/10 Physical	x				
		#166	9/22/10 Physical	x				
		#57	10/19/10 Physical	x		11/18/09 2/9/10(A) 4/20/10(A) 4/28/10(A) 9/27/10(A) 10/4/10(A) 10/11/10(A)	3/11/10	Not dated
			9/28/10 Physical	x				
			9/27/10 Physical	x				
			9/26/10 Physical	x				
			9/25/10 Physical	x				
			9/24/10 Physical	x				
			9/23/10 Physical	x				
			9/23/10 Physical	x				
			9/13/10 Physical	x				
		#170	9/2/10 Physical	x		2/25/09	2/25/09	
		#244	10/3/10 Physical	x		9/14/10 6/1/10(A) 8/6/10(A) 9/13/10(A) 9/24/10(A) 10/6/10(A)	4/1/10	
			9/20/10 Physical	x				
			9/12/10 Physical	x				
			8/5/10 Physical	x	x			
			8/4/10 Physical	x	x			
			5/30/10 Physical	x				

#488	8/20/10 Mechanical	x	x	8/9/10 7/13/10(A)	8/1/10	8/1/10
	8/17/10	x				
	7/11/10	x				
	7/11/10	x				
	6/13/10	x				
	6/2/10	x				

- Personal Support Plans (PSPs) for:
  - Individual #67, Individual #77, Individual #194, Individual #167, Individual #431, Individual #43, Individual #339, Individual #124
- Positive Behavior Support Plans (PBSPs) for:
  - Individual #488, Individual #57, Individual #203, Individual #600
- Functional Assessments for:
  - Individual #488, Individual #57, Individual #203, Individual #600
- Personal Support Plan Addendum (PSPA) for:
  - Individual #488 (dated 6/24/10), Individual #57 (dated 4/20/10), Individual #312 (dated 8/10/2010), Individual #600 (dated 8/17/10)

Interviews and Meetings Held:
- Interviews with various direct support professionals in homes and day programs
- Stacie Cearley, Program Compliance Monitor
- Sylvia Middlebrook, Ph.D., Chief Psychologist, and Chair Restraint Reduction Committee
- Kenneth Self, Glenn Heath, Todd Miller, Keith Bailey, Rotley Tankersley, Unit Directors
- Jason Peters, Human Rights Officer

Observations Conducted:
- Observations at residences
- Observations at the onsite workshop
- Daily Incident Management Meeting 10/19/10
- Daily Incident Management Meeting 10/20/10
- PSPA Meeting for Individual #600 10/19/10
- Woodland Crossing Morning Meeting 10/20/10
- Human Rights Committee Meeting 10/20/10

Facility Self-Assessment:

The facility's self-assessment, its POI, for section C indicated that all items were in noncompliance. The POI noted, that for most sections of this provision, the facility would continue to review restraints and retrain staff as needed. The monitoring team agrees with the facility's determination of noncompliance for section C. This section was rated based on review of restraint incidents, interviews, and observations. The

	monitoring team found that while most staff had received training in the use of restraint and documenting restraint, staff were not implementing procedures included in training. Prior to retraining staff, the facility should review training methods to determine if changes are needed in current training methods. There were systems in place for the monitoring and review of restraint incidents, but these did not appear to be effective as evidenced by findings throughout section C. The facility will also need to take a look at the restraint review process for determining compliance with this provision. In order to gain substantial compliance with this provision, it will be essential for all staff at the facility to adopt the philosophy that restraints will be used as a last resort measure and that staff must be provided with the tools and knowledge necessary to make this a realistic outcome.
	Summary of Monitor's Assessment: The facility gathered and analyzed data on restraints monthly and produced a monthly and a quarterly report that looked at restraint types, individuals and staff involved, residential unit, location of restraint, and the method of restraint. The facility's restraint trend analysis indicated that there had been a total of 322 restraints utilized at the facility from January 2010 through August 2010. There had been 95 total restraint incidents at the facility during the quarter prior to the monitoring visit (FY10 4th quarter). This was a decrease of 32% when compared with the previous quarter. Of the 95 restraints for the last quarter, 73% were medical restraints (69), 13% were emergency restraints (12), 9% were programmatic restraints (9), and 5% protective restraints (5). Trending of data indicated that there had been an overall reduction in the use of restraints at the facility since last year. The facility was still struggling with the classification of restraint types and data were not clear on what types of restraints were being used for what purpose, particularly in regards to self-injurious behavior. The facility will need to address this in order to develop a plan of compliance that effectively targets restraint reduction. Observation during the monitoring visit indicated that many individuals restrained to prevent self-injurious behaviors spent a large portion of the day not engaged in activity, even though staffing levels had been increased for those individuals. The increased staffing levels appeared to be in place to intervene when the behavior occurred rather than to offer additional interaction for replacement behaviors. There were many meetings frequently held at the facility to address restraint incidents, including PST meetings for individuals involved in restraints, Restraint Reduction Committee meetings, daily incident management meetings, morning unit meetings, and Human Rights Committee (HRC) meetings. It was observed by the monitoring team that most of these meetings were attended by an appropriate interdisciplinary team and discussion took place among meeting participants regarding specific restraint incidents. The facility did not have a fully developed Human Rights Committee. The HRC meeting observed the week of the monitoring visit was only attended by the Human Rights Officer, one QMRP, and a community representative. This did not allow for informed discussion around rights and restrictions for each individual. Program auditors at the facility frequently reviewed restraint incidents and noted any procedures that were not in compliance with facility policies and provisions of the Settlement Agreement. It appeared that many of the problems with restraint documentation and monitoring identified by the program auditor had not yet

	been addressed by the facility as noted throughout section C of this report. Restraint data and trend information were not being used at the facility to develop specific strategies for reducing restraints. The facility had a Restraint Reduction Committee that met quarterly to review restraint use. The committee set goals to reduce different types of restraints by various percentages, but did not develop strategies for how restraints would be reduced, and did not focus on any specific problem areas identified by program auditors, such as monitoring and documentation of restraints or individual engagement. A new written procedure had been developed by the facility entitled Dental/Medical Sedation and Restraint, dated 7/16/10. This procedure defined medical restraints and outlined procedures to be taken when medical and dental restraints were used. The facility was in the initial stages of implementing these procedures in regards to documenting and tracking medical and dental restraints. While there was considerable focus by the facility on tracking and trending restraints used for crisis intervention, there was less information and data available on the use of protective and medical restraints. The facility was in the beginning stages of addressing reduction of medical restraint which comprised the largest number of restraints at the facility

#	Provision	Assessment of Status	Compliance
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 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.	The state policy prohibited the use of prone restraints and mandated that restraints only be used if the individual posed a serious risk of harm to himself, herself, or others, after a graduated range of less restrictive measure had been exhausted, and be terminated as quickly as possible and as soon as the individual was calm and no longer a danger to self or others. The policy further specified what types of restraints were allowable at the facility. These policies were in line with the requirements of this provision. There was no evidence that prone restraint had been used by the facility or any other restraint technique that was not approved in the state policy. Thirty-eight restraint reports across 11 individuals were reviewed. Restraint forms reviewed indicated that staff had only applied restraints for behavioral intervention after a graduated range of less restrictive measures had been attempted. Other interventions attempted were documented on the restraint checklist for each restraint incident. As noted in the summary section for this provision, in most cases, the facility was not addressing the root cause of behavior, particularly the lack of engagement, in order to address restraint reduction. Internal audits of some restraints questioned whether the individual restrained was at immediate or serious risk of harming him/herself or others. PSTs should discuss behavior indicators for each individual and ensure that staff know what indicators are true risk indicators for that individual.	Noncompliance

#	Provision	Assessment of Status	Compliance
		As noted in the following sections, restraints were not always monitored as required and desensitization plans had not been developed for all individuals receiving sedation prior to routine medical and dental appointments. Therefore, the facility was not in compliance with this provision.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The facility policy mandated that restraints be terminated as soon as the individual was calm and no longer a danger to self or others. All restraint checklist reviewed indicated that the individual was released from restraint when calm. Restraint duration was typically low, with the majority of restraints lasting under five minutes. The monitoring team was able to find the facility in substantial compliance with this provision item from documentation provided during the review.	Substantial compliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The facility had policies governing the use of restraints. The policies were in compliance with the requirements of this provision. The policy on restraints required that all staff persons who assume work responsibilities that might require the staff person to participate in restraint receive competency-based training, initially, and with subsequent annual refresher training in restraint use and PMAB. Training transcripts for 12 direct support staff were reviewed and all had completed PMAB training and training on applying restraints. Restraint Monitors were required to have training initially, and with subsequent annual refresher training in restraint use, PMAB, abuse and neglect, rights of an individual, and documenting restraints. They were also required to have current CPR training. Training transcripts for four restraint monitors were reviewed. Three had all training as required by the facility policy; one restraint monitor did not have training on the use of restraints or PMAB training annually, as required. In many cases, restraints were not documented or monitored according to methods included in required training. See section C5 for specific details regarding documentation and monitoring. The monitoring team observed Individual #192 and reviewed her safety plan. It specified the noncontingent removal of her helmet every 55 minutes. Review of the restraint log, and conversations with staff, revealed that her helmet was not consistently removed. The monitoring team notified a facility QA program compliance monitor when this was discovered and it was addressed by the facility. The facility was rated as being in noncompliance with this provision item.	Noncompliance

#	Provision	Assessment of Status	Compliance
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.	There was some confusion over whether some mechanical restraints used with individuals displaying self-injurious behaviors were to be classified as medical restraint or restraint for behavioral intervention in data gathered. Regardless of the classification of these restraints, the facility should ensure that a determination is made by the PST for when these restraints should be removed to monitor for circulation, injuries, and skin integrity. A plan should also be put into place to try to reduce the use of the restraint. One individual at the facility was wearing mitts to prevent further damage to an open skin wound (Individual #146). It was noted that staff were not removing the mitts frequently enough to ensure that the skin integrity of her hands was not compromised by wearing the mitts. When pointed out to facility staff by the monitoring team, the physician was consulted and a plan was immediately implemented to correct this problem. Another individual was wearing a helmet due to self-injurious behavior (Individual #192). It appeared from documentation that the helmet was only removed at mealtime. Again, when pointed out by the monitoring team, staff immediately implemented a plan to offer snacks throughout the day so that the individual would remove her helmet to allow staff to monitor skin integrity. The PST is to be commended for quickly implementing correction in both instances, however, it was of concern that these were not noticed by staff until the monitoring team brought it to their attention. Observations made throughout the week by the monitoring team, moreover, indicated that both of these individuals were seldom engaged in activities, even though both had one-to-one supervision throughout the day. Plans to reduce restraint use should include strategies for engaging individuals in meaningful activities. The monitoring found that not all individuals had desensitization plans in place when restraints were used for medical or dental treatment. • Individual #431's PSP indicated that desensitization strategies would be implemented for dental care, but there was no documentation showing that strategies had actually been developed and implemented. • The need for a desensitization plan had not been addressed by the PST for Individual #67 or Individual #194. Both PSPs indicated that pretreatment sedation was needed for dental appointments. • Individual #167's PSP indicated that he had a dental desensitization plan in place, though specific strategies were not included in his PSP. His most recent PSP noted that his oral hygiene "needs improvement on a large scale." • Sedation was used prior to an annual checkup for Individual #133 though the log of individuals with desensitization plans did not indicate that she had a plan in place. • IMT meeting minutes indicated that Individual #34 was sedated prior to a medical evaluation on 8/18/10. She was not included on the list of individuals	Noncompliance

#	Provision	Assessment of Status	Compliance
		with medical desensitization plans in place. • IMT meeting minutes indicated that Individual #14 was sedated prior to a medical evaluation on 8/18/10. She was not included on the list of individuals with medical desensitization plans in place. • IMT meeting minutes indicated that Individual #242 and Individual #234 were sedated prior to medical appointments on 8/12/10. Neither was included on the list of individuals with medical desensitization plans in place. • IMT meeting minutes indicated that Individual #457 was sedated prior to a medical appointment on 8/9/10. He was not included on the list of individuals with medical desensitization plans in place. • IMT meeting minutes indicated that Individual #97 was sedated prior to a medical appointment on 8/10/10. He was not included on the list of individuals with medical desensitization plans in place. Even so, a log provided to the monitoring team indicated that 95 individuals at the facility had dental desensitization plans in place and 23 had medical desensitization plans in place. These were written by the dental department and represented an increase since the baseline monitoring review. The facility needs to ensure that individuals using restraint for medical or dental appointments have a desensitization plan in place that includes concrete strategies, strategies are implemented, progress is documented, and plans are revised as necessary.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the	It was not evident that restraints were always monitored as required by state policy. In most instances reviewed, observation of the individual restrained was consistently documented at least every 15 minutes as required by Appendix A. Two examples were found where 15 minute observations were not documented. Restraint incidents for Individual #269 on 4/16/10 and for Individual #562 on 8/20/10 did not document the required monitoring during restraint. A licensed health care professional had not monitored and documented vital signs and mental status of each person restrained as required. • A restraint checklist for Individual #488 on 6/2/10 did not indicate that a licensed health care professional had monitored and documented his vital signs and mental status during or following the restraint. • A restraint checklist for Individual #244 indicated that the nurse did not check vital signs and mental status until 70 minutes after the restraint was initiated. • A restraint checklist for individual #244 indicated that the nurse did not check vital signs and mental status until 45 minutes from the start of the restraint.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• A restraint checklist for Individual #170 indicated that the nurse did not check vital signs and mental status until 63 minutes after the start of the restraint. • A restraint checklist for Individual #176 indicated that the nurse did not check vital signs and mental status until 75 minutes after the start of the restraint. Although the program auditor had noted these deficiencies in her review of restraints, it was not evident that the facility had developed a plan of correction for addressing deficiencies that were identified. The facility needs to develop a plan to ensure that monitoring and post restraint reviews are conducted as required and documented consistently. The facility was rated as being in noncompliance with this provision item.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with	All restraint documents reviewed indicated that the individual had one-to-one supervision during the restraint. Restraint documentation reviewed did not indicate that restraints interfered with mealtimes or that individuals were denied the opportunity to use the toilet. All restraint checklists indicated that individuals were checked for restraint related injuries. When restraints occurred, notifications were to be made to a restraint monitor, a nurse, and a psychologist. Additionally, the restraint checklist was to be reviewed by the restraint monitor and the psychologist. Notifications and/or reviews were not documented on all restraint checklist reviewed by the monitoring team as required. • For Individual #312, a restraint checklist completed on 8/9/10 did not indicate when the restraint monitor and psychologist were notified or by whom. • Another restraint checklist for Individual #312 dated 8/10/10 did not indicate when the nurse or psychologist were notified or by whom. • For Individual #488, two restraint checklist completed on 7/11/10 did not indicate that the nurse or psychologist had been notified in either instance. • Another restraint checklist for Individual #488 completed on 6/13/10 did not indicate that the nurse was notified. • A restraint checklist for Individual #488 on 6/2/10 did not indicate that the psychologist was notified. • The restraint checklist for Individual #244 on 9/12/10 did not indicate that the psychologist was notified. • The restraint checklist for Individual #244 on 8/5/10 did not indicate that the	Noncompliance

#	Provision	Assessment of Status	Compliance
	Appendix A.	psychologist was notified. • A restraint checklist completed on 5/30/10 for Individual #244 did not document notification of the restraint monitor or psychologist. • A restraint checklist for Individual #170 on 9/2/10 did not document notification of the psychologist. • A restraint checklist for Individual #57 on 9/28/10 did not document notification of the psychologist. • Restraint checklists for Individual #57 on 9/25/ and 9/26/10 did not indicate that the nurse or psychologist was notified in either instance. • A restraint checklist for Individual #57 on 9/24/10 did not indicate that the psychologist was notified. • The restraint checklist for Individual #57 on 9/5/10 did not indicate that the restraint monitor or psychologist had been notified. • A restraint checklist for Individual #176 on 10/9/10 did not indicate that the psychologist was notified. • The restraint monitor was not notified until after a chemical restraint was administered to Individual #562 on 8/20/10. Staff completing documentation should be reminded to complete all sections of the restraint checklist and retraining should occur when audits of restraint incidents indicate a pervasive deficiency in documentation or process. The facility was rated as being in noncompliance with this provision item.	
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:	According to documentation provided by the facility, there were five individuals (i.e., Individual #488, Individual #57, Individual #312, Individual #600, and Individual #203) with safety plans in place at LSSLC who required the use of restraints more than three times in a rolling thirty-day period. There were no individuals who had more than three restraints in any rolling thirty-day period who did not have a safety plan. The monitoring team was provided with documentation of Personal Support Plan Addendum (PSPA) meetings held for four of these individuals (i.e., Individual #488, Individual #57, Individual #312, and Individual #600) in response to the increase in restraint use. PSPA meeting minutes indicated that various antecedent conditions (both physical and environmental) and functions of the target behavior that provoked restraint were discussed at these meetings. Additionally, each individual's functional assessment and PBSP were reviewed and potential changes discussed. The substance of some aspects of all four of the PSPAs and all five PBSPs, however, were not consistently adequate to reduce the need for restraint and, therefore, this item is rated as being in noncompliance.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Some of the PSPA meetings included identification of new, potentially important, variables that were hypothesized to affect the target behaviors. For example Individual #488's increase in self-injurious behavior was hypothesized to be related to constipation, and actions to address constipation were implemented. Additional practical actions that were documented in his PSPA meeting were the padding of his headboard and a referral to the Neurology clinic. Other discussions documented in the PSPA meeting minutes did not appear to be adequate to understand and, ultimately, change the target behaviors that provoked increases in physical restraint. For example, Individual #600's PSPA reviewed the environmental conditions contributing to her physical aggression. It concluded, however, that she engaged in aggression when she became frustrated. It is possible that Individual #600 was consistently frustrated prior to becoming physically aggressive, however, in order for this discussion to be helpful to generate practical interventions to reduce her physical aggression, one needs to attempt to understand what environmental variables resulted in her becoming frustrated and physically aggressive (see K5 for a detailed review of functional assessments at the facility). Additionally the PBSPs reviewed were not consistently adequate to reduce the target behaviors that provoked restraints. For example Individual #203's intervention to prevent physical aggression was not based on his functional assessment results (see K9 for a discussion of the importance of functional assessment based PBSPs). Individual #203's functional assessment suggested that his physical aggression functioned to allow him to escape or avoid undesired events. His PBSP, however, specified that if he became agitated, staff should determine what was upsetting him and eliminate it. If in fact Individual #203's physical aggression did function to escape undesired events, then this intervention would likely result in an increase in physical aggression. Similarly Individual #57's PBSP specified the following intervention for his agitated behavior (which sometimes led to physical restraints): • Intervene early • Separate him from others • Redirect him • Use PMAB procedures This intervention was very general and was not clearly related to his functional assessment results. Therefore, it was not likely to effectively decrease Individual #57's target behavior and reduce the need for physical restraint.	

#	Provision	Assessment of Status	Compliance
		The PSPAs discussed the establishment of alternative or replacement behaviors to take the place of target behaviors and, thereby, reduce the need for physical restraint. Replacement behaviors should be functional. That is, they should represent desired behaviors that serve the same function as the undesired behavior (see K5 for a review of the facility's replacement behaviors). Some of the functional assessments and PBSPs, however, did not appear to be related to the function of the target behavior. For example, Individual #57's replacement behavior was "Helping staff as they request and accepting their suggestions and support. Activities which legitimately boost self esteem…Using communication skills…Walking away from conflicts… " This replacement behavior is not functional, that is, it is not clearly related to the function of Individual #57's physical aggression. A functional replacement behavior might include providing him with a rich schedule of positive attention (attention was hypothesized as a function of his agitated behavior), and allowing him to escape or avoid selected undesired activities (another hypothesized function of Individual #57's agitated behavior was escape of undesired events). Finally, none of the functional assessments or PBSPs reviewed included specific instructions for how to train replacement behaviors. Therefore it is unclear how, or if, DCPs would train replacement behaviors (see S1).	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	See C7 above	Noncompliance
	(b) review possibly contributing environmental conditions;	See C7 above	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	See C7 above	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	See C7 above	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint,	See C7 above	Noncompliance

#	Provision	Assessment of Status	Compliance
	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	See C7 above	Noncompliance
	(g) as necessary, assess and revise the PBSP.	See C7 above	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	Restraint incidents were discussed at unit meetings each weekday and then presented at the Incident Management Team meeting for review. Restraint incidents which occurred during the weekend were reviewed at these meetings on Monday mornings. The monitoring team attended morning unit meetings and IMT meetings during the week of the monitoring visit. It was observed that restraints were routinely reviewed at the morning meetings and attendees made recommendations where appropriate regarding restraint incidents. PST meetings were held to discuss restraints and review behavior management strategies as evidenced by PSP addendums reviewed. There was no indication that incorrect procedures or errors in documentation were noted or addressed with staff. In the examples listed throughout this section, there was no indication that a plan of correction had been developed to address problems even though administrative staff had reviewed each incident. The facility was rated as being in noncompliance with this provision item.	Noncompliance

Recommendations:

1. Formalize the Restraint Reduction Committee's review of restraint trends and use this committee to analyze data and develop specific strategies to further reduce the use of restraints at the facility.

2. Behavior support plans should identify which behaviors indicate a true risk for potential harm to the individual or others and train support staff to recognize those behaviors.

3. The facility needs to look at engagement levels for individuals frequently restrained for self-injurious or aggressive behaviors and develop plans to increase engagement levels when indicated.

4. The facility needs to develop a plan to ensure that monitoring and post restraint reviews of vital signs and mental status are conducted as required and documented consistently..

5. Include specific desensitization strategies in PSPs for individuals who require restraints for routine medical and dental appointments. Monitor and document progress on plans and modify plans as necessary.

6. Ensure that all staff have completed required training in regards to restraint use.

7. Develop a plan of correction to address any deficiencies noted in the review of restraints. Continue to monitor restraints and retrain staff as necessary.

8. The facility needs to include additional members on the Human Rights Committee to ensure informed discussion regarding rights and restrictions for individuals.

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o LSSLC Procedure: Investigations of Client Abuse, Neglect, and Exploitation dated 8/10/10 o DADS Policy: Incident Management #002.2, dated 6/18/10 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021 dated 6/18/10 o Incident Management Committee meeting minutes for June 2010 – August 2010 o List of most recent incidents of peer to peer aggression o Training transcripts 39 employees , including the last three hired and the facility's investigators o Acknowledgement of Obligation to Report Abuse form for nine employees o Training transcripts for DFPS investigators o Spreadsheet of all current employees, volunteers, and foster grandparents documenting results of fingerprinting, EMR, CANR, NAR, and CBC if a fingerprint was not obtainable. o Documentation for four employees whose fingerprinting revealed arrest, but were eligible for hire o Fingerprint results revealing a job offer rescinded or termination of employment o Documentation of CBC that resulted in Pass/Unsuited for job o Documentation of Self Reported arrests for nine employees o Background check for the last three volunteers o Log of Injuries by Individual since 1/1/10 o Client Injury Reports: • Individual #600, 8/21/10, 8/14/10, and 8/12/10 • Individual #176, 8/21/10 • Individual #260, 8/20/10 • Individual #67 10/19/10 o Injury Trend Analysis FY08-FY10 o Log of all ANE allegations since 1/1/10, including case disposition and any employee disciplinary action taken o Log of employees reassigned due to ANE allegations since 1/1/10 o Unusual Incident Investigation Reports: • #40, #41, #68, #137, #158, #159, #161, #195, #190, #196, #201, #102

- Documentation from the following completed DFPS investigations:

Case	Allegation	Disposition	Date/Time of APS Notification	Date Completed
35151889	Physical Abuse/Neglect	Unconfirmed	2/6/10 4:18pm	3/1/10
35154869	Physical Abuse/Neglect	Unconfirmed	2/7/10 9:55pm	2/19/10
35045549	Neglect	Inconclusive-DFPS No criminal activity - OIG	1/27/10 1:54 pm	2/11/10
35180049	Physical Abuse/Neglect	Unconfirmed No criminal activity - OIG	2/9/10 3:01pm	2/25/10
35490551	Physical Abuse (6) Neglect (2)	Confirmed (2 Neglect/3 Physical abuse), Inconclusive (1 Physical Abuse), Unconfirmed (2 Physical Abuse)- DFPS Will not investigate - OIG	3/8/10 11:33am	3/16/10
35484010	Physical Abuse	Unconfirmed	3/7/10 7:39pm	3/9/10
35483530	Neglect	Unfounded Will not investigate - OIG	3/7/10 5:40pm	3/8/10
35438849	Physical Abuse	Unconfirmed No evidence of criminal activity - OIG	3/3/10 1:47pm	3/10/10
35575869	Physical Abuse/ Emotional /Verbal Abuse	Unfounded	3/15/10 9:30am	3/17/10
5730776	Physical Abuse	Unconfirmed	3/28/10 10:48 pm	6/24/10 Methodology review
35809649	Physical Abuse (3)	Inconclusive Evidence of criminal activity- OIG	4/3/10 7:15pm	4/9/10
35949302	Physical Abuse/Neglect	Inconclusive	4/14/10 10:36pm	4/28/10 6/4/10
36049669	Physical Abuse/Neglect	Confirmed/Inconclusive-DFPS No evidence of criminal activity – OIG	4/22/10 4:05pm	6/4/10 Methodology review

		Inconclusive (after review)		
36656009	Emotional/Verbal Abuse	Confirmed	6/14/10 10:04am	6/24/10
36721471	Neglect	Confirmed	6/18/10 12:07pm	6/28/10
36734830	Emotional/Verbal Abuse (8) Neglect (10) Physical Abuse (1)	Unconfirmed (8) Unconfirmed (10) Unconfirmed (1)	6/20/10 9:36pm	6/28/10
36942293	Physical Abuse Emotional/Verbal Abuse	Unconfirmed OIG did not take case	7/7/10 5:43pm	7/17/10
37032009	Physical Abuse/Neglect	Confirmed/Confirmed – DFPS Evidence of criminal activity - OIG	7/15/10 10:30am	7/22/10
37132530	Physical Abuse	Unconfirmed	7/23/10 10:43am	8/2/10
37257602	Neglect (2)	Confirmed (2) Inconclusive (after review)	8/2/10 3:03pm	8/10/10 Requested review
37448820	Physical Abuse/Neglect	Unfounded	8/14/10 7:06pm	8/24/10
37611402	Emotional/verbal Abuse	Confirmed	8/25/10 4:45am	9/3/10
37635260	Serious Injury-Determined Cause	Referred back to facility	8/24/10 9:45am	8/31/10
UIR#4	Neglect	Inconclusive	9/3/10 4:32am	9/14/10
37957820	Physical Abuse Emotional/Verbal Abuse	Confirmed Inconclusive	9/16/10 1:38pm	9/23/10 Requested methodology review
38040660	Neglect	Inconclusive	9/21/10	10/1/10

(#) indicates multiple allegations

Interviews and Meetings Held:

- Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs
- Gail Wasson, Facility Director
- Michael Ramsey, Lead Investigator

	o Luz Carver, QMRP Coordinator o Stacie Cearley, Program Compliance Monitor o Sylvia Middlebrook, Ph.D., Chief Psychologist o Kenneth Self, Glenn Heath, Todd Miller, Keith Bailey, Rotley Tankersley, Unit Directors o Jason Peters, Human Rights Officer o Norma Crawford, Risk Management o Royce Garrett, Consumer/Family Relations Director o Mary Stovall, Assistant Ombudsman <u>Observations Conducted</u>: o Observations at residences o Observations at the onsite workshop and day program o Daily Incident Management Meeting 10/19/10 o Daily Incident Management Meeting 10/20/10 o PSPA Meeting for Individual #600 10/19/10 o Woodland Crossing Morning Meeting 10/20/10 o Human Rights Committee Meeting 10/20/10 o Self Advocacy Meeting for Oak Hill and Castle Pines o Health Status Team Meeting o Observation of video surveillance
	Facility Self-Assessment: The facility's self-assessment, its POI, for section D indicated that some items for this provision were in noncompliance and some were in substantial compliance. The POI did not indicate how the rating was determined for each item. Some compliance ratings were justified by the facility's mandate to provide training to all staff, though, as evidenced throughout the findings in section D, training was not being provided as mandated by policy. The facility needs to include a measure of compliance with agency policies in consideration of substantial compliance. The POI acknowledged that the facility was in the beginning stages of developing corrective action plans to address deficiencies. The facility needs to determine how substantial compliance will be assessed and develop a plan of action to address any deficiencies noted.
	Summary of Monitor's Assessment: According to a log of investigations provided to the monitoring team, 105 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility from 1/1/10 through 9/21/10. Of these 105 allegations, seven (7%) were confirmed by DFPS. This included three confirmed allegations of physical abuse, two confirmed allegations of neglect, and two confirmed allegations of verbal or emotional abuse. DFPS confirmed abuse in two other cases during this time period. The facility requested a methodological review of those two cases and the findings were changed to inconclusive. In one case, OIG found evidence of criminal activity, though DFPS completed the investigation with an inconclusive finding. Fifteen

	additional investigations were found to be inconclusive, indicating that there was not enough evidence available to determine whether or not abuse or neglect had occurred. The facility requested a methodology review by DFPS in four (15%) of the 26 cases reviewed in the sample. There were 3,016 injuries reported at the facility from January 2010 through August 2010. A total of 1,073 of these injuries occurred in the 4th quarter of FY10. This was a decrease of 8% from the 4th quarter in FY09 and a decrease of 16% from the 3rd quarter of FY10. According to the facility trend report, the top three causes of injuries for the 4th quarter of FY10 had been bumping into something (189), scratches (160), and slips/trips/falls (132). Of the 1,073 injuries recorded in the 4th quarter, 480 were witnessed injuries and 593 (55%) were not witnessed. According to a log of all injuries since 1/1/10, there had been 24 serious injuries. The facility needs to trend injuries by cause and implement injury prevention strategies, when possible. When trends are identified, such as the 33 injuries attributed to lifting/transfers, the facility should address these injuries with a plan of correction. Video surveillance cameras had been installed in common areas throughout the facility since the baseline monitoring visit. A review of incident investigations indicated evidence from the surveillance cameras was being used in only few investigations. It was reported in interviews during the monitoring visit that this evidence was beneficial in confirming abuse and neglect in cases where evidence might not otherwise have been available to support the allegations. It was a concern that the facility director was the only staff person at the facility allowed to review video evidence. According to the Risk Manager and Facility Investigator, investigators completing reports were not able to view evidence first hand to confirm or deny witness statements or gather additional information. The video was reviewed by the Facility Director and the investigator was given a written statement of findings. Some of the items in this provision were found to be in substantial compliance, though the majority were found to be in noncompliance.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	Assessment of this item required review of policies and an examination of implementation of those policies. The state had recently updated policies regarding incident management and protection from harm. The Incident Management Policy was numbered 002.2, and was dated 6/18/10. It included a number of addenda and forms, such as regarding unusual incidents, high profile incidents, and client injury reporting procedures. The Protection from Harm - Abuse, Neglect, and Exploitation policy was also Revised 6/18/10 and numbered 021. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. All staff were required to report suspected abuse, neglect, and exploitation. There were posters regarding this mandate posted in most, but not all, facility locations visited. There were no posters with the	Noncompliance

#	Provision	Assessment of Status	Compliance
		DFPS hotline number in homes 520A and 523. The facility needs to ensure that the DFPS hotline number is accessible to all staff and individuals. The obligation to report was stressed at new employee orientation, and was to be confirmed by a signed statement acknowledging the employee's duty to report. This statement must be signed annually. Nine employee records were reviewed for acknowledgement of their obligation to report. Five (56%) of the nine records did not contain a current signed Acknowledgement of Responsibility for Reporting Abuse, Neglect, and Exploitation form.	

#	Provision	Assessment of Status	Compliance
		Competency-based training on abuse and neglect (ABU0100) and incident reporting procedures (UNU0100) was required annually for all employees. Training transcripts for 39 current employees at the facility were reviewed for current ABU0100 and UNU0100 training. Sixteen (41%) employees had not had UNU0100 training in the past 12 months. Three employees (7%) had not had ABU0100 in the past 12 months. The facility was rated as being in noncompliance with this provision item.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	The state policy specified reporting requirements for all serious incidents and was in line with this provision item. The facility policy included a section on incident reporting responsibilities for determining to whom incidents should be reported, and within what time frame. The facility utilized a standardized reporting form for all serious injuries and incidents. Unusual Incident Reports documented notification to the Director/Designee, After-Hours Duty Officer, Unit Director, QMRP, Correspondent, DFPS, Law Enforcement, State Office, OIG, and DADS Regulatory. The agency used form SSLC.001-UII to document all serious incidents. All reports included an area to document notification date and time to the facility director, DFPS, law enforcement, the state office, and DADS regulatory. DFPS was responsible for notifying local law enforcement or OIG, though it was noted that the facility typically notified OIG in the cases that were reviewed. In all cases reviewed, except one, notifications were made within required timelines. DFPS case #36721471 involved a choking incident that occurred on 6/13/10. Individual #191 choked after being served food not cut to the size required in his dining plan. The incident was not reported to DFPS until 6/18/10. The allegation of neglect was confirmed. Employees had been hired for video surveillance at the facility. Interviews with video monitoring staff during the onsite monitoring review indicated that they had been trained in recognizing abuse and neglect and were aware of their responsibility to report abuse if observed during video surveillance. Additionally, part of their training	Substantial compliance

#	Provision	Assessment of Status	Compliance
		requirement included spending time observing individuals living at LSSLC and getting to know them. The facility was rated as being in substantial compliance with this provision item.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	A review of Incident Management Team (IMT) meeting minutes, observation of IMT meetings, and observation of morning Unit meetings confirmed that the facility reviewed all incidents and injuries and shared information regarding those incidents. Alleged perpetrators were immediately removed from direct contact with individuals and reassigned to other duties until investigations were completed. This was confirmed by a list of employees reassigned due to ANE investigations provided to the monitoring team. A list of employees reassigned due to allegations was reviewed at the Daily Incident Management meetings. A review of disciplinary action for confirmed perpetrators indicated that in one case of physical abuse, the employees resigned; in one case of neglect and one case of abuse, the employee was discharged; and in one case of neglect and two cases of emotional/verbal abuse the employees were issued a letter of reprimand and then returned to regular duties. Nursing staff completed injury assessments on individuals involved in all serious incidents. Levels of supervision were routinely increased when deemed appropriate for individuals involved in any type of serious incident until team members could determine that the increased level of supervision was no longer necessary. A review of individuals on one-to-one supervision at the time of the onsite monitoring visit indicated that individuals were place on heightened supervision for medical monitoring, to minimize the risk of aggression towards others, to minimize the risk of self-injury, and to minimize the risk of injury. Observation at the facility and a review of PSPAs indicated that PSTs met following most incidents to review the incident. Incidents were also reviewed each day at morning unit meetings, and at daily Incident Management Team (IMT) meetings. IMT meeting minutes did not include protections put into place for individuals during investigations or recommendations regarding injury incidents. Investigations reviewed by the monitoring team indicated that the facility routinely took steps to safeguard individuals when serious incidents occurred. For example: • Case #37032009 was a confirmed case of abuse and neglect. The AP was dismissed following the outcome of the case.	Substantial compliance

#	Provision	Assessment of Status	Compliance
		• In case #37448820 involving abuse and neglect allegations, DFPS was notified at 7:06pm, a body assessment was completed for the victim at 7:15pm, and the AP was removed from duty at 7:51pm. • UIR #197 involved a serious injury to Individual #468 when he fell off a loading dock. The UIR indicated that staff were retrained and the maintenance department was notified to evaluate safety issues following the incident. • In the investigation of UIR #4, DFPS found the allegation of neglect to be inconclusive, but recommendations noted concern that several staff members noticed the AP missing from the home, but did not report it until the incident occurred. The Unit Director followed up on the report by providing Positive Performance Counseling to the AP and to staff who failed to report the incident in a timely manner. The PST met to discuss the sexual incident between two individuals. The individuals involved were moved within the home to prevent similar incidents from occurring. The facility was rated as being in substantial compliance with this provision item.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The facility provided initial training and annual retraining on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation. All staff were required to complete ABU0100 Abuse and Neglect and UNU0100 Unusual Incidents initially upon employment and every 12 months thereafter. Documentation of training was kept by the facility and a sample of 39 staff training transcripts was reviewed. Not all training had been completed as required. Three of the records reviewed indicated employees had not received ABU0100 in the past 12 months and 16 had not received UNU0100 refresher training. The facility needs to ensure that all employees receive annual training as required by the state policies on abuse and neglect and incident management. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	(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	The policy addressed mandatory reporters. Initial staff training provided during orientation included information on recognizing and reporting abuse and neglect. All staff who were interviewed were aware of their obligation to report. Staff were required to attend annual training on reporting abuse and neglect, but as noted in section D2c, not all staff had received training as required. Additionally, not all staff had signed a current Acknowledgement of Responsibility for Reporting Abuse, Neglect, and Exploitation as required by agency policy. A sample of staff personnel records was requested (for nine employees). Current signed statements were only available for four of the nine employees.	Noncompliance

#	Provision	Assessment of Status	Compliance
	evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	The facility was rated as being in noncompliance with this provision item.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	The policy stated that a training and resource guide on recognizing and reporting abuse and neglect was to be provided by the facility to all individuals and their LARs at admission and annually. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. PSPs indicated that information regarding reporting of abuse and neglect was shared with families. A review of abuse and neglect investigations indicated that at least some of the individuals and their family members were aware of reporting procedures and had reported suspected abuse and neglect incidents to DFPS. In #36656009, the individual called DFPS to report abuse that was confirmed. The facility was found to be in substantial compliance with this provision item.	Substantial Compliance
	(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.	Posters were found posted in most, but not all, common areas throughout the facility with a statement of individuals' rights. These posters included information on reporting violation of rights. Information on the poster was clear and easy to understand, including pictures for individuals who could not read. Additionally, there were posters throughout most homes and other buildings on campus, identifying the facility's assistant ombudsman. There was not a rights poster posted in the large workshop at the facility and a poster identifying the assistant ombudsman at the facility was not found in home 563-B The assistant ombudsman position had been created at the facility. There was also a rights officer position. Both were new to their positions and were in the process of developing new procedures and activities to address rights issues at the facility. The facility was attempting to develop a more active self advocacy group on campus. Monitoring team members had the opportunity to attend a self advocacy group meeting during the visit for individuals living in two units. The meeting was well attended by individuals at the facility, but many did not appear to understand the purpose of the meeting. Staff reported that the facility is looking at making some changes to the group to try to encourage group leadership and involvement (also see comments in section E of this report).	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The facility was rated as being in substantial compliance with this provision item.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The state policies included procedures for referring, as appropriate, allegations of abuse, neglect and other criminal acts to law enforcement. A Memorandum of Understanding issued by the state on 5/28/10 regarding Investigations of Abuse and Neglect in State Supported Living Centers, mandated that DFPS notify local law enforcement and The Office of the Inspector General (OIG) within one hour of any allegation that may constitute criminal activity. DFPS was responsible for making the determination of when it was appropriate and following through with reporting. The facility investigator reported that he often called DFPS investigators to remind them to call OIG. It was evident in the sample of investigations reviewed that LSSLC routinely took the initiative to report incidents to OIG. Incident reports noted whether or not OIG would be opening an investigation and if an investigation was completed, findings were included in the final incident report. The facility was found to be in substantial compliance with this provision item.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	State policy specified how to report retaliatory action and stated that employees engaging in retaliatory action were subject to employee disciplinary procedures. All staff interviewed stated that they were not hesitant to report suspected abuse, neglect, or mistreatment, and were able to state to whom incidents of abuse, neglect, and mistreatment should be reported. No cases of retaliatory action or allegations of retaliatory action were found by the monitoring team. All direct care staff interviewed during the monitoring visit indicated that they must report allegations of abuse or neglect to their supervisor, as well as, to the DFPS Hotline. The facility was rated as being in substantial compliance with this provision item.	Substantial compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	There was no evidence that formal audits were conducted to determine whether significant resident injuries were reported for investigation. As noted in the baseline review, all injuries at the facility were not consistently documented and staff were not always able to state how injuries had occurred or	Noncompliance

#	Provision	Assessment of Status	Compliance
		whether or not the injury had been reported. When asked by the monitoring team about a large open wound on Individual #235, staff assigned to support her were not able to give information about the incident or injury causing the wound, though after looking through the individual record, she was able to find an entry in staff notes with information regarding the wound. It was noted in the IMT meeting on 10/21/10, that a fall resulting in an injury for Individual #556 was not documented as required. The unit director was assigned to follow up to ensure that the documentation was completed. Staff need to be instructed to always follow up on an injury that they notice on an individual to make sure that it has been reported and if care is required, they know what care is needed. It was not evident that injuries, not deemed serious, that may indicate abuse had occurred are reported for investigation when preliminary investigations had not ruled out abuse or maltreatment. This was a concern, particularly with bruises of significant size or multiple bruises of unknown origin. While these may not be designated as a serious injury, they may be signs of abuse. Particularly with individuals who are nonverbal, staff need to be aware of signs of possible abuse and thoroughly investigate injuries. Possible causes should not be assigned to injuries without some evidence supporting the cause of injury. On 10/19/10 at 6:10 am, it was discovered that Individual #67 had a large bruise on her hip. The bruise was significant enough that Dr. Chang ordered an x ray to rule out further injury. A preliminary investigation was completed and staff were unable to confirm how the injury occurred. The incident was not reported to DFPS until the next morning at 10:29 am. This type of injury should be reported as soon as a brief preliminary investigation indicates that there is no known cause for the injury. The facility needs to develop a process to ensure that all significant injuries are investigated. The facility was found to be in noncompliance with this provision item.	
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:		

#	Provision	Assessment of Status	Compliance
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The state policy addressed the conduct of investigations and qualifications of investigators. The policy stated, "within one (1) month of employment or assignment as an investigator, and prior to completing an Unusual Incident Report (UIR), all investigators who are responsible for completing any part of the UIR must complete the courses, "Comprehensive Investigator Training (CIT0100)" and "People with MR (MEN0300)." The policy further mandated that all Incident Management Coordinators, campus administrators, and facility investigators "must complete Conducting Serious Incident Investigations or Fundamentals of Investigation" training (INV0100) and a class in Root Cause Analysis." Training documentation for the facility investigator and 14 other employees responsible for completing preliminary investigations was reviewed. One of the investigators had not had ABU0100 training in the past 12 months and 10 had not had UNU0100 in the past 12 months as required for all employees. Four of the campus coordinators reviewed had not completed a class in Root Cause Analysis and four had not completed INV0100 (or CSII0100). Training transcripts were provided to the monitoring team for six DFPS investigators. All of the investigators had completed training on working with individuals with developmental disabilities. The facility needs to ensure that all staff complete training required by state policy. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The facility policy mandated that staff cooperate with all investigations at the facility. The facility investigator reported a good working relationship with DFPS, local law enforcement, and OIG. There was no evidence that the facility had not cooperated with outside investigations. The facility was rated as being in substantial compliance with this provision item.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	There was no evidence of interference with investigations completed by law enforcement agencies. As noted in other sections of this report, cases were referred to local law enforcement or OIG, but details of those investigations were not included in investigation files. The facility was rated as being in substantial compliance with this provision item.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The state policy mandated that the facility investigator should prioritize the collection of evidence that is at most risk of contamination. It included guidelines for the collection,	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		identification and storage of physical evidence that may be essential to the investigation. It was evident that facility staff were quick to react to incidents and begin preliminary investigations. Staff informally interviewed regarding procedures when abuse and neglect was suspected stated their responsibility for safeguarding evidence in an investigation. There were no investigation reports that indicated the need to collect and store physical evidence. The facility was rated as being in substantial compliance with this provision item.	
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	The Interagency Memorandum of Understanding (MOU) Regarding the Investigation of Abuse and Neglect in State Supported Living Centers specified timeframes for the investigation process consistent with this provision. As of 6/1/10, DFPS was to complete investigations within 10 days unless a written extension was granted. The LSSLC procedure titled Investigations of Client Abuse, Neglect, and Exploitation, dated 8/10/10, described the mandated procedures to be used in investigations of abuse, neglect, and exploitation. Item XI.N stated that Priority I and II investigations must be completed and submitted to the facility director within 14 days, and Priority III investigations must be completed and submitted to the director within 21 days. This did not meet the requirements of this provision of the Settlement Agreement, however, out of the 14 investigations reviewed that occurred after 6/1/10, all but one were completed within 10 days. One was completed in 11 days. The facility will need to revise its policy to meet the new state guidelines in order to achieve substantial compliance with this provision item. DFPS investigations did not always begin within 24 hours of receiving the report. Some examples are below. • DFPS case #36942293 involving allegations of physical and emotional abuse was reported on 7/7/2010 at 5:43 pm. The investigation began on 7/9/10 at 12:15 pm. • DFPS case #36049669 involving allegations of physical and neglect was reported on 4/22/10 at 4:05 pm. The investigation began on 4/26/10 at 4:35 pm. • DFPS case #35151889 involving allegations of physical abuse was reported on 2/6/2010 at 4:18 pm. The investigation began on 2/9/10 at 4:30 pm. • DFPS case #35045549 involving allegations of neglect was reported on 1/28/2010 at 1:54 pm. The investigation began on 1/30/10 at 2:00 pm. All Unusual Incident Reports (UIR) completed by the facility indicated that internal investigations began as soon as the incident occurred or was discovered, usually within	Noncompliance

#	Provision	Assessment of Status	Compliance
		minutes. Individuals were examined by a facility nurse immediately in most cases. UIRs reviewed, however, rarely included recommendations and an action plan for following up on the incident. Some reports included the statement that the individual had received medical attention or would be seen by the psychologist, but no further steps for corrective action were indicated, and recommendations or follow up were not noted. For example: • Sections 10 and 13 were left blank on UIR #196, though medical care was provided immediately, and follow up medical care was needed. • UIR #161/DFPS case #36656009 was a confirmed case of emotional/verbal abuse. The UIR completed by the facility did not include recommendations for follow up. The facility needs to include any recommendations for corrective action or follow up in the UIR and indicate when the action is completed. DFPS reports included a summary of the investigation. Some of the investigations included recommendations for follow up action by the facility based on information gathered during the review. The facility was rated as being in noncompliance with this provision item. The facility policy needs to be updated to address current timelines as outlined in the MOU implemented 6/1/10.	
	(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	The policy mandated consistent investigation procedures and recordkeeping, including elements listed in this provision item. Investigation files were consistently compiled in a clear and easy to follow format. All investigations included the serious incident or allegation of wrongdoing, the name(s) of all witnesses, and the name(s) of all alleged victims and perpetrators (when known). Reports included a summary of topics discussed, a summary of all documents reviewed, and all sources of evidence considered. A log of previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency were included in evidence considered. The facility director had requested methodological reviews in four of the cases reviewed in the sample. As noted in the baseline report, DFPS had many new investigators and the facility was not in agreement with the investigation process completed in some cases. In three cases confirmed at the facility, a requested review of the case resulted in the finding changed to inconclusive. Eight (31%) of the 26 cases reviewed resulted in inconclusive findings. The high number of inconclusive cases, coupled with the number of methodological reviews requested by the facility, raised some concerns over the thoroughness of investigations completed by DFPS.	Noncompliance

#	Provision	Assessment of Status	Compliance
	recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	Investigations completed by the facility were thorough in summarizing the investigation and included a summary of evidence gathered and a basis for the conclusion.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	The state policy required that the Incident Management Coordinator review all investigations to ensure that they were thorough, accurate, coherent, and complete. All investigations were to be reviewed by the Incident Management Coordinator and the facility director or designee. Investigations remained an item for discussion on the Incident Management Team Meeting agenda until cases were closed and recommendations were completed. All investigations reviewed indicated that the final report had been reviewed by the IMC and the facility director or her designee. As noted in D3f, the facility requested further review from DFPS when they determined that evidence was not sufficient to support findings in an investigation, however, as noted in D3f, facility investigations did not always follow guidelines for a thorough and complete investigation. UIR #84 was the written report summarizing DFPS investigation #35045549. The UIR stated that the investigation was unconfirmed for abuse. The allegation investigated by DFPS was neglect and the finding was inconclusive. The report was reviewed and approved by both the IMC and the facility director as written. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The state policy required the facility to complete an Unusual Incident Report (UIR) for each incident at the facility. A sample of 20 UIRs completed by the facility investigators was reviewed by the monitoring team. A majority of reports included a summary of investigative procedures,	Noncompliance

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		relevant history, personal information about the individual, a time line of notifications, and an analysis of findings and recommendations for remedial action to be taken. There were some exceptions as noted in subparagraphs f and g above.	
	(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.	A log of employees reassigned due to ANE allegations and observation of Unit and Incident Management Team meetings indicated that employees were routinely reassigned to duties not requiring contact with individuals immediately when named in an abuse or neglect allegation. A review of disciplinary action for confirmed perpetrators in DFPS investigations indicated that in one case of physical abuse, the employees resigned; one case of neglect and one case of abuse, the employee was discharged; and in one case of neglect and two cases of emotional/verbal abuse, the employees were issued a letter of reprimand and then returned to regular duties. In case #35809649, DFPS reported findings were inconclusive, while OIG found evidence of criminal activity. The AP was returned to his position after the facility director determined that there was not strong enough evidence to change the DFPS finding from inconclusive to confirmed. Details of OIG findings were not available. Some examples of corrective action taken by the facility in response to incidents include: • UIR #197 indicated that disciplinary action was taken when the investigation revealed that staff left individuals unattended when she went to the restroom after an individual sustained injuries from a fall. The PST met to discuss safety measure to prevent a similar incident and maintenance was contacted to further safeguard the area. • UIR #190 involving a serious injury, indicated that the PST met to review the individual's level of supervision and an environmental check was completed. • UIR #200 indicated that that PST was to meet and discuss concerns noted by DFPS regarding the individual's safety and the unit director was to address concerns regarding staff's behavior. The facility is found to be in substantial compliance with this provision item.	Substantial compliance
	(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	All investigations requested by the monitoring team were quickly accessed by the facility. Investigation reports included a summary of previous investigations involving the individual and alleged perpetrator, indicating that information was readily available to investigators. The facility was found to be in substantial compliance with this provision item.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	particular staff member or individual.		
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The facility was able to provide the monitoring team with multiple logs of injuries and other incidents as requested. Incidents were trended by individual, home, cause, location, and date. It was not clear how the facility was using this information to address trends at the facility. Allegations and investigation trends were not provided to the monitoring team. This information needs to be trended, as well, to provide guidance in identifying any trends in regards to abuse and neglect. Information collected by the facility should be used to address systemic problems that are barriers to protecting individuals from harm at the facility. As the facility continues to develop a system of quality improvement, these reports will be critical in evaluating progress towards improvement. The facility needs to frequently evaluate how data can best be used to evaluate that progress. The facility was found to be in noncompliance with this provision item.	Noncompliance
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	The facility provided the monitoring team with a spreadsheet documenting fingerprinting, EMR, CANR, NAR, and criminal background check (if fingerprint results were not obtainable) for all employees and volunteers at LSSLC. Additionally, all employees were required to sign a form upon employment acknowledging their obligation to self report all arrests or indictments. DADS had developed a bar to employment indicating criminal charges that would make an applicant or employee ineligible to work at a state supported living center. When employees were charged with a criminal act that was not included on the list of bars, employment was at the discretion of the facility director. A sample of documents was reviewed that indicated employees were hired when criminal charges did not meet those bars to employment. Nine records were reviewed for employees with criminal charges. Documentation indicated that allegations were reviewed and the employee was required to submit findings from criminal charges and documentation of action taken in each case. Documents showed that when warranted, employees were placed on leave until cases were resolved and had restrictions placed on employment when warranted. For example, one employee charged with public intoxication returned to employment, but was no longer authorized to drive a facility vehicle. A sample was reviewed of employees who passed a criminal background check, but were	Substantial compliance

#	Provision	Assessment of Status	Compliance
		determined to be unsuitable for employment because they did not accurately disclose criminal history. The facility director made the final determination in all cases. The facility was found to be in substantial compliance with this provision item.	

Recommendations:

1. Implement an audit process to ensure all serious injuries are investigated thoroughly and reported to DFPS if evidence does not fully support how the injury occurred

2. Examine facility trends and look at specific indicators to develop a plan of correction to address any trends identified in injuries and incidents.

3. Posters with information on reporting abuse, neglect, and exploitation need to be posted in all common areas throughout the facility.

4. The facility needs to ensure that all employees receive annual training as required by state policies on abuse and neglect and incident management.

5. Investigations completed by the facility should represent objective reviews completed by staff outside of the direct line of supervision of the alleged perpetrator, as required by the Settlement Agreement. Unit Directors should not be charged with investigating incidents within the unit to which they are assigned job responsibilities.

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS policy #003: Quality Enhancement, dated 11/13/09 o Organizational chart, dated 9/21/10 o LSSLC policy list, 9/23/10 o Updated policies since April 2010 o List of typical meetings that occurred at LSSLC o LSSLC policy, Quality Enhancement Processes, Administrative-14, 1/5/10 o LSSLC policy, Quality Assurance Quality Improvement Council, Committee Councils-02, 9/22/10 o LSSLC POI, updated September 2010 o LSSLC POI Supplement, September 2010 o LSSLC QA Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 10/18/10 o LSSLC QA working document for a QA plan o QA department meeting minutes and materials for 7/5/10 o Description of QA activities, including thank you project, QA marquee flyers, and staff meetings o QA tools used by QA department: these were the monitoring team's tools, plus: • a PSP meeting observation checklist • meal monitoring • medication administration • individual notebook observation notes (for purposes related to protection from harm) • schedule II medications • infection control • treatment and protection of rights (in response to ICFMR findings) o Trend analysis: typical statewide information, but only the following was submitted: • Injuries, March 2010, 3rd quarter, 4th quarter • Restraints, March 2010, 3rd quarter, July 2010, 4th quarter o Individual to individual aggression data for 3rd quarter 2010, June 2010, July 2010, August 2010, and 4th quarter o PIC meeting minutes: 5/24/10 through 8/124/10 (four meetings) o QAQI Council meeting minutes: 9/22/10 and 10/21/10 o Kathy Thompson, QA director, email regarding inter-rater reliability on monitoring tools, 9/15/10 o DADS survey of staff engagement (satisfaction) for LSSLC staff, 2010 o Draft survey of family satisfaction, September 2010 o Self-advocacy meeting minutes since the baseline review: House 520 (two), Main St. (one), Woodland Crossing (one), Lone Pine (one). <u>Interviews and Meetings Held</u>:

	o Gale Wasson, Facility Director o Kathy Thompson, Director of Quality Enhancement o QA staff program compliance monitors: • Tabitha Anastasi, Elizabeth Canley, Stacie Cearley, Gena Hanner, Marvin Stewart, Stephen Webb o Nikki Yost and Sherry Roark, Settlement Agreement Coordinators o Residential Unit Directors: • Rotley Tankersley, Glenn Heath, Kenneth Self, Keith Bailey, Todd Miller o Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs. <u>Observations Conducted</u>: o Many residences, day program, and vocational program o Facility administration meeting, 10/19/10 o QAQI Council Meeting, 10/21/10 o Self-advocacy meeting, Oak Hill/Castle Pines, 10/19/10
	Facility Self-Assessment: The facility completed its self-assessment for this provision, called the POI. The POI listed all of the outcomes the facility hoped to measure to work towards achieving substantial compliance with this provision. The facility rated itself as being in noncompliance with every item in its self-assessment. Little information was provided as to what the facility did to make these determinations other than providing one or more of the same comments for most all of the items. The comments were about upcoming policy changes from the state or that the facility would initiate CAPs at upcoming QAQI Council meetings. Given the many upcoming changes to quality assurance practices that are anticipated to occur at LSSLC over the next few months, it is hoped that the facility will engage in specific activities to self-assess the status of its performance for this provision and all of its components. The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the self-assessment's findings of noncompliance in all areas, except that the monitoring team noted highlights regarding some quality assurance-related activities that were occurring across the facility (e.g., data collection, some graphing of data). The monitoring team's review was based upon observation, interview, and review of a sample of documents. The facility will need to do much of the same in order to conduct an adequate self-assessment.
	Summary of Monitor's Assessment: LSSLC was not in compliance with this provision. Little activity had occurred since the baseline monitoring review. There were plans to revise the overall QA program at the facility and across the state. This included the creation of a Quality Assurance and Quality Improvement Council (to replace the PIC) and the

	contracting with an outside vendor to develop a QA program at each facility. At the time of this monitoring review, an adequate, comprehensive quality assurance plan did not exist. Facility-wide data were not directed to the QA department. Regular reports were not completed by the QA department for use by senior management. Even so, a number of QA-related activities continued to occur at LSSLC, including the observation and monitoring of various areas by department staff across the facility. The data, however, were not organized under a QA plan as to what data should be collected by QA staff, what data should be submitted by facility departments to the QA department, and how those data should be handled once submitted. The monitoring team's checklist tools were being sampled and tried out by the QA staff and many other managers around the facility. QA staff had engaged in many activities to integrate their work into the overall operation of the facility and to have the QA department become known to staff and to be seen in a positive light. This included the distribution of Thank You notes to staff observed doing a good job, a weekly drawing for a small prize, a monthly one-page newsletter, and a weekly meeting of QA staff to discuss the prior week's activities and successes. Initial attempts at CAPs were seen at the facility. There appeared to be confusion, however, between CAPs, PETs, and PITs. This will require some attention from facility management and, perhaps, DADS central office. Self-advocacy activities remained weak. Little had occurred since the baseline monitoring review. A new rights protection officer had recently been assigned at the facility. It is expected that the quality assurance program will develop and mature over the next few years at LSSLC. Improvements and developments will be needed in the breadth of the quality assurance activities, the validity and reliability of the QA department's data collection activities, the thoroughness of the QA Plan, the use of graphic presentations, and the writing and disseminating of a regularly produced quality assurance report. Other comments are detailed below in this section of the report.

#	Provision	Assessment of Status	Compliance
E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care;	Based upon a review of documents, interviews with facility staff, and observations at the facility, LSSLC was not in compliance with this provision item. This was due to a number of factors, some of which are listed below. • DADS was in the process of changing the overall approach of QA at the facilities to one that addressed the overall operation of the facility and incorporated all aspects of programming (as required by the Settlement Agreement and as	Noncompliance

#	Provision	Assessment of Status	Compliance
	individual staff; and/or individuals receiving services and supports.	recommended in the baseline report). The major shift was to change the PIC to a new committee called the Quality Assurance Quality Improvement Committee. This new committee and process were beginning at LSSLC; the first meeting had occurred in September 2010 and the second meeting occurred during the week of the onsite review and was observed by the monitoring team. • New policy revisions were being developed for the facilities by DADS central office. These had not yet been disseminated at the time of the onsite review. • DADS contracted with an outside vendor to develop and help implement a quality assurance system at each facility. The focus appeared to be on ICFMR regulatory compliance. Activities had not yet started at LSSLC at the time of the onsite review. In addition, the DADS central office was re-organizing somewhat, and a new central office head of quality assurance was not yet appointed. As a result, all of the procedures and processes that were in place at the time of the baseline review, remained in place. So, although LSSLC was not in compliance with this provision item, the many activities that were noted in the baseline report continued to occur. Therefore, there remained a solid base upon which a quality assurance program could be built to meet the requirements of this provision. Further, some new activities were occurring as detailed below. <u>Policies</u> The Director of Quality Assurance told the monitoring team that the state policy on quality enhancement (policy #003, dated 11/13/09) was the policy used by the facility. In addition, the facility policy, Quality Enhancement Processes, Administrative-14, dated 1/5/10, remained active in the facility's policy and procedure manual. This facility policy was not adequate to direct facility quality assurance activities, as described in the baseline report. An updated facility policy will need to be developed if the facility chooses to have a policy in addition to the state policy. Either way, the QA director should ensure that outdated QA-related policies are updated, removed, or incorporated into newer policies. Consideration should be given to having facility policy only include those aspects that are above and beyond what is in the state policy. In this way, future revisions to state policy might not require a revision to facility policy. LSSLC will need to ensure that any facility policies regarding quality assurance are in line with any state policies. Further, any facility policies related to QA should be reviewed and approved by DADS central office. <u>Quality Assurance Plan</u> The DADS policy required the development and implementation of a quality enhancement plan (QA plan). Moreover, a QA plan will increase the likelihood of the facility meeting the requirements of this provision. A QA plan did not exist at LSSLC.	

#	Provision	Assessment of Status	Compliance
		In general, a QA plan should indicate all areas that are to be audited, the tools to be used, the frequency of audits, and the staff who are responsible for these audits. It may also include the types of data that should be submitted to the QA department from the various departments and divisions of the facility. It should also describe the type of report(s) to be generated. Again, there was no QA plan at LSSLC and the absence of a plan should not be taken lightly by the facility. A plan needs to be developed. The QA director, however, shared a working document with the monitoring team. It listed 17 LSSLC staff members (from QA and other departments) and their responsibilities for certain Settlement Agreement provisions, CAPs, ICFMR plans of correction, and risk management. It also included a brief description of the purpose of, and attendees required to attend, 16 different committee meetings at the facility. The monitoring team did not believe that this document would lead to an adequate QA plan because it did not delineate the types of data collected throughout the facility, the methods of data collection, and how the data were handled and reviewed once collected. The QA director will need guidance from DADS central office and from facility senior management to develop a comprehensive QA plan that will meet the informational and operational needs of the facility. The QA department should play a role as a repository for all activities at the facility so that the information can be synthesized, summarized, analyzed, and presented to senior management in a manner that is useful for decision making and efficient and effective management of all services and supports at LSSLC. A number of comments regarding the QA plan were made in the baseline report in section E1, under the heading Quality Enhancement Plan. The comments in the baseline report remained relevant at the time of this monitoring review. The comments addressed the following topics and are not repeated in detail in this report: • Areas to be included in the QA plan • Specific items to be included in the QA plan • Inclusion of all QA-related activities being conducted at LSSLC • Satisfaction of individuals, families and LARs, staff, and the community • Role of the self-advocacy group In the baseline report, the monitoring team recommended that a variety of satisfaction measures be obtained as part of the QA system at LSSLC. One measure should address staff satisfaction. A statewide staff satisfaction survey was conducted in February 2010	

#	Provision	Assessment of Status	Compliance
		and the results were separated out for each facility. The survey was conducted by the University of Texas. It contained 71 standard items across a variety of work areas, as well as an additional 20 items specific to DADS facilities. The results provided the facility with relevant information that, according to the facility director and QA director, was going to be used by management, with direction from DADS central office, to develop and implement a plan in response to these results. About one-third of facility staff participated (445) and about half of the participants considered themselves to be in a supervisory role. Some of the items that were rated highly were about staff valuing their jobs and doing important work. Interestingly, for item #63 about half of the respondents disagreed with the statement "I believe favoritism (special treatment) is not an issue in my organization." This was an example of an item that needed to be further explored by the facility. Either this was a serious issue for staff, or perhaps the double-negative wording might have caused confusion (i.e., disagreeing with a statement about favoritism not being an issue). In addition to responding to the findings in the survey, the facility should also consider ways of increasing participation in future surveys, ensuring more participation from direct care staff, and including some way for staff to make suggestions, either within the survey or through some other procedures. For example, Mexia SSLC had suggestion boxes located throughout the facility. Each week, senior management reviewed all suggestions submitted and responded, when possible. The ongoing submission of suggestions indicated that it was likely that facility management was responsive (otherwise the number of suggestions would have likely decreased to zero). In addition to the staff survey, DADS was coordinating the development of a survey of family member satisfaction. A workgroup of staff and administrators from different facilities participated. The monitoring team had the opportunity to see the draft survey. Overall, there were many relevant questions. Questions regarding planning for community placement, however, were not included and should be added. During the week of the onsite review, the monitoring team had the opportunity to meet family members of three individuals (Individual #312, Individual #349, and Individual #96). All family members expressed their satisfaction with the services and supports received by their adult child or sibling. A measure to survey the satisfaction of related community agencies, providers, and vendors was not yet in place. The monitoring team discussed ways of doing so with the Quality Assurance director during the week of the onsite review. As also noted in the baseline report, self-advocacy meetings present another way of obtaining information that may be useful to the QA department and facility management.	

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		It also can provide a context in which individuals can be taught group problem solving and decision making skills. Self-advocacy activities at LSSLC, however, were weak. Meetings were infrequent (too infrequent for individuals to learn and practice self-advocacy skills) and appeared to contain not much more than the presentation of information to individuals. As evidence from meeting notes and observation: • The self-advocacy group for Home 520 had met twice, once in March 2010 and once in June 2010. In March 2010, the facilitators (facility social workers) discussed people first language style. In June 2010, the facilitators reviewed the first half of a rights book, and discussed active treatment activities and home schedules. • One meeting for the Main Street homes occurred in March 2010. The topics were people first language style, and recreational activities. • One meeting occurred in June 2010 for Woodland Crossing. The topics were speaking up for oneself, rights (e.g., religion, possessions), responsibilities, and the role of the rights officer and ombudsman. • The one Lone Pine meeting also occurred in June 2010 and topics were a discussion of the individuals' rights poster, and one individual's request for more outings to the community. • The Oak Hill/Castle Pines group had not met since the week of the baseline review. The group met again during the onsite monitoring review week and was attended by the monitoring team. The topics were the importance of attending one's own PSP meeting, recreational activities, and plans for upcoming meetings. A new rights officer was hired since the baseline monitoring review. One of his responsibilities was to develop the self-advocacy activities at LSSLC. The monitoring team suggests that problem solving and decision making skills be included. That is, that self-advocacy meetings and activities include methodologies to teach individuals to define problems, generate possible solutions, choose a solution, develop a plan, and implement and evaluate the plan, in other words, that they be taught <u>how</u> to self-advocate. <u>QA Department</u> All of the staff in the QA department remained the same since the baseline review. The director, Kathy Thompson, supervised six QA program compliance monitors (one of whom was the QA nurse), the human rights officer, a data analyst, three unified records coordinators, the facility lead investigator, the director of staff training (Competency Training and Development), four overnight campus administrators, and a QA clerk. Since the baseline review, LSSLC had responded to the monitoring team's recommendation to	

#	Provision	Assessment of Status	Compliance
		review the director's responsibilities and had determined that no changes were necessary. The QA program compliance monitors were each assigned specific responsibilities. The monitoring team met with this group and talked about their responsibilities, the use of monitoring tools, QA reports, and data graphing (when to use a line graph versus when to use a bar graph). The program compliance monitors were more knowledgeable about the content of their specific areas than they were during the baseline and they continued to display a desire to provide a useful service to the facility. The facility was fortunate to have this group of staff working in the QA department. Nikki Yost and Sherry Roark, the Settlement Agreement Coordinators, played a large role in the QA processes at the facility. The role of the SAC was likely to change somewhat given the upcoming modifications to state and facility policy, the QAQI Council format, and the development of a comprehensive QA plan. The SACs were extremely helpful to the monitoring team, including obtaining documents, arranging for interviews, and describing facility processes. They were professional, organized, and responsive to the many requests of the monitoring team during the weeks before, during, and following the onsite review. The QA department, under the director's leadership, had taken a number of steps to more fully integrate the QA department into the facility. The goals were to make facility staff more aware of their work, to see QA staff as a reinforcing presence, and to create a well-working QA team. Some of the QA department's activities in this area are listed below. The monitoring team was impressed with these efforts and hopes they will continue. • QA staff read and learned from published team building literature (e.g., Soup books by Jon Gordon). • QA staff gave out thank you cards to many staff members who were seen doing a good job at the facility. This began in July 2010. Approximately 30 cards were given out each month. At the end of the month, a drawing was held and two staff selected received a gift certificate to a local store. • The QA department published and distributed a monthly one-page newsletter about QA activities. It contained a listing of all staff who received a thank you card, the names of the two staff who won the drawing, short biographies of QA staff, and a short paragraph about a different Settlement Agreement provision each month. • The QA team met on Friday mornings to discuss/share activities from the previous week.	

#	Provision	Assessment of Status	Compliance
		Continued professional development for quality enhancement staff was recommended in the baseline report and a number of QA staff had, or were scheduled to attend training sessions on a variety of topics. Moreover, the state central office had conducted a two-day training session for QA directors and Settlement Agreement Coordinators in May 2010. A second gathering had been cancelled, but the plan was to reschedule for sometime soon. The QA director had also attended an orientation to the new state consultant for QA and she reported that she will receiving training on conducting mock ICFMR surveys. Other trainings included the new PSP process and attending a conference on habilitation therapies. More training on content areas and in general quality assurance practices is recommended for the QA staff. The director might obtain suggestions from the QA program compliance monitors regarding some of their training needs. In addition, the QA director reported that she and four other staff had traveled to Mexia SSLC and met with QA staff there. This type of cross-facility communication will likely be helpful to both facilities in achieving substantial compliance with this provision of the Settlement Agreement. <u>QA Activities and Indicators</u> Most of the tools described in the baseline monitoring report continued to be implemented at LSSLC. In addition, the facility was working on incorporating the use of the monitoring tools used by the monitoring teams (see below for more comments). Some tools were used by the QA program compliance monitors. Others were used by staff throughout the other departments at the facility. Examples included tools for the following areas: • PSP meetings • mealtimes • medication administration • individual notebook observation notes (for purposes related to protection from harm) • schedule II medications • infection control • treatment and protection of rights (in response to ICFMR findings) • Facility Support Performance Indicators (FSPI, a standardized tool, entered into a statewide computer database; this was the first time the monitoring team had heard about these indicators) • Three tools used for psychology and psychiatry • PNMP positioning • tracking of individual to individual aggression In addition to the QA and SAC staff, many other staff (e.g., managers, clinicians,	

#	Provision	Assessment of Status	Compliance
		therapists) around the facility collected data for their own departmental operations and services. Some of these data were given to the QA department, some were given to the SACs, and some were kept by the department for its own use. These data, however, were not organized by any overall QA plan, there was no consistent analysis process, and a report for senior management did not exist. A standard data set across all DADS facilities was called the Trend Analysis. At all facilities, four types of data were collected. From LSSLC, only two of these four types of data were submitted to the monitoring team as listed below (data for allegations of abuse and for unusual incidents were not submitted). • Injuries, March 2010, 3rd quarter 2010, 4th quarter 2010 • Restraints, March 2010, 3rd quarter 2010, July 2010, 4th quarter 2010 Also, there was no special attention paid to ensuring that quality assurance activities were occurring for the four specific provisions of the Settlement Agreement that called for quality assurance or quality improvement activities (F2g, L3, T1f, and V3). In addition, there was no special attention paid to the Health Care Guidelines or Dental Guidelines by the QA department. Below are examples of other areas that might be incorporated into the LSSLC QA program. • Set of nursing data collected by the nursing department, especially regarding the incidence of certain disorders and illnesses. • Set of data collected and managed by the medical department, including, for example, hospital admissions and discharges, ER visits, facility admissions, sick calls, labs, x-rays, and outside referrals. • Direct care staffing levels. Comments made in the baseline report in section E1, under the heading QA Activities, also continued to apply at the time of this onsite monitoring review, including those related to the reliability and validity of the QA process. The monitoring team was pleased to see that LSSLC had made some efforts to incorporate the contents of many of the tools used by members of the monitoring team. As discussed at length with the QA director, and again at the exit session during the onsite review, please remember that these tools were designed for use by the monitoring team and, therefore, many items will need to be adapted for use by facility staff. Additional points are listed below. • The monitoring tools do not include instruction sheets or guidelines. These	

#	Provision	Assessment of Status	Compliance
		would need to be developed to: o Ensure that various facility staff implementing the tools were using the same methodologies to rate indicators, thereby increasing the likelihood of inter-rater reliability; and o Provide adequate guidance to reviewers who did not have specific subject-matter expertise to ensure accurate rating of the tools. Again, these tools were developed by and for the use of monitoring team members with substantial subject matter knowledge. If they are going to be used by, for example, QA staff, who had more limited subject matter expertise, it will be essential that specific, written guidance is available to assist in rating indicators, as well as training, and ongoing technical assistance by subject-matter experts. • These tools should not be used to generate a cumulative score with regard to substantial compliance. The items on the tools have not been weighted, but would need to be if they were going to be used in this manner. • Some of the indicators on the tool were specifically designed for a team approach to monitoring. For example, some indicators reference gathering information from other team members who have specific expertise or who engaged in specific activities during the week of the onsite monitoring review. • At times, it may be beneficial for separate scoring sheets to be developed to assist with the data collection necessary to score some of the indicators. Not all of the current monitoring tools facilitate this process because they track very closely the requirements of the Settlement Agreement that calls for, for example, policy development, as well as policy implementation. As a result, they are not necessarily formatted to allow easy review of only individual records or only policy. A separate sheet likely would assist in this process. On 9/15/10, QA director sent an email to the facility management staff that after reading the Corpus Christi SSLC compliance monitoring report (that had comments similar to the above), she had instructed her QA staff to hold off on any efforts to determine inter-rater reliability on the current monitoring tools due to questions about their usage. She instructed her staff to continue using these during this period while the tools were being revised and updated for facility usage. Similarly, on 10/1/10, DADS sent a note to the QA director telling her that the monitoring tools will be updated and modified for facility use. The monitoring team was pleased to learn about these plans and looks forward to their development and implementation. <u>QA-Related Committees</u> The DADS policy required a minimal number of operating committees to be in operation at the facility. The policy listed restraint reduction, human rights, health status, incident	

#	Provision	Assessment of Status	Compliance
		management, behavior support committee, pharmacy and therapeutics, infection control, and skin integrity. Most of these were in operation (or were soon to be in operation) at LSSLC, according to the QA director. The policy required a program improvement council; this was in place at LSSLC and is described in section E2 below. It was changed to a new title, the QAQI council and it is likely the new policy for this area will describe the QAQI council. The facility held a daily Incident Management Team meeting. This was a daily meeting during which senior management reviewed the previous day's incidents, emergency restrictions and supervision levels, restraints, sedations, injuries, infirmary status, and aggression between individuals. Although this meeting was not a QA meeting, it might be used by facility administration (in addition to the QAQI council described in section E2 below) as a way to incorporate QA activities into the daily operation of the facility (also see section D of this report). Once each week, the meeting was expanded to review the status of community placement referrals and transitions. <u>QA Reports</u> The DADS policy also required performance improvement reports. These were to be self-assessments completed on a monthly basis, but there was no evidence of any type of performance improvement report at LSSLC. The monitoring team believes that a QA report will help the facility to achieve substantial compliance with this provision.	
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.	This provision item required the facility to analyze the data collected by the QA processes that were implemented at the facility. Based upon a review of documents, interviews with facility staff, and observations at the facility, LSSLC was not in compliance with this provision item. The facility's POI also indicated noncompliance. Further, the comments provided in the baseline report in section E2 continued to be relevant. A quality assurance report did not exist and was not in the process of being developed or created. A quality assurance report should include data, line graphs, and narrative, at a minimum. LSSLC did not have any type of quality assurance report other than the state required trend analysis, but as indicated above, the monitoring team was only given data and information regarding two of the four areas that were typical of the trend analysis report. The monitoring team, however, wishes to note the facility's responsiveness to the recommendation made in the baseline monitoring report for the use of line graphs. A number of line graphs had been added to recent trend analysis reports. The monitoring team had discussions with QA staff about the line graphs and ways to improve their use and determine when it was, and was not, appropriate to use line graphs versus bar	Noncompliance

#	Provision	Assessment of Status	Compliance
		graphs. Line graphs should be used to portray trends over time (e.g., injuries by month). Bar graphs are more appropriate for data that are independent from each other, such as aggression by home. <u>Performance Improvement Council and QAQI Council</u> The Performance Improvement Council (PIC) was one component of the analysis of data system as called for by the state policy on Quality Enhancement. As noted above, the purpose of the meeting will change to have a facility-wide focus. This change had recently begun at LSSLC. The monitoring team reviewed minutes from four PIC meetings. Topics included the Settlement Agreement, general comments from the monitoring team's baseline report (no details noted), the POI, ICFMR regulatory, injury and restraint reports, the new individual record system, and community relations. The minutes from the first QAQI Council indicated some discussion of the new policy and procedures for this group as well as informational updates from the facility director. In general, it appeared to be a meeting during which information (albeit important and relevant) was presented rather than a discussion of data and findings from QA. The monitoring team attended the second meeting of the QAQI Council during the week of the onsite review. The monitoring team appreciated the facility director's re-scheduling of the meeting to a day and time that accommodated the monitoring team's schedule. The meeting lasted for about an hour and was led by the facility director. For the most part, the meeting was a sharing of information from the facility director and from many members of senior management (e.g., new binders for QAQIC participants, upcoming management retreat, employee survey results, ICFMR investigation status, Settlement Agreement, POI, Life Safety Code). The meeting will likely evolve into a more thorough discussion of QA-related topics. It was evident that the participants were ready to move in this direction. For example: • Data were collected by the QA staff due to observed increases in individual to individual aggression. Data were reviewed and indicated that most occurrences were at two homes and many occurred in the morning. There was a suggestion that, in those homes, breakfast was served at the same time that the individuals were supposed to be at work (8:30 a.m.). This was an excellent example of how a problem was identified, data were collected, and the data indicated some areas in which intervention could occur. • The assistant director of programs talked about perhaps developing a PIT for the correct labeling of clothing to identify the individual owner. • The director of the QMRP talked about and presented data on PST member	

#	Provision	Assessment of Status	Compliance
		attendance at annual PSP meetings. • There was discussion of the new food cutting and dicing machine and how it addressed a CAP. • There was discussion of the development of a new CAP to address correct documentation of seizures. • Formation of a PIT was discussed to address alternative dining arrangements. <u>CAPS, PETS, and PITs</u> There was no organized system of generating, developing, disseminating, implementing, monitoring, documenting, modifying, or managing corrective action plans (CAPs) at LSSLC. The facility, however, was preparing to begin to do so, as evidenced by the above examples. There appeared to be a lot of confusion regarding the differences between CAPs, Performance Evaluation Teams (PETs), and Performance Improvement Teams (PITs). The facility will need direction from state office (perhaps via the upcoming revisions to the state policy) regarding definitions, and when it is appropriate to start a CAP versus a PET versus a PIT. The monitoring team expects that an organized system of CAPs will be created and maintained in the future and be available for review for the next monitoring review.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	LSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
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.	LSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	LSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance

Recommendations:

1. Implement the new QAQI process.

2. Implement new state policy when disseminated.

3. Ensure all facility policies are in line with state policy. Obtain DADS approval for facility policies.

4. Create a facility QA plan that is functional, meaningful, and useful to LSSLC managers, administrators, and clinicians regarding Settlement Agreement provisions and other areas of service provision (e.g., ICFMR regulations). The plan also needs to include:
    - all requirements of the DADS policy on Quality Enhancement,
    - a narrative,
    - all of the areas listed on page 4 of the policy, and
    - the Health Care Guidelines and Dental Guidelines

5. Ensure validity and reliability of data collected at the facility and by the QA program.

6. Subject the QA department to quality assurance review, feedback, and assessment.

7. Respond to recently obtained staff satisfaction survey data.

8. Develop a satisfaction measure for individuals, family members and LARs, and affiliated agencies and providers.

9. Develop a QA report that includes a summary of all activities, data, trends, and narrative that describes important points about the data.

10. Develop a system to develop and manage CAPs, following all requirements of provision items E1, E2, E3, E4, and E5.

11. Plan for the professional development of QA staff. Ensure QA staff participation in the development of these plans.

The following are offered as additional suggestions to the facility:

12. Consider ways to incorporate the teaching of problem solving and decision making into the self-advocacy group meetings.

13. Implement a procedure to obtain suggestions from staff members.

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o PSPs for the following individuals: • Individual #387 dated 7/7/10 • Individual #203 dated 10/20/09 (including BSP and Safety Plan) • Individual #67 dated 7/14/10 (including PFW and Functional Assessment) • Individual #339 dated 8/16/10 (including PFW and Assessments) • Individual #312 dated 10/20/09 • Individual #491 dated 5/12/10 • Individual #557 dated 10/15/09 (including BSP) • Individual #194 dated 5/4/10 • Individual #573 dated 7/6/10 (including PFW and Assessments) • Individual #57 dated 11/18/09 (including BSP and Safety Plan) • Individual #524 dated 4/20/10 (including PFW and Assessments) • Individual #431 dated 7/20/10 (including PFW and Assessments) • Individual #238 dated 1/27/10 • Individual #122 dated 11/9/09 • Individual #600 dated 1/12/10 (including BSP) • Individual #167 dated 10/23/09 • Individual #176 dated 4/6/10 (including BSP) • Individual #124 dated 12/16/09 • Individual #57 dated 4/20/10 • Individual #323 dated 2/10/10 • Individual #77 dated 6/9/10 • Individual #106 dated 3/9/10 • Individual #560 dated 10/13/10 (PSPA/ transfer plan) • Individual #244 dated 9/14/10 (including BSP) • Individual #43 dated 8/16/10 (including PFW and Functional Assessments) • Review of the PSPs and addendums for 21 individuals prescribed psychotropic medications (see section J) • List of individuals in Supported Employment • List of individual referred for community placement since 1/1/10 <u>Interviews Held:</u> o Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs

	o Luz Carver, QMRP Coordinator o Lisa Curington, Director of Day Programs o Patricia Whittington, Supported Employment o Stacie Cearley, Program Compliance Monitor o Sylvia Middlebrook, Ph.D., Chief Psychologist o Kenneth Self, Glenn Heath, Todd Miller, Keith Bailey, Rotley Tankersley, Unit Directors o Jason Peters, Human Rights Officer o Royce Garrett, Consumer/Family Relations Director o Facility psychiatrists <u>Observations Conducted</u>: o Observations at residences o Observations at the onsite workshop and day program o Daily Incident Management Meeting 10/19/10 o Daily Incident Management Meeting 10/20/10 o PSPA Meeting for Individual #600 10/19/10 o PSP Annual Meeting for Individual #140 and Individual #167 o Woodland Crossing Morning Meeting 10/20/10 o Human Rights Committee Meeting 10/20/10 o Health Status Team Meeting 10/20/10
	Facility Self-Assessment: The facility was waiting on the new state policy to offer direction prior to implementation of a self assessment for section F. The policy had been revised at the time of the monitoring visit, but had only been implemented for a few weeks prior to the monitoring visit. The facility was only in the beginning stages of addressing this provision of the Settlement Agreement and, therefore, most of the items required by this provision were either not developed or not yet implemented. As a result, noncompliance was the rating determined for most of the items in this provision.
	Summary of Monitor's Assessment: The DADS policy for this section had been revised and approved 7/30/10. The forms and instructions relative to PSP development had been revised prior to the monitoring visit, though QMRPs had only recently completed training on the new procedure. Most of the PSPs reviewed for compliance with this provision were dated prior to the approved policy revision and subsequent changes in PSP format, therefore, the monitoring team was unable to fully assess implementation of the new policies and procedures for compliance with this provision. QMRPs had attended training on developing person centered plans. They were just beginning to implement the new process at annual PST meetings. Four PST meetings were observed the week of the monitoring visit. For all QMRPs facilitating the meetings, it was only their first or second time to facilitate

	PST meetings using the new format. As expected, the meeting format was noticeably uncomfortable for the QMRPs and the other team members. On the other hand, a family member at one of the meetings stated at the end of the meeting that this was the best team meeting she had ever attended. She felt that she was more involved in the discussion around the needs of her brother and less time was spent reviewing information. In two of the meetings observed, it was noted that the QMRP attempted to facilitate open discussion around the individual's likes, dislikes, and preferences. Team members contributed to the discussion and, in both meetings, a fairly comprehensive list of what the individual wanted in his or her life was developed, however, it was not clear that this led to person centered outcome development. After much discussion around the interest and needed supports for Individual #140, the meeting ended with no discussion specific to what outcomes would be worked on during the upcoming year. The monitoring team met with the QMRP Coordinator and some of the QMRPs during the monitoring visit. The QMRP department had already implemented some changes and were trying to focus on a process that would encourage better person centered planning and bring PSP development in line with requirements of the Settlement Agreement. Quality Enhancement activities with regards to PSPs were in the initial stages of development. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan based on the preferences and vision of the individual. A sample of 25 Personal Support Plans (PSPs) was reviewed. Plans in the sample ranged in development date from 10/15/09 to 10/13/10. The most recent plan dated 10/13/10 for Individual #560 was an update to her annual PSP. The format of the plan indicated that there were some very positive changes occurring in PSP development that would lead to individuals having plans that were useful guides to staff supporting the individual on a daily basis. Information regarding the individual's diagnosis and support needs were much more clearly stated in terms of how those needs would be addressed on a daily basis to ensure the individual's health, safety, and ability to function more independently. Some examples of positive changes in the informational/assessment section of the PSP included the following:. <u>Physical/Medical Section</u> • Individual #122's plan dated 11/9/09 stated a continual medical program was in effect and acute medical care was provided as needed. • Individual #106's plan dated 3/9/10 stated Dr. Chang gave an oral report at the PSP meeting, with no new recommendations. • Individual #560's plan dated 10/13/2010 stated the last medical evaluation was dated 12/29/09. The following active diagnoses were noted on the summary: seizure disorder, complex partial evolving to generalized; Down Syndrome; venous stasis and pedal edema of the lower extremities; recurrent hypothermia; Alzheimer-type dementia; gastrostomy tube, hypothyroidism; peripheral vascular insufficiency, disc degenerative disease consistent with cervical degenerative disease; and chronic UTI. She was currently in the infirmary, post hospital discharge for the treatment of pneumonia.

	Dental • Individual #122's plan notes: continue with good oral hygiene • Individual #106's plan notes: recall for prophylaxis • Individual #560's plan notes: has one remaining tooth. Staff should continue the usual brushing of that tooth and her gums. There was no history of dental desensitization Individual #560's plan instructed staff in supports. We hope to see plans more specific in what supports should be offered to follow up on assessment recommendations as the new PSP process develops. There was little integration of psychiatry into the treatment planning process. Per interviews with psychology and psychiatry staff, psychiatrists were attending some treatment-planning meetings. Reviews of selected PSP sign in sheets did not reveal signatures of the psychiatric physicians indicating attendance, however, tracking documentation indicated that the psychiatrist had attended 42 of 497 PST meetings between the dates of 8/2/10 and 9/30/10 (only 8%). A review of the personal support plans for 21 individuals prescribed psychotropic medication did not contain detailed discussions of pharmacological plans or the thought processes behind the use of particular medications (see section J below). The PSPs reviewed included a list of "What's most important to the person?" For the majority of plans reviewed, this list was individualized, fairly comprehensive, and offered a good starting point for plan development. It was not evident that this list was always the central focus in planning for the person. As the facility continues to progress toward developing person centered plans for all individuals at the facility, QMRPs need to keep in mind that PSPs should be a working document that will guide staff in providing supports to individuals with changing needs. Plans should be updated and modified as individuals gain skills or experience regression in any area. Recommendations throughout this report regarding implementation and monitoring of treatments should be considered when developing the PSP. PSPs should include a description of all supports that the individual will receive, including a description of residential, day, medical, psychological, psychiatric, and therapy services, along with a schedule of when these services will be provided, where they will be provided and what types of supports the individual will need throughout the day to support participation. Outcomes should reflect a plan to provide supports necessary to help each individual achieve his or her individualized vision. The overall goal of the plan should be to ensure that each individual develops or maintains skills necessary to participate to the extent possible in daily activities that are meaningful to that individual. All healthcare and behavioral risks should be identified and the team should integrate recommendations from specialists into one comprehensive plan that offers clear guidance to direct support professionals responsible for implementing the plan.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
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.	QMRPs at the facility were responsible for facilitating PST meetings, and for developing, monitoring, and revising treatments, services, and supports. Interviews with QMRPs during the review process revealed that they were generally aware of the range of supports and services being offered to the individuals whom they supported. As discussed in other sections of this report, it was not evident that assessments relevant to planning for each individual were being completed prior to PSP development, nor were plans consistently revised when not adequate or effective. See comments throughout this report regarding plan implementation and documentation. It was noted during the monitoring visit that PSPs were not always available to support staff. QMRPs should ensure that direct care staff have current information needed to support each individual safely and consistently, and that all plans are being implemented as written. Current PSPs should be available to all staff responsible for plan implementation and implementation should be documented. The facility was found to be in noncompliance with this provision item.	Noncompliance
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	The PST annual meetings observed during the monitoring visit indicated that the PST was comprised of an interdisciplinary team based on the individual's strengths, preferences, and needs. The individual was present at the meetings observed and staff that provided direct support to the individual were present at the meeting and given the opportunity to contribute to discussion. Only four of the PSPs requested by the monitoring team included a sign in sheet indicating who participated in the annual PST meeting. A review of the sample of attendance sign in sheets indicated that relevant team members were not always present at annual PST meetings: • For Individual #43, the PST signature sheet did not indicate the presence of some key team members. The LAR/advocate, habilitation therapy, RN Case Manager and the individual were present for the meeting. • For Individual #339, the PSP did not indicate that the LAR, individual, or	Noncompliance

#	Provision	Assessment of Status	Compliance
		Habilitation Therapy staff were in attendance at the meeting. • For Individual #431, there was no indication that habilitation therapy was in attendance at the annual PST meeting. This individual was a diabetic and currently received SLP services. • There was no indication that Individual #67 attended the meeting, nor did the LAR. • There was little integration of psychiatry into the treatment planning process. Reviews of selected PSP sign in sheets did not reveal signatures of the psychiatric physicians indicating attendance. If individuals are present at their PST meetings, but unable to sign the attendance sheet, the QMRP should indicate that the individual attended the meeting on the sign in sheet. When key members of the PST are unable to attend meetings, it is suggested that the team documents any attempts to get input before the meeting and include recommendations from the team member not attending in the individual's PSP. The facility was rated as being in noncompliance with this provision item.	
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.	Assessments were performed prior to PSP development. Brief summaries of those assessments were included in the PSP narrative. It was not always evident that relevant assessments based on each individual's needs and preferences had been considered prior to PSP development in all cases. The Personal Focus Worksheet (PFW) was the individualized assessment screening tool used to find out what was important to the individual, such as goals, interests, likes/dislikes, achievements, and life style preferences. The PFW was not always completed in a manner that allowed the PST to develop a plan to include the individual's preferences. For example, the PFW summary for Individual #339 was blank for what he wanted to accomplish, what made him happy, what made him upset, and whether or not he was satisfied with his life. These questions are key to being able to develop a person centered plan. Once the team establishes the individual's life-style preferences, then all members of the team should have input into supports necessary for achievement of outcomes based on each individual's preferences. As noted in a number of other sections in this report, the monitoring team found the quality of some assessments to be an area of needed improvement. In order for adequate protections, supports, and services to be included in individual's PSPs, it is essential that adequate assessments be completed that identify the individual's preferences, strengths, and supports needed. Information from assessments should be included in the PSP body and used to develop supports based on the individual's preferences and needs.	Noncompliance

#	Provision	Assessment of Status	Compliance
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	Assessments results were not always used to develop, implement, or revise PSP supports. Individual #339's recreational assessment and interest survey identified activities that he enjoyed. Activities identified included going to the park, fishing, picnics, cooking class, going out to eat, movies, parties, and ice cream socials. None of these activities were included in developing outcomes for him. His community living options discussion noted that he would not comprehend the difference between community living options and noted that "the team did not feel he would benefit from a referral due to being blind in one eye and not being able to see well in the other." These perceived barriers to community placement were not addressed in his PSP. On his annual dental assessment, the dentist noted that his oral health was "terrible, it appeared his teeth had not been brushed in a week." The dental section of his PSP stated, "keep oral hygiene good" and "continues to see the dentist once a year for a comprehensive examination and the hygienist for a complete Prophylaxis." There was no discussion around the need to see the dentist more frequently than his annual visit. His nutrition assessment noted that he had choked multiple times and had a history of aspiration. He was identified as being low risk for aspiration and choking. His nursing assessment indicated that he had osteoporosis and COPD. The team had determined that he was at low risk for osteoporosis and respiratory issues. The assessments included important information that should have been used as the basis for planning for this individual, however, it was not apparent that the information was integrated into one comprehensive plan. Some additional examples where assessment information was not integrated into the PSP included: • Individual #176's PSP noted that she was deaf and communicated using ASL. It further stated that there was no one on her home who could communicate with her using sign. Her BSP stated that she was deaf and her inability to communicate with others contributed to her frustration and "lead to behaviors." Her PSP did not describe how her communication needs would be supported. Additionally, she was diabetic and, though her diet restrictions and medical monitoring was addressed in her PSP, there was no indication of health or behavioral signs that direct support staff should be aware of in order to monitor her medical condition. If she had a history of exhibiting certain signs or symptoms when her blood sugar was not within a therapeutic range (e.g., aggression, thirst, confusion), DSPs needed to be aware of this and know what steps they should take to keep her safe. • Individual #573's PSP indicated that his health risks were low though his nursing assessment indicated that he had been admitted to the infirmary 12	Noncompliance

#	Provision	Assessment of Status	Compliance
		times since August 2009, including twice for seizures, three times for aspiration pneumonia, twice for respiratory distress, and once for dehydration, indicating that he was at risk for aspiration, respiratory issues, dehydration, constipation, dysphasia, and seizures. His healthcare summary indicated that he had been diagnosed with osteoporosis, GERD, hypothyroidism, and hypothermia. Additionally, he was on a repositioning schedule to prevent skin breakdown. The team noted in his PSP that "although he has an extensive history of health concerns, the team agreed that his medical needs are currently being met and there's nothing else that can be done to improve his health status." The PSP indicated that he had a PNMP in place, but there were no details of the plan included in the PSP body. The PSP also noted that an audiological evaluation was discussed and the team agreed to recommendations from the evaluation. It did not state what those recommendations were. • For Individual #67, it appeared that parts of assessments were randomly "cut and pasted" into the PSP document leaving staff with no clear direction on how to best support her. For example, the OT/PT section of the PSP stated, "recommend diet texture is chopped with regular salad. Food services to cut salad into nickel sized pieces." Immediately under that statement, "it is noted that a regular diet texture is not recommended due to the need for food to be cut into regulation size pieces." Then, the next statement included, "Staff to cut food into nickel sized pieces." Food texture was addressed three more times without any clear direction for what the current assessment recommended. The consumer services section stated, "staff will continue to offer different activities to gain her interest and participation" without any indication what types of activities she enjoyed. The PNMT section stated, "the following changes need to be made:," but there were no recommendations or changes listed. The PSP indicated that sedation was used for dental exams. The PSP did not address a desensitization plan. • Individual #312's assessments indicated that work was important to her and she would like to explore community living options. Neither was addressed in PSP outcomes. It was noted, however, that her PSP did include very specific recommendations from her communication assessment Some examples where assessment information was integrated into the PSP included: • Individual #43's SLP assessment included specific recommendations for staff to use in communicating with her. These recommendations were included in her PSP. Her PFW indicated that she would like to live in the community in a group home. An outcome was developed to explore community placement. Additionally, recommendations from her PNM evaluation were summarized in her plan including adaptive equipment needed, modified diet and risks.	

#	Provision	Assessment of Status	Compliance
		• Individual #600's psychological assessment stressed the importance of work for her. Her PSP also addressed her desire to work. Her PSP included an outcome for a referral to DARS for supported employment.	
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).	LSSLC homes lacked a real feeling of home and personal space. Many staff and individuals referred to the residential buildings on campus as dorms. Dorms in the community are typically places where people live briefly on their way to somewhere else, they are not considered homes. Many of the residential buildings on campus did resemble dorms; rooms were small and crowded, furniture was in disrepair from years of use and abuse, and rooms often lacked more than the most basic personal touches. Given this lack of commitment to providing comfortable personal living space, it was concerning that so many PSPs noted that the individual considered LSSLC home and were not being considered for community placement. Community placement was discussed at most PST meetings according to the PSP, though often, discussion was limited and little action was taken to move forward with community placement. PSPs indicated that individuals and their LARs were provided with information regarding community placement. In both PST meetings observed the PST concluded that current placement was appropriate without any real discussion around removing barriers to living in a less restrictive environment. Only 23 individuals at the facility were on one of the lists of individuals referred by the PST for community placement. The PST meeting for Individual #140 included a short discussion around living options for the individual. His sister stated that she had visited group homes in the past, but had not seen anything suitable for him. She was never offered the opportunity for more information on possible placements that might provide the needed supports. The nurse stated that his medical issues were barriers to placement and that there was a concern that he would not have a doctor available to him in the community. Rather than looking at what supports he might need to successfully live in the community, the team concluded that he had too many needs to live in the community. The contracted MRA worker attended the meeting. When she was asked for input in the living options discussion, she commented that she did not know what he would prefer, but did not feel that it would benefit him to visit a home. Interestingly enough, the team agreed that he had become less tolerant of living in such a crowded, noisy environment and they thought those factors might be contributing to increased depression. The team also noted that he enjoyed one–to-one interaction throughout his day, a support that may be more realistic in a smaller community setting. Some PSPs reviewed, however, indicated that some teams were actively addressing	Noncompliance

#	Provision	Assessment of Status	Compliance
		barriers to community placement. • Individual #43's team had taken step towards community placement. Community living options were discussed at the annual PST meeting on 8/16/10. The team determined that exploring community placement would be beneficial because she could possibly move into the community. The PST decided that a community tour would be advantageous to increase her awareness of community living and for the team to assess and address any concerns that they might have in regards to a community living home. Outcomes were also developed for increasing independent living skills in the area of community awareness in order to ensure personal safety. • Individual #244's team met on 9/14/10 and the PST determined that the optimal placement would be in a group home near her family. Outcomes were developed to assist her in several areas in preparation for transition including safety, employment, money management, and health and wellness. • The PSP for Individual #524 indicated that the individual had lived at LSSLC for 30 years and had no knowledge of other living options. The contracted MRA worker with the Burke Center met with the individual to discuss living options. The PSP noted that the individual did not express or verbalize any desire to leave or stay in current placement. His PSP further noted that he had limited communication abilities. The team put an objective into place to educate the individual and his family on community living facilities and sheltered workshops. Other PSPs reviewed indicated that this type of planning was not occurring for all individuals at the facility. For example: • The PSP for Individual #183 indicated that optimal living options for him would be to live at home or in the community in a small group setting with a minimal amount of roommates. His PSP noted that he had no knowledge of living arrangements other than at LSSLC or his father's home. The team justified continued placement by stating that it was unclear if his father was aware of any other options that he would consider for his son. The PSP did not indicate if additional information was made available for the family concerning community living or if there were plans for the individual to explore community placement. • The PSP for Individual #491 indicated that his long term goal was to return home or maybe to a community based home close to his family. It then was noted that no action plan was needed at this time to address community placement. His list of what was most important to him included many community based activities. The only barrier to community placement was his "LAR's choice to remain at the facility."	

#	Provision	Assessment of Status	Compliance
		There was generally no consideration of community-based day programs or supported employment by the team in PSPs reviewed. Although trips were planned in the community each week, active treatment did not focus on functional learning in the community and outcomes in individual PSPs did not focus on training in the community. Observation at the sheltered workshop on campus indicated that there were many individuals who had valuable job skills that would transfer well into a more integrated setting. There were job opportunities available at the facility and three individuals worked in community jobs, but there was little indication that employment outside of the facility had been considered for most individuals. The facility had a small supported employment program. The monitoring team was able to observe a PST meeting convened to discuss employment. Supported Employment was identified as a priority for Individual #600. She had been referred to DARS for supported employment services. According to the facility, DARS only had one contracted provider in the area, so the individual was referred to that provider for services. The service provider had notified DARS that they could not place this particular individual, based on rumors about her behavior. DARS notified LSSLC to let them know that they could not provide employment services for Individual #600 because they felt that she could not be successfully placed in a job in the community. There was no indication that they had completed an assessment or any job trials to make this determination. The facility job coach indicated that LSSLC would begin looking for jobs for the individual. The facility was rated as being in noncompliance with this provision item.	
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 monitoring team looks forward to reviewing this provision once there is further implementation of newly developed state policies to address PSP development and implementation.	
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths,	Conversations with the QMRPs indicated that plans were based on individual's preferences and needs, however, assessments did not capture preferences and needs, as noted throughout this report.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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;	Teams should use "what's most important to the person?" section of the PSP to then develop outcomes and include supports that the individual needs to maintain or increase the occurrence of those things in his or her life, and address any barriers to occurrence. Moreover, the Personal Focus Worksheet process also provided valuable information regarding individual's preferences that might be used in the PSP process (as well as in the obtaining of individual satisfaction information as described in section E). The facility was rated as being in noncompliance with this provision item.	
	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;	As discussed in F1 above, outcomes were not always related to the individual's preferences and long-term vision, and plans were not consistent in addressing supports needed to achieve outcomes. Strategies included supports needed for implementation, but due to the lack of integration among disciplines at the facility, it was difficult to assess if plans were carried out consistently as written. See section K4 for more detail on implementation. As discussed in F1e above, plans did not typically focus on addressing barriers identified to living in a more integrated setting. Further, it was evident, from a review of PSPs and conversations with staff at LSSLC, that there was a lack of knowledge regarding how supports could be provided in the community for individuals with more complex needs. Team members need to know how supports can be provided in the community and what options are available for community placement in order to be able to address concerns from families and have any real discussion around community options. The contracted MRAs, who should have been a primary resource for this information, were often not in attendance at meetings and were not adequately addressing concerns expressed by families. Additionally, QMRPs and social workers at the facility need to be better informed of living options and available supports in the community to continue this discussion with individuals and their families and ensure support needs are fully addressed in PSPs prior to transition. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	As noted throughout this report, many recommendations from assessments were not integrated into outcomes and strategies to support individuals throughout their day. Treatment plans and clinical care plans were often stand alone documents that were not integrated into an overall plan. PSPs developed following the new person centered training showed progress in this area.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Risk for individuals was not consistently addressed throughout the PSP to ensure that staff knew how to provide safe supports for each individual. See section I of this report for specific examples. When developing the PSP for an individual, the team should consider all recommendations from each discipline along with the individual's preferences and incorporate that information into one comprehensive plan that directs staff responsible for providing support to that individual. It is expected that full implementation of new state policies and training on person centered planning will guide QMRPs in developing more meaningful plans. The facility was rated as being in noncompliance with this provision item.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Plans designated staff responsible for implementation of the objectives by discipline. There were strategies for implementing objectives, but supports were not clearly integrated into plans so that support staff could consistently implement plans. Target dates for completing objectives were not included in most plans reviewed. The team should assign completion dates that correspond with the individual's rate of learning and develop a set of next step objectives that will move the individual closer to his or her long-range goal. Specific training strategies should be included in the PSP. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	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	As noted in previous sections, a majority of outcomes in the PSPs reviewed did not adequately address supports needed by the individual to achieve outcomes and did not consider what the individual would need to learn to become more independent in the community. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	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	The plan specified where data would be recorded, but not what data would be collected for each outcome. A discipline was named as responsible for each outcome, but was not specific in terms of who would actually collect that data and who would review the data. The facility was rated as being in noncompliance with this provision item.	Noncompliance

#	Provision	Assessment of Status	Compliance
	individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.		
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.	The monitoring team found a lack of coordinated supports and services throughout the facility. Although team members from various disciplines met together to develop the PSP, it was not evident that supports were integrated into one plan. The facility did not have a process to ensure coordination of all components of the PSP. This provision of the Settlement Agreement will also require substantial compliance with several sections throughout this report, including confirmation that psychiatry, psychology, medical, PNM, and communication services are integrated into daily supports and services as evidenced in sections J, K, M, O, P, and R of this report. Please refer to these sections of the report regarding the coordination of services. The facility is encouraged to implement a monitoring process that reviews which services and supports are needed by an individual and assess whether or not those services are addressed in the PSP. See comments throughout this report regarding the lack of integration of services for individuals. The facility was not rated as being in compliance with this provision item.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	A sample of 36 individual records was reviewed in various homes at the facility. Current PSPs were not available in 23 of the 36 records, indicating that support staff did not have information necessary to fully implement PSPs. The facility needs to implement a monitoring system to assure PSPs are accessible to all staff providing supports to individuals at the facility. As noted throughout this report, PSPs did not offer staff clear guidance on providing a range of supports to each individual to ensure training was consistently implemented and the person would remain safe and healthy. The facility was rated as being in noncompliance with this provision item.	Noncompliance
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two	A review of records indicated that the PST routinely met to discuss significant changes in an individual's status, particularly regarding healthcare and behavioral issues. It was not evident that the facility had a system in place to monitor implementation monthly and	Noncompliance

#	Provision	Assessment of Status	Compliance
	years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	revise the PSP if there was a lack of progress. It was also not evident that teams met when there was lack of progress towards PSP outcomes or when outcomes were completed. Few of the PSPs reviewed had been modified outside of the annual PSP meeting, though data collection indicated that individuals had completed outcomes or had made no progress at all on outcomes during the year. QMRPs should monitor plan implementation for progress and convene the team to address barriers when progress is not being made. The facility was rated as being in noncompliance with this provision item.	
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.	As noted above, staff responsible for developing plans will need to be trained on new policies relating to PSP development. Staff responsible for implementing the PSP should have competency-based training initially and when plans are revised. There was no system in place to ensure that this occurred and there was no documentation in place to show that staff had been trained on individual specific plans initially or when they were updated or modified. The facility was rated as being in noncompliance with this provision item.	Noncompliance

#	Provision	Assessment of Status	Compliance
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 sample of new admissions was not reviewed during this monitoring visit. All PSPs in the sample reviewed had been developed within the past 365 days. The PSP provided to the monitoring team for Individual #269 was dated 7/2/09, but he was placed in the community prior to his annual review. The monitoring team found that PSPs were not available for implementation in a majority of records reviewed onsite. The facility was rated as being in noncompliance with this provision item.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	Quality enhancement activities with regards to PSPs were in the initial stages of development and implementation (also see section E above). As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan.	Noncompliance

Recommendations:

1. Develop a system to ensure that PSPs are in individual records and updated as necessary.
2. Conduct comprehensive assessments that identify the individual's preferences, strengths, and supports needed.
3. Develop a system to ensure all staff receive competency-based training on providing supports to individuals as outlined in their PSP.
4. Focus on developing PSPs that address community integration that is meaningful for each individual based on his or her preferences, interests, and supports needed.
5. PSPs should include a description of all supports that the individual will receive, including a description of residential, day, medical, and therapy services, along with a schedule of when these services will be provided, where they will be provided and what types of supports the individual will need throughout the day to support participation.
6. All action steps should include information that would direct staff in how to implement the action step consistently and to determine what level

of participation by the individual is needed to successfully complete each step.

7. The team should assign completion dates that correspond with the individual's rate of learning and develop a set of next step objectives that will move the individual closer to his or her long-range goal.

8. Ensure that outcomes are consistently implemented and progress is documented and reviewed.

9. Develop a system to monitor the PSP, the implementation of services and supports, and the timely modification of plans when services and supports are not effective.

10. Implement a quality assurance process for assessing whether PSPs are developed consistent with this provision.

11. Integrate psychiatry into the treatment planning process.

12. Include information regarding the individual's psychotropic medication regimen in the PSP. This information should be documented in collaboration between psychology and psychiatry to ensure the accuracy of information promulgated.

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o Organizational chart, dated 9/21/10 o LSSLC policy list, 9/23/10 o Updated policies since April 2010 o List of typical meetings that occurred at LSSLC o LSSLC POI, updated September 2010 o LSSLC POI Supplement, September 2010 o LSSLC Sections G and H Presentation Books o Presentation materials from opening remarks made to the monitoring team, 10/18/10 o PIC meeting minutes: 5/24/10 through 8/124/10 (four meetings) o QAQI Council meeting minutes: 9/22/10 and 10/21/10 o List of clinical positions, staff and consultants o Staffing vacancies Interviews and Meetings Held: o Gale Wasson, Facility Director o Dr. Brian Carlin, M.D., Medical Director o Mary Bowers, Chief Nurse Executive o Sylvia Middlebrook, Ph.D., Director of Psychology o Residential Unit Directors: Rotley Tankersley, Glenn Heath, Kenneth Self, Keith Bailey, Todd Miller o Settlement Agreement Coordinators: Nikki Yost and Sherry Roark o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Presentation made to monitoring team by senior staff at LSSLC at opening meeting o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Many residences, day program, and vocational program o Facility administration meeting, 10/19/10 o QAQI Council Meeting, 10/21/10 o Psychiatry clinics
	Facility Self-Assessment: The facility's self-assessment was called the POI. It listed all of the outcomes the facility hoped to engage in and measure to work towards achieving substantial compliance with this provision. The facility rated itself

	as being in noncompliance with every item in its self-assessment. Even so, many of the items had information in the comments section that provided the monitoring team with some details about what the facility had done, and what it planned to do. The comments indicated a number of activities were occurring, or were planned to occur, to work towards the provision of integrated services.
	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the onsite review to address this provision of the Settlement Agreement. The facility had identified the medical director as the lead manager for this provision of the Settlement Agreement, and a number of activities had occurred regarding this provision item since the baseline review. Clinicians across the facility were becoming familiar with this provision. A number of examples of ways in which LSSLC was working towards a greater integration of clinical services, as well as examples of areas in which integration was not occurring, are presented below. It is likely that a specific focus to ensure that all areas of clinical service provision as specified in provision item G1 are included in the facility's provision of integrated clinical services. The importance of the provision of integrated services was acknowledged by facility management and clinicians. Moreover, there was an interest and desire to have this occur.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	A plan was not in place to address this item, policies and procedures did not exist, and there was an absence of integrated clinical services to the extent required by this provision item. Even so, the facility had made progress in this area as demonstrated by examples of new activities towards integration of clinical services. More work needed to be done, as acknowledged by the facility and described below. Consequently, this provision item is rated as being in noncompliance. The state and facility were in the process of developing a policy to guide the facility in meeting the requirements of this Settlement Agreement provision. Policy might include specific examples for the facility. Clinical staff at LSSLC were aware of this provision of the Settlement Agreement; the medical director had been assigned lead responsibility for this provision, and some actions had occurred towards addressing this provision. Dr. Carlin and Ms. Bowers described facility activities towards meeting the requirements of both section G and H and noted that they were in early development. In addition, the	Noncompliance

#	Provision	Assessment of Status	Compliance
		monitoring team observed, or heard about, efforts to provide integrated clinical services. These are listed below. • A daily morning meeting at 8:00 am was occurring. It was attended by the PCPs, psychiatrists, and nurses (CNE, NOO, hospital liaison, ICN, and infirmary nurse manger). • A daily facility management meeting to review incidents and other important information occurred daily at 11:00. The meeting was led by the facility director. • The medical director stated that the PCPs were easy to get a hold of. • The medical director noted that not all discussion and phone calls made it into active record. • The new PSP process was designed to include greater participation by clinical service providers (though this was only in the earliest stages of implementation and was not yet accomplishing this goal). • The medical director stated that the integrated progress notes (IPN) had contributed greatly to integrated service provision. • Nurses were to do more work with OT/PT on positioning. • A monthly meeting between the facility director and the PCPs was occurring. This was recommended during the baseline monitoring review and the monitoring team was pleased to see that it had been implemented and maintained. • Psychiatric physicians were beginning to integrate with the primary care physicians, and there were modalities to ensure that some information, especially emergent information, was transmitted. • There were beginnings of integration between psychiatry and psychology. Psychiatry and psychology interacted in the pre-clinic rounds in the individual's home setting. They were also present together in clinic and in the PST meetings psychiatry was able to attend. • The QA staff reported that there was more integration between habilitation therapy and staff from other disciplines. The monitoring team met with the three unit directors. They had years of experience at LSSLC (ranging from 23 to more than 30 years each) and had responsibility for the day-to-day operations of the facility's residences, including staffing ratios, activities, and direct care staff performance. The monitoring team was impressed by their knowledge of, and support of, the Settlement Agreement. They were extremely positive about the beneficial outcomes they had observed, or expected to observe, due to the work the facility was doing towards meeting the requirements of the Settlement Agreement. Some of their impressions and opinions are summarized below. • Psychology and psychology assistants were more available and present than	

#	Provision	Assessment of Status	Compliance
		they were before. • Mealtime observation had led to dietary and pharmacy services coming together on challenging cases. • There appeared to be more OT and PT services available. • Staff were now trained during times when they did not have direct care responsibilities at the same time. • The campus tram system allowed for improved transportation of individuals who used wheelchairs. • Community outings had increased, such as going on shopping trips. They reported that more than 30 outings occurred per month per home. This was due to more staff availability and better scheduling. • They noted that the DADS commissioner's recent visit to LSSLC was valuable, allowing staff to ask questions and to meet the commissioner. • They appreciated that staff no longer needed to wear the blue identifying vests. • They felt that staff were becoming more comfortable with the new video surveillance on campus. The POI described other ways in which the facility was working towards the provision of integrated clinical services. Other examples indicated that more work needed to be done • The lack of meaningful integration of clinical services was evident in the absence of skill acquisition plans targeting communication and language programming. • Policy was still in development. • PCPs were not attending most PSP meetings. It was acknowledged that it was important for the PCP to attend the annual PSP. • Psychiatrists were often unable to attend monthly neurology clinics, PSPs, and other PST-related activities. • The facility psychology staff were not producing useful data for the psychiatrists to base decisions regarding medication adjustments. While some graphs were being created, there were issues with the addition of medication adjustment information and sentinel events (e.g., social stressors) that were not included on the graphs. • There was a need for collaborative case formulation and diagnostics, as well as for the collaborative development of a behavioral/psychopharmacological treatment hypothesis. • There was an absence of necessary data provided in psychiatric clinics for Psychiatrists to make data based medication decisions (see K4 below). • Psychologists reported that DCPs did not collect data reliably (see K4 below). • Psychologists reported that DCPs were not consistently made available to them	

#	Provision	Assessment of Status	Compliance
		for PBSP training. There was unanimity in a desire to work towards and achieve an integration of clinical services, including more communication, acceptance of input and opinion from all clinical disciplines, and notification of treatment changes to all relevant clinicians. Achieving integration will be a facility-wide process, that is, it will require that all departments and all levels of staff participate. Under the leadership of the facility director, LSSLC should address the need for integration of clinical services. Modifications to the PIC meeting into the QAQI Council may contribute to setting the occasion for this integration to occur.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The facility appeared to be responsive to recommendations from non-facility clinicians. LSSLC should include in its operating procedures the requirement for an explicit statement, in the integrated progress notes, of the PCPs' agreement or disagreement with each of these recommendations. The records reviewed that are listed in section L of this report demonstrated that primary care providers were dating and initialing consultation reports. In some instances, there were notations on the consultations related to the primary provider's agreement with the recommendations. Only one of the five primary care providers, however, consistently documented in the progress notes acceptance or disagreement with the recommendations of consultants. As LSSLC works to complete psychiatric assessments as per the Appendix B format, the psychiatry staff will review prior records and integrate that information into the document. The case formulations in the records reviewed, however, were weak. In the handful of assessments completed as per Appendix B, it was difficult to determine if recommendations proffered by prior treatment providers (i.e., non-facility clinicians) were utilized.	Noncompliance

Recommendations:

1. Develop and implement policy.

2. Develop a system to assess whether or not integration of clinical services is occurring. This will require creating measurable actions and outcomes.

3. Ensure explicit statement of agreement or disagreement with each recommendation from non-facility clinicians is included in the integrated

progress notes.

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Organizational chart, dated 9/21/10 o LSSLC policy list, 9/23/10 o Updated policies since April 2010 o List of typical meetings that occurred at LSSLC o LSSLC POI, updated September 2010 o LSSLC POI Supplement, September 2010 o LSSLC Sections G and H Presentation Books o Presentation materials from opening remarks made to the monitoring team, 10/18/10 o PIC meeting minutes: 5/24/10 through 8/124/10 (four meetings) o QAQI Council meeting minutes: 9/22/10 and 10/21/10 o List of clinical positions, staff and consultants o Review of records of 21 individuals prescribed psychotropic medication (see section J) o Review of records as listed in the nursing section of this report (see section M) Interviews and Meetings Held: o Gale Wasson, Facility Director o Dr. Brian Carlin, M.D., Medical Director o Mary Bowers, Chief Nurse Executive o Director of psychology department o Residential Unit Directors: Rotley Tankersley, Glenn Heath, Kenneth Self, Keith Bailey, Todd Miller o Settlement Agreement Coordinators: Nikki Yost and Sherry Roark o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Presentation made to monitoring team by senior staff at LSSLC at opening meeting o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Many residences, day program, and vocational program o Facility administration meeting, 10/19/10 o QAQI Council Meeting, 10/21/10 o Psychiatry clinics
	Facility Self-Assessment: The facility's self-assessment was called the POI. It listed all of the outcomes the facility hoped to engage in

	and measure to work towards achieving substantial compliance with this provision. The facility rated itself as being in noncompliance with every item in its self-assessment of this provision. Even so, many of the items had information in the comments section that provided the monitoring team with some details about what the facility had done, and what it planned to do. Many of the items indicated upcoming new practices, changes to current practices, and implementation of monitoring and data collection.
	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the onsite review to address this provision of the Settlement Agreement. Even so, some activities were occurring at LSSLC. Similar to section G described above, medical and clinical staff were beginning to work towards meeting what they considered to be the criteria of this provision further highlighting the need for state policy to provide guidance and direction to the facility. Across the facility, there was great desire for coordinated clinical treatment, and to have that treatment contain more than just the minimum generally accepted professional standards of care as set forth in this provision. Mary Bowers, the CNE, was the facility's lead for this provision item. She had done some work to address the contents of the provisions for the nursing department and will need to include the range of clinical services as required by this provision. It is recommended that the facility's QA play a role in addressing this provision.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	A plan was not in place to address this provision item and the facility did not have any procedures in place to ensure assessments and evaluations were completed on a regular basis and in response to developments or changes in an individual's status. This was also acknowledged in the facility's POI for this provision item; it was rated as being in noncompliance. The CNE, however, reported that a system was in place for nursing assessments, however, it was not yet integrated or centralized with all of the assessments from all clinical areas of service. The medical staff performed evaluations on sick call based on acute medical problems and the need for follow-up. Follow-up of acute and chronic medical problems and post-hospitalization evaluations were inconsistent and at times inadequate. Quarterly evaluations were not completed at the facility. See section L of this report for more	Noncompliance

#	Provision	Assessment of Status	Compliance
		details. As discussed in the psychiatry section of this report (section J), the facility had been completing annual psychiatric evaluations, however, they had only just begun this process, having completed a total of six evaluations at the time of this monitoring review. Those comprehensive evaluations were reviewed, and were in need of improvement. They were variable in regard to completeness, specifically with regard to the case formulation and treatment planning/recommendations. This is an area, which could be amenable to increased collaboration with psychology for the creation of a diagnostic formulation. It is also an area that could be impacted via quality assurance or peer review processes. For all 20 individuals reviewed by the monitoring team listed in section M of this report, annual and quarterly nursing assessments were filed in their records. The assessments were conducted by RN case managers, and they were completed in a timely manner, however, problems were noted with the conduct of nursing assessment, diagnosis, planning, implementation of planned interventions, and evaluation of plans. Further, comprehensive documentation in the individuals' records of their significant changes in health status from identification to resolution was inconsistent and incomplete. Nursing assessments failed to provide a complete, comprehensive review of each individual's past and present health status and needs. Thus, the conclusions (i.e., nursing diagnoses) drawn from the assessments did not consistently capture the complete picture of the individual's clinical problems, needs, and actual and potential health risks. The facilities functional assessments (K5), PBSPs (K9), and psychological assessments (K5, K6, K7) were not consistent with generally accepted professional standards of care. There was little evidence of the change over time noted in the habilitation therapies documentation. Issues and problems in the assessment processes are described in sections O, P, and R below in this report.	
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	There was no policy in place to require or guide the activities required to meet this provision item. LSSLC was not tracking or monitoring this requirement. In terms of psychiatric diagnoses, this was difficult to determine because, per a review of psychiatric evaluations and quarterly medication reviews, there were no diagnostic formulations outlining the specific symptoms that individuals were experiencing, such that they met criteria for a specific diagnosis. For additional information regarding this issue, please refer to the section J below.	Noncompliance

#	Provision	Assessment of Status	Compliance
	Classification of Diseases and 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.	LSSLC did not have a plan procedure in place to ensure that treatments and interventions were implemented timely and were clinically appropriate. The facility did not, at the time of this onsite review, a way to manage this requirement. The CNE noted that the nursing department met this requirement and would be able to demonstrate it at the next onsite review and that more work was still needed to do so for the entire facility. The medical staff conducted sick call daily to address new issues, acute medical issues, and follow-up. Follow-up care was often lacking based on the documentation in the records (see section L of this report). Further, because it was difficult to determine the accuracy of psychiatric diagnoses, it was difficult to determine the appropriateness of medication. A review of the records revealed medications prescribed for indications that were not described as specific target symptoms, that were not being monitored by psychology via data collection and graphing, and that were not in concert with the proposed diagnosis. For additional information (see section J). Health management plans did not consistently address all of the health care needs of the individuals and ACPs did not address all of their emergent health care problems and risks. The interventions in the HMPs were the same across many of the individuals even though the individuals, as well as the precursors, nature, scope, and intensity of their problems, were very different. Despite changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes, their HMPs and ACPs were not revised. The objectives and expected outcomes referenced in the HMPs and ACPs were not consistently individualized, and they did not reflect the individuals' participation in their development or their desired health outcomes. (see sections M2 and M3). Examples are described in this report, including regarding changes in psychiatry treatment (Section J), updates and modifications to PBSPs based upon the functional assessment and/or a lack of progress (Section K), and changes in risk status based upon occurrences of medical-related events (Sections I, M, and O).	Noncompliance
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	Neither a plan nor activities were in place to address this across the variety of clinical disciplines at the facility. The facility did not have a way of determining if appropriate clinical indicators of efficacy of treatments were being used across all disciplines. Consequently, this provision item was rated as being in noncompliance. The CNE and medical director noted that processes were in development and provided	Noncompliance

#	Provision	Assessment of Status	Compliance
	a clinically justified manner.	some specific examples (e.g., hemoglobin and diabetes). They expected to focus upon those outcomes and indicators that could be measured. They planned to look at well-known and established benchmarks. The facility and state should be sure to address clinical indicators for all areas of clinical practice, not only in medical care and nursing services.	
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.	A plan was not in place to address this item and, therefore, this item was rated as being in noncompliance. The POI reported some processes that were in place at LSSLC. These included using a system they called the Big Master Tracker to track completion of the MOSES and DISCUS, nursing's use of a weight worksheet for monitoring for early detection of weight loss or gain, and the use of a new tool, the Standardized Comprehensive Nursing Assessment The Health Status Team was operating and reviewing each individual every six months, but, as noted elsewhere in this report, the HST did not look at all aspects of health (it looked primarily at risk) and had numerous problems as indicated in other sections of this report. The HST had been functioning in absence of the psychiatrist. During this onsite review, however, one of the psychiatrists sat in the meeting. Unfortunately, the assignment of risk with regard to polypharmacy and treatment with psychotropic medication appeared arbitrary. It is hoped that as the psychiatrist is integrated into the HST that the determination of an individual's risk for polypharmacy can be better assessed.	Noncompliance
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	Neither a plan nor activities were in place to address this item and without clinical indicators identified (see H4 above), treatments and interventions cannot be modified in response to clinical indicators. The monitoring team had a good discussion with the medical director and CNE about quality assurance, and medical quality improvement activities. Across all 20 individuals reviewed in section M, however, the HMPs did not consistently address all of the health care needs of the individuals; and NCPs were not consistently prepared in a timely manner, or at all, in response to individuals' acute and/or emergent health care problems and risks.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three	Policies, procedures, and guidelines were not in place regarding Section H and, therefore, this provision item was found to be in noncompliance.	Noncompliance

#	Provision	Assessment of Status	Compliance
	years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	Facility management also acknowledged that this provision item was not yet being addressed.	

Recommendations:

1. Develop and implement policy.

2. Develop a system to assess whether or not minimum common elements of clinical care are being provided to individuals. This will require defining minimum common elements of clinical care, creating measurable actions, and monitoring measurable outcomes.

3. Improve the way HMP objectives are determined and written as described above in section H3.

4. Involve the facility's QA department in the many monitoring and data tracking activities that will be required to increase the likelihood of meeting the requirements of this provision.

The following are offered as additional suggestions to the facility:

5. Consider an electronic medical record; this may be an effective way to implement clinical indicators and provide for accurate tracking.

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS Policy #006: At Risk Individuals o DADS Risk Assessment Tools, dated 8/31/09 o List of individuals requiring sutures/dermabond 1/1/10-6/30/10 o List of Risk Level for all individuals at the facility o List of individuals hospitalized since 1/1/10 o List of individuals seen in the ER since 1/1/10 o List of 10 individuals with the most injuries since 1/1/10 o List of 10 individuals causing the most injuries to peers since 1/1/10 o Plan of Improvement High Risk Submission List o List of all injuries since 1/1/10 o Incident Management Team meeting minutes 6/1/10-8/30/10 o PSPs for the following individuals • Individual #183, Individual #339, Individual #57, Individual #524, Individual #431, Individual #176, Individual #573, Individual #323, Individual #387, Individual #203, Individual #238, Individual #269, Individual #167, and Individual #67 o List of infirmary admissions 4/1/10 – 10/15/10 o List of expired individuals since 4/1/10 o List of pneumonia diagnoses since 1/1/10 o List of individuals with pica as of 9/8/10 o List of individuals who receive nutrition enterally o List of individuals' oral hygiene assessment ratings by dental staff o List of choking incidents since 1/1/10 including a summary of interventions for each episode o Medication Errors FY10 and the Medication Error Synopses through September 2010 o Nutritional Management Team Reports for last six months, 3/10-8/10 o Unusual Incident Reports for the last six months, 3/10-8/10 o HST Meeting Minutes 6/10 through 8/10 o Individual records identified in section M below <u>Interviews and Meetings Held</u>: o Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs o Luz Carver, QMRP Coordinator o Stacie Cearley, Program Compliance Monitor o Sylvia Middlebrook, Ph.D., Chief Psychologist o Kenneth Self, Glenn Heath, Todd Miller, Keith Bailey, Rotley Tankersley, Unit Directors o Jason Peters, Human Rights Officer o Norma Crawford, Risk Management

	o Royce Garrett, Consumer/Family Relations Director Observations Conducted: o Observations at all residences o Observations at the onsite workshop and day program o Daily Incident Management Meeting 10/19/10 o Daily Incident Management Meeting 10/20/10 o PSPA Meeting for Individual #600 10/19/10 o PSP Annual Meeting for Individual #140 and Individual #167 o Woodland Crossing Morning Meeting 10/20/10 o Human Rights Committee Meeting 10/20/10 o Health Status Team Meeting 10/20/10
	Facility Self-Assessment: The facility POI indicated that the facility was not in compliance with the provisions of section I. Notations in the POI indicated that the facility was focusing on learning the monitoring tools in order to review areas of section I and ensure processes were occurring. The monitoring team agreed with most of the findings in the facility's POI for this provision.
	Summary of Monitor's Assessment: State Policy #006: At Risk Individuals had been developed by the state to address assessing risks for individuals. Additionally, the state had developed standardized forms to assess health risks, challenging behaviors, injuries, and polypharmacy. The rating forms allowed individuals who were at risk to be rated low if plans were in place to address specific risk. This practice continued to be a concern to the monitoring team because it did not alert staff that individuals at risk needed to be monitored more frequently for signs and symptoms of risk. The other concern of the monitoring team regarding risk ratings was that plans addressing risk were often not sufficient or were not monitored adequately placing the individual at risk, even with a plan in place. Note that, for the most part, the population of individuals served at LSSLC were admitted due to their high risk for health and/or behavioral issues. Risk levels often conflicted with information included in the PSP by specific disciplines. Comprehensive risk reviews that considered and analyzed influencing factors contributing to each risk area needed to be completed. All staff needed to be aware of and trained on identifying crisis indicators. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual. The monitoring team recommends that the facility clarify the purpose and process of the identification of at-risk individuals. Revisions to the At Risk Individuals policy was under revision at the time of the review and changes to the system at LSSLC were reported to be on hold pending the final policy. LSSLC's Health Status Team (HST) Coordinator was scheduling and conducting meetings according to the

	policy. An HST meeting was held during the monitoring team's onsite review. The HST was observed and documented to be an interdisciplinary review of risk factors. There was minimal discussion among team members regarding supports and services needed to address risk factors for individuals. It was noted that accurate risk levels were not being assigned through this process. Members of the monitoring team provided input at the HST meeting to clarify the purpose of risk identification and assigning accurate ratings. The committee revised their assessment process on the spot and expanded discussion on risk ratings at the meeting. The state had revised the policy regarding risk identification. It is now in draft form and is being reviewed prior to implementation. The hope is that this will more accurately describe risks for particular individuals and ensure services and supports necessary to protect each individual will be put into place.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	Per current state policy a risk review at least every six months for each individual was conducted by the LSSLC Health Status Team (HST). The policy identified who should participate on the team and assigned specific responsibilities to team members. The implementation and ongoing revisions to the process were facilitated by the Health Status Team Coordinator. Determining risk levels was done in a manner that allowed very vulnerable individuals to not be properly identified as being at risk, in part because of the assumption that if a plan, no matter how inadequate, was developed to address the risk, risk no longer existed Health risk status assessments were completed by members of the PST for most individuals reviewed. These assessments were routinely reviewed by the facility HST and an overall risk level was assigned. Observation of an HST meeting the week of the monitoring visit revealed that the HST engaged in minimal discussion of each individual's risk factors. As noted above, the assignment of risk levels did not support the true risk for each individual. This resulted in what appeared to be incorrect ratings of risk for many individuals in important areas of risk and/or failure to increase level of risk in a timely manner such that the likelihood of harm and negative health outcomes was minimized. This led to concerns over whether or not support staff were aware of risks for individuals who they supported and if they knew appropriate risk signs to monitor for each individual. The facility had compiled a list of all individuals considered to be at high risk at the facility. The list indicated that there were 14 individuals with high risk ratings in one or more categories. Three individuals were designated high risk for aspiration, one for cardiac, three for diabetes, one for osteoporosis, one for seizures, six for medical	Noncompliance

#	Provision	Assessment of Status	Compliance
		concerns, two for challenging behaviors, and one for respiratory. No individuals at the facility were identified as being at high risk for choking, constipation, dehydration, GI concerns, hypothermia, skin integrity, urinary tract infections, weight, injuries, or polypharmacy. This was not in line with findings of the monitoring team. The team identified many individuals at high risk for multiple health and behavioral issues. In the 21 records chosen for review for use of psychotropic medication, while individuals had an assigned risk rating for polypharmacy, it was unclear how this risk level (low, medium, or high) was assigned. It was also unclear how the facility utilized the information gleaned as a result of a review of the individual's health risk status. Finally, although not directly related to the assessment of risk of any specific individual, the monitoring team, during its observation at the workshop rooms on campus at LSSLC, noted a strong chemical odor in the rooms in which individuals were folding and packaging laundered shop rags. The monitoring team recommends that the facility ensure that the individuals working in this location are not being exposed to any dangerous chemicals or fumes. The facility was not in compliance with this provision item.	
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.	The policy stated that the Health Status Team (HST), chaired by the Primary Care Provider, would ensure a preventative approach to the health and safety of persons served by assigning each individual a risk level/rating. High Risk (level 1) would apply to an acute or unstable condition that would require increased intensity of intervention to achieve an optimal health outcome. Furthermore, it stated that individuals discharged from the hospital should have their risk level reviewed by the physician. The policy mandated that once a high-risk condition was identified, the PST would meet within five working days to formulate a plan. The plan had to be implemented within 14 days and incorporated into the individual's PSP. The PST was required to meet at least every 30 days to monitor the effectiveness of the plan of care until the individual's condition was stabilized and the risk level was reduced. As the facility PSTs did not regularly include psychiatry, it was not possible for them to discuss specific risks associated with the administration of psychotropic medications. The current policy allowed for a risk level to be deemed medium risk (level 2) if the individual had adequate supports that were actively monitored for any assigned risk category. The HST meeting observed by the monitoring team on 10/20/10 included all the appropriate team members. The physician led the meeting. The review of each individual involved the physician stating the risk category and an appropriate team	Noncompliance

#	Provision	Assessment of Status	Compliance
		member making a health risk rating recommendation. If there was no discussion, the next risk category was read, and so on for all the risk categories. Often the polypharmacy medications and assigned rating were not read aloud, prompting the monitoring team to ask questions regarding psychotropic medications. The physician had the pharmacy and dental written recommendations. The monitoring also questioned the medium risk rating for skin integrity for Individual #146 who had been in medical restraint, bilateral mittens, for at least two months due to open skin lesions. Inconsistencies in risk scores were noted in all of the PSPs reviewed. Some examples of inconsistencies in risk scores and actual risk factors for individuals are provided below. • Individual #573 was rated by the HST as low risk in all categories. His nursing assessment indicated that he had been admitted to the infirmary 12 times since August 2009 including twice for seizures, three times for aspiration pneumonia, twice for respiratory distress and once for dehydration, indicating that he was at risk for aspiration, respiratory issues, dehydration, constipation, dysphasia, and seizures. His healthcare summary indicated that he had been diagnosed with osteoporosis, GERD, hypothyroidism, and hypothermia. Additionally, he was on a repositioning schedule to prevent skin breakdown. The team noted in his PSP "although he has an extensive history of health concerns, the team agreed that his medical needs are currently being met and there's nothing else that can be done to improve his health status." • Individual #323 had a risk level of 3 indicating a low risk level for aspiration, dehydration, and skin integrity, though his PSP indicated that he was at risk for aspiration, dehydration, and skin integrity. • Individual #203 had a plan in place to reduce the risk of aspiration, but was listed as low risk for aspiration by the HST. GERD, high blood pressure, weight and seizure disorder were all listed as barriers to living in a less restrictive setting though the HST rated him as low risk in all of these areas. • Individual #387 was considered low risk in all areas except for medical concerns (medium risk) by the HST. His PSP indicated that he was at risk for aspiration and GERD. • Individual #339 was hospitalized for aspiration pneumonia in March 2010. His PSP indicated that he on a modified diet due to his risk for choking and aspiration. He was rated as being at low risk for choking and aspiration by the HST. • Individual #191 was listed as at low risk for choking by the HST, though he had two choking incidents over the past year. • Individual #57 was rated at low risk for challenging behaviors, though he had caused 22 injuries to peers since 1/1/10; he had a BSP for challenging behaviors and a safety plan in place for the use of restraints. He was prescribed Thorazine	

#	Provision	Assessment of Status	Compliance
		and Trazadone for impulsive aggressive behavior. • Individual #524 was rated as low risk in all categories by the HST. He was on a modified diet to reduce the risk of choking, and had health care plans to address osteoporosis, obesity, diabetes, and hypertension. His oral hygiene was noted as poor at his annual dental exam. • Individual #431 was rated as low risk by the HST in all categories. His PSP indicated that he was on a diabetic diet chopped diet and took medication for high cholesterol. He was diagnosed with hypertension and was 50 pounds overweight. • Individual #183 was rated by the HST as low risk for choking and aspiration, though he was on a modified textured diet. His challenging behaviors rating was also considered low, though he has a behavior support plan to address, self-injurious, destructive and aggressive behaviors and takes Depakote and Thorazine to address these behaviors. • Individual #269 was on a low calorie, low cholesterol diet, though his PSP noted that he was not at risk for weight gain. • Individual #238 was on a chopped diet with thickened liquids, though the HST had rated him as low risk for aspiration and choking. He was also rated at low risk for injury, though his PSP indicated that he had fractured his finger on 11/9/09, and had four significant falls in the past year resulting in significant injuries. • Individual #290 had pneumonia three times in 2009 according to HST meeting minutes. The HST rated him at low risk for pneumonia. • Individual #380 was rated as low risk for challenging behaviors, though a list of peer-to-peer aggression incidents show that she was the aggressor in 17 incidents between 6/1/10 and 8/30/10. • Individual #21 was listed as low risk for challenging behaviors, though a list of peer-to-peer aggression incidents show that he was the aggressor in 7 incidents in August 2010. • Many additional examples are included in section M5 of this report. Review of support plans did not support that adequate preventative measures or plans were in place or that adequate monitoring of implementation was occurring. Thus, the monitoring team could not support the practice of lowering individual's risk level from high to medium just because a plan was in place to address the issue. Until the facility develops an effective plan of monitoring and revising supports as needed, it is recommended that risk levels be assigned cautiously to ensure proactive measures are taken to monitor each individual's health and safety. One of the most important aspects of a health risk assessment process is that it	

#	Provision	Assessment of Status	Compliance
		effectively prevent the preventable and reduce the likelihood of negative outcomes through the provision of adequate and appropriate health care supports and surveillance. A way in which this is accomplished is through the timely detection of risk and proper assignment of level of risk. This feature of health risk assessment is in need of improvement at LSSLC. The facility was not in compliance with this provision item.	
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.	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the PST. A majority of the PSPs that were reviewed included strategies to address identified risks, but again, not all risks were identified as a risk for each individual. Some identified risks had no individualized plans developed to address them. Rarely were all the relevant clinical indicators to be monitored, and the monitoring frequency, clearly specified in individuals' PSPs or Health Management Plans (HMPs). See sections M1 and M3 of this report for examples. Direct care professionals reported that they were notified of changes in plans by therapist, the QMRP, the psychologist, the Unit Director or their supervisor and implementation of changes began immediately. Although PSPs included a number of plans to address risk identified by the PST, during observations of homes by the monitoring team, it was noted that PSPs were often missing from individual records, so direct support staff did not have current information regarding risks available to them. Out of 36 individual records reviewed in six homes, 23 of those individual either had no PSP at all or no current PSP. Only 36% of the individuals in the sample had current PSPs accessible to their support staff. If there is not a current PSP in the home, staff do not have the information that they need to provide safe supports and services to individuals in the home. Staff cannot be held responsible for implementing a plan that they do not have. The facility needs to implement a monitoring system to ensure that staff have information readily available at all times to provide necessary supports to each individual in the home. As noted throughout this report, intervention plans were often not carried out as written, therefore, individuals remained at risk. The facility was not in compliance with this provision item.	Noncompliance

Recommendations:

1. Develop a system to accurately identify any individuals whose health or safety is at risk. Risk levels should be evaluated considering the level of support needed in each risk area.

2. All staff should receive individual specific training on each safety and health care risk identified for the individuals they are assigned to support and implementation of plans should be routinely monitored.

3. All health issues should be addressed in PSPs and direct care staff should be aware of health issues that pose a risk to individuals and know how to monitor those health issues and when to seek medical support.

4. Implement a monitoring system to ensure that support staff have PSPs and other plans readily available at all times to provide necessary supports to each individual in the home.

5. Ensure that the individuals working with shop rags are not being exposed to any dangerous chemicals or fumes.

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u> o Policies, procedures, and/or other documents addressing the use of pre-treatment sedation medication. o List of individuals who received pre-treatment sedation medication for medical or dental procedures that included date the pre-sedation was administered, and the name dosage, and route of the medication, and an indication of whether a plan is in place to minimize the need for the use of pre-treatment sedation medication. o Any auditing monitoring data and/or reports addressing the use of pretreatment sedation medication. o A description of any current process by which individuals receiving pretreatment sedation are evaluated for any needed mental health services beyond desensitization protocols. o A spreadsheet of individuals prescribed psychotropic/psychiatric medication, listing name of individual, residence/home diagnoses, and medication regimen (including psychotropics, nonpsychotropics, and PRNs, including dosage of each medication and times of administration). o A list of individuals prescribed benzodiazepines, including the name of medication(s) prescribed and duration of use. o A list of individuals prescribed anticholinergic medications, including the name of medication(s) prescribed and duration of use. o A list of individuals prescribed intra-class polypharmacy, including the names of medications prescribed and each medication's start date. o Facility-wide data regarding polypharmacy, including intra-class polypharmacy. o A list of individuals being monitored for tardive dyskinesia. o A list of individuals with tardive dyskinesia. o A separate list of individuals being prescribed: • Anti-epileptic medication being used as a psychotropic medication, Lithium, Tricyclic antidepressants, Trazodone, Beta blockers being used as a psychotropic medication, Clozaril/clozapine, Mellaril, Serentil o List of new admissions since January 1, 2010, and whether a Reiss scale was used. o List of new admissions since 1/1/10 and whether a Reiss scale was used. o For five individuals most recently admitted, and for the seven other individuals • Their most recent psychiatric assessment; • Last three psychiatric progress review notes, including data provided to the psychiatrist by the psychologist and/or other team members; and • For the past year, Dates of all Psychiatric Treatment Reviews, Health Services Team notes, MOSES and DISCUS exams, Neurology consults (if any); and The most recent Medical, Pharmacy, and Nursing summaries.

	• Across these individuals, at least one individual from each psychiatrist's caseload. o A list of families/LARs who refuse to authorize psychiatric treatments and/or medication recommendations. o Description of availability of genetic screening for individuals. o A list of all meetings and rounds that are typically attended by the psychiatrist, and which categories of staff always attend or might attend. o A list and copy of all forms used by the psychiatrists. o Examples of forms used to document side effects, such as AIMS, MOSES, and DISCUS. o All policies, protocols, procedures, and guidance that relate to the role of psychiatrists o Job description of psychiatrists. o A list of all psychiatrists, including board status, whether employed or contracted, and number of hours worked each week. o Example of contract with contracted psychiatrists. o CVs of all psychiatrists, including any special training such as forensics and disabilities o Overview of psychiatrists' weekly schedule. o Over the past 12 month, a list of continuing medical education activities attended by medical and psychiatry staff. o Academic affiliations with educational institutions. o For the past six months, minutes from the committee that addresses polypharmacy. o For the last 10 newly prescribed psychotropic medications: • Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication, • signed consent form, • PBSP, and • HRC documentation o Since 1/1/10, a list of any individuals for whom the psychiatric diagnoses have been revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s). o Facility policy and procedure manual, and any related departmental manuals. <u>Additional Documents Reviewed That Were Requested Onsite</u> o All psychology data presented and other information provided by the psychiatry assistant and doctor's progress notes from Dr. Jane's clinic for the following individuals: Individual #148, Individual #395, and Individual #410 o All psychology data presented and other information provided by the psychiatry assistant and doctor's progress notes from Dr. Orocofsky's clinic for the following individuals: Individual #600, Individual #176, Individual #244 o Caseload for each psychiatrist o Clinic schedule for each psychiatrist. o List of all individuals evaluated per Appendix B o Examples of psychiatric evaluations performed per Appendix B for Individual #170, Individual

	#57, Individual #249, Individual #176, Individual #131, and Individual #91 o Examples of informed consent performed by psychiatry for Individual #131, Individual #526, Individual #, 57, Individual #562, and Individual #99 o Examples of psychiatric consultation performed prior to individuals receiving pretreatment sedation for Individual #306, Individual #245, and Individual #102 o Tracking/attendance information for psychiatry in PSP and PSPA meetings o All psychology data presented and other information provided by the psychiatry assistant and doctor's progress notes from Dr. Isern's clinic for the following individuals: Individual #33, Individual #417, Individual #308, and Individual #460 o Five dental desensitization plans for Individual #567, Individual #525, Individual #375, Individual #568, and Individual #469 o Five medical desensitization plans (requested, but none were available) o Five nursing post sedation monitoring examples for Individual #183, Individual #552, Individual #257, Individual #245, and Individual #271 o All psychology data presented and other information provided by the psychiatry assistant and doctor's progress notes from Dr. Buckingham's clinic for the following individuals: Individual #161, Individual #563, Individual #392, and Individual #131 o Pharmacy audit tools and lab matrix o These documents: • Rights section • Consents section • Positive Support Plan (PSP) • PSP review • Behavioral Services section • Restraint checklist • Physicians annual medical review • Active problem list • All hospital information • Health Status Section • All labs including EKG • Psychiatry section • Side effect screening section (MOSES/DISCUS) • Pharmacy section • All consults • All physician orders • All integrated progress notes • Nursing section • Seizure record • Dental section o For the following individuals: • Individual #600, Individual #176, Individual #244, Individual #57, Individual #488,

	Individual #562, Individual #103, Individual #33, Individual #417, Individual #308, Individual #460, Individual #52, Individual #426, Individual #21, Individual #93, Individual #368, Individual #587, Individual #392, Individual #148, Individual #395, and Individual #400 o Tracking spreadsheet for MOSES and DISCUS (Big Master Tracker 2010) <u>Individual Interviews and Meetings Held</u>: o Vasantha Orocofsky, M.D., Director of Psychiatry o Louis Kavetski, D.D.S., Dental Director o Pat Husband, Psychiatry Assistant o Linda Nouwen, B.A., Psychiatry Assistant o Raul Isern, M.D., facility psychiatrist o Abimbola Farinde, Pharm D., clinical pharmacist o Brian Carlin, M.D., Medical Director o Sylvia Middlebrook , Ph.D., Director of Psychology with Robin McKnight and Mike Fowler, psychologists o Mary Bowers, R.N., Chief Nursing Executive with Laura Flowers, R.N., Nursing Operations Officer <u>Observations Conducted</u>: o Observation of rounds with Dr. Buckingham. Observation of psychiatry clinic with Dr. Buckingham for the following individuals: Individual #161, Individual #563, Individual #392, and Individual #131 o Observation of psychiatry clinic with Dr. Orocofsky for the following individuals: Individual #600, Individual #176, and Individual #244. o PSPA for Individual #57 o Observation of rounds with Dr. Isern. Observation of psychiatry clinic with Dr. Isern for the following individuals: Individual #33, Individual #417, Individual #308, and Individual #460 o PSP for Individual #600 o Morning medical report o Health Status Team o Observation of rounds with Dr. Janes. Observation of psychiatry clinic with Dr. Janes for the following individuals: Individual #148, Individual #395, and Individual #410.
	Facility Self-Assessment: The facility's self-assessment, its POI, for section J indicated substantial compliance in subsections of two areas, J1 (having qualified psychiatric physicians) and J13 (performing quarterly psychiatric reviews). The assignment of substantial compliance for J1 was echoed in this report because the psychiatric physicians currently providing care at the facility, were, by virtue of their board certification and/or eligibility status, qualified to provide care at the facility. The facility reported substantial compliance in one subset of J13, specifically, performing quarterly

	psychiatric reviews. As follows in the report below, J13 was found to be in noncompliance per this report due to the lack of psychiatric physician participation in PST, the lack of treatment plans authored either by or in collaboration with psychiatry for individuals treated with psychotropic medication, and due to the lack of appropriate case formulations allowing for the determination of a justifiable diagnosis and associated appropriate treatment interventions. With the exception of J1 and J13 as detailed above, the monitoring team's review of the remainder of this provision, as detailed in this section of the report, was congruent with the facility's self-assessment. The monitoring team's review was based upon observation, interview, and review of sample of documents. The facility will need to do the same in order to conduct an adequate self-assessment.
	Summary of Monitor's Assessment: Although psychiatry consultations were occurring, LSSLC was found to be in noncompliance with all but one of the items in this provision of the Settlement Agreement. The facility did have physicians providing care, however, until very recently (May 2010) it did not have a full-time psychiatrist on staff. The four physicians currently accounting for 2.25 full-time equivalents (FTE) were qualified by virtue of their board eligibility/certification status to provide services at LSSLC. One physician had been designated as the Director of Psychiatry. The facility has reportedly had a history of difficulty recruiting and retaining physicians. As such, the primary goal must be to recruit and retain psychiatrists, such that the psychiatric program can be expanded to provide clinical services and integrated with other disciplines to meet the requirements of the Settlement Agreement. The current psychiatric physicians had integrated themselves well with the primary care physicians. There was a morning meeting where all physicians met to review the cases of individuals who were currently admitted to the hospital or to the facility infirmary. In addition, the physicians frequently reviewed the cases of individuals who were experiencing behavioral challenges or medication side effects that did not rise to the level of requiring inpatient or infirmary care. This was the area where integration was most developed. Although psychiatry was interacting with psychology on some levels, there were marked deficits in the interaction. It was apparent that some duties that should fall in the realm of psychiatry were being provided by psychology (e.g., informed consent and risk/benefit analysis for psychotropic medications). Also, there were areas where psychology could be more integrated with psychiatry (e.g., identification of target symptoms, data collection, collaboration regarding case formulation). The staff from both disciplines were aware of the challenges and the need for increased structure and integration, however, they were also aware of the manpower shortage and history of a lack of clinical resources in psychiatry, which did not lend itself to close collaboration. What was most striking during the onsite review, was that staff overall were caring and invested in the treatment of the individual and had the desire to see the individual benefit from treatment. It was also apparent that the teams had been functioning for so long in the absence of psychiatry (due to the lack of

	clinical resources), that it was difficult for them to even consider psychiatry as a part of the team. This was evident in some clinical and team observations. Over time, psychiatry staff will need to establish themselves as a viable department and establish themselves as a viable member of the individual's treatment team.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	LSSLC had a total of 2.25 FTE (full-time equivalent) psychiatrists. All four physicians who were responsible for providing psychiatric treatment were either board certified (three) or board eligible (one) in adult psychiatry. One physician was also board certified in child and adolescent psychiatry and another was board eligible in child and adolescent psychiatry. As such, the physicians were qualified. Of the four physicians, the two part-time physicians had been providing care at the facility for an extended period of time, and one had been providing services since 2003. The two full-time psychiatrists were recent additions to the staff, joining the psychiatry department in May 2010 and August 2010, respectively. One of the full-time psychiatrists had been designated as the Director of Psychiatry and performed administrative psychiatric functions as well as having clinical responsibilities. The two most recent additions to the psychiatric department were new to the practice of psychiatry within the context of a residential supports and services center. Practicing psychiatry in a supports and services center is different than clinical practices in other settings. It may be helpful to provide the newer physicians with some mentoring from other physicians who are more experienced in the supports and services living center model. The facility should consider the development of a "pearls of wisdom" book. This would be an information book for psychiatry that outlines information that is specific to the practice of psychiatry within the facility, and that will likely ease the transition for both the physician and staff. Although the psychiatrists practicing at the facility were either board certified or board eligible, the report that follows will indicate areas of concern with regard to their practice at the facility. It was recognized that many of the challenges to providing care in the facility were out of the physician's control. For example, these included the lack (until very recently) of clinical resources, the lack of provision of appropriate data, and the lack of their integration into the overall facility treatment program. It was apparent that there were other difficulties with the physician's practice as well (e.g., documentation issues) that were directly within physician control. Improvements necessary in the quality of services provided will be reviewed over the course of subsequent monitoring visits.	Substantial Compliance

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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.	The psychiatrists had begun comprehensive psychiatric assessments per Appendix B (six had been completed). While all individuals prescribed psychotropic medication had a five-axis diagnosis documented, there were minimal case formulations or descriptions of what led the psychiatrist to make a specific diagnosis. A review of 21 records of individuals at LSSLC revealed varying quality of the documentation in the quarterly medication reviews. There were no detailed descriptions of the justification for the use of specific psychopharmacological agents located in any of the records. Given these deficits, it was difficult to determine the adequacy of the evaluation and diagnosis of the individuals and, therefore, this provision item was found to be in noncompliance. Examples are provided below in J13. These include the six recent evaluations noted in J6. The examples include formulations and inadequacies are noted. It is hoped, as the facility had recently recruited two full-time psychiatrists, that the increased clinical consultation time will allow for improvements in overall quality of the clinical interaction and documentation thereof. The facility could consider quality assurance monitoring and/or the implementation of a peer review process for psychiatric documentation. For further discussion regarding diagnostic practices, see the discussion below in sections J6 and J10.	Noncompliance
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.	Per this provision item, individuals prescribed psychotropic medication must have an active positive behavior support plan (PBSP), sometimes referred to as a behavior support plan (BSP) in the individuals' records. In all records reviewed, individuals prescribed medication did have a PBSP on file. It will be important for collaboration to occur between psychology and psychiatry in order for there to be effective case formulation, joint determination of target symptoms, and joint determination of descriptors and definitions of the target symptoms, as well as the use of objective rating scales normed for the developmentally disabled population. Further discussion regarding the quality and utility of the PBSP is the subject of provisions relating to psychological services, discussed in section K of this report. As indicated in section K, overall, the PBSPs did not meet the generally accepted professional standard of care. Therefore, it must be considered that some psychotropic medications were being used in lieu of, and perhaps as a substitute for, a comprehensive treatment program. While all individuals prescribed medication had diagnoses noted in the record, there were concerns regarding the justification and case formulation for specific diagnoses as well as the indications for psychotropic medications prescribed to address the diagnoses. For further discussion regarding this issue, please see the discussion below in sections J8 and J13. There was no indication that psychotropic medications were being used as punishment or for the convenience of staff. There were, however, concerns regarding the lack of	Noncompliance

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		documentation of treatment integration between psychiatry and psychology and the need for improved treatment team functioning. Review of the attendance tracking log for psychiatry participation in the PST meetings revealed that the psychiatrists participated in 8.4% of the PST meetings, that is, for only 42 out of 497 meetings between the dates 8/2/10 and 9/30/10 (for additional information regarding this issue please see the discussion regarding J13). A review of the behavior support plan (BSP) sign in sheets available for review (there may have been a facility document submission error because, of the 21 charts available for offsite review, only 40% included a BSP, and the list of individuals prescribed psychotropic medication who had an active BSP revealed that 100% had this documentation) revealed that psychiatry did not routinely attend or participate in the formulation of the BSP. This was evidenced by both the history of the psychiatric physician's poor attendance (likely due to a lack of physician resources) at the PST meetings (where the BSP was developed), and at the PST meetings where the BSP was reviewed. A review of the list of meetings attended by psychiatry did not include the BSP meetings. While it was understandable that psychiatry would not always participate in these meetings, the psychology staff developing the BSP should seek the psychiatrist input/collaboration with regard to case formulation, target behaviors for monitoring, symptom monitoring, and the behavioral-pharmacological hypothesis for the individual's clinical presentation prior to the development, review, and approval of the BSP document. During the review, the monitoring team had the opportunity to observe two PSP meetings regarding Individual #57 and Individual #600. There was good discussion regarding the individual and what interventions could be implemented in an effort to assist the individual. In the case of Individual #57, there was some recent increase in physical aggression in response to an antecedent (regarding a peer). Although the team discussed multiple possibilities for keeping these individual's apart from each other, ultimately, they opted to continue the individual's enhanced supervision rather than consider other positive behavioral supports to reduce the conflict between the two individuals. There were no specific behavioral-pharmacological hypotheses regarding the individual's treatment located in the 21 records reviewed. It will be imperative that psychiatry and psychology staff meet and collaborate to formulate a cohesive diagnostic summary inclusive of behavioral data and, in the process, generate a hypothesis regarding behavioral-pharmacological interventions for each individual.	
J4	Commencing within six months of the Effective Date hereof and with	As part of the document request, any auditing monitoring data and/or reports addressing the use of pretreatment sedation medication were requested. In response to	Noncompliance

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	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.	this request, information regarding the use of restraints at the facility was provided. A review of these data revealed that restraints were utilized at the facility for medical/dental procedures at a frequency much greater than for other reasons (e.g., emergency, programmatic, or protective). For example, for the third quarter of 2010, there were 107 incidents of restraint for medical/dental procedures. A request to review medical and dental desensitization plans revealed that the facility did not implement medical desensitization plans. Per an interview with the facility dental director, the dental hygienist was developing dental desensitization plans. A sample of these plans was requested for review. The plans were included in the Positive Assessment of Living Skills (PALS) and were not individualized to the specific challenges an individual was experiencing with regard to dental clinic, nor did they specify what positive reinforcement could be utilized with the individual in order to motivate change. Documentation of the coordination of the pretreatment sedation process with psychiatry was located in some charts. Interviews with both the facility's director of psychiatry and dental director revealed that a list of individuals who were scheduled for TIVA (general anesthesia) and who were also prescribed psychotropic medications was presented to the director of psychiatry such that a medication review could be performed by psychiatry prior to TIVA. Individuals who received other medications in preparation for dental clinic or medical appointments (oral or intramuscular injections of Ativan or Valium) were not receiving this consultation, and per interviews with facility psychiatrists, they were generally unaware when individuals assigned to their caseload received this additional medication. This lack of communication was concerning given the potential for interactions between psychotropic medications and the additional medication prescribed for pretreatment sedation. When the listing of individuals prescribed psychotropic medications was compared to the list of individuals who had received pretreatment sedation for medical or dental procedures, the importance of the above paragraph was elucidated. For the months of July 2010, August 2010, and September 2010, there were 25 individuals who received pretreatment sedation for dental procedures. Of these, 18, or 72%, were concomitantly prescribed psychotropic medications. During this same period, there were a total of 49 individuals who received pretreatment sedation for medical procedures. Of these, 35, or 71%, were concomitantly prescribed psychotropic medication. As medications utilized for pretreatment sedation could result in unwanted challenging behaviors or sedation that could be mistaken by psychiatrists as symptoms of exacerbations of mental illness or as side effects from the regular medication regimen, communication regarding the utilization of pretreatment sedation must be improved.	

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J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	At the time of this onsite review, there were a total of four psychiatric physicians providing services at the facility. Two physicians were providing 40 hours of service each, working four days per week, 10 hours each day. One of these physicians was a board certified adult psychiatrist, and another was board eligible in adult psychiatry and had completed a fellowship in child psychiatry. A third psychiatrist, board certified in adult psychiatry, was providing one day of clinical services per week, eight hours per day. A fourth psychiatrist, board certified in both adult and child psychiatry, was providing one day of clinical services per month, eight hours per day. These four physicians accounted for a total of 2.25 full-time equivalents (FTE). One of the full-time psychiatrists had been designated as the Director of Psychiatry at the facility. None of the psychiatric physicians were responsible for after hours call. These duties were assigned to the primary care physicians. At the time of this monitoring review, there were 211 individuals prescribed psychotropic medication. With this volume of individuals, it was uncertain what the optimal number of FTEs would be for this facility. Similar to Mexia SSLC, at LSSLC, psychotropic medications were being reviewed by psychiatry a minimum of quarterly as opposed to monthly. Individuals were seen more frequently, however, if they had adjustments to their medication regimen or were experiencing increased psychiatric symptoms or behavioral challenges. Therefore, it would be useful to develop workload indicators to determine optimal staffing, taking into account not only clinical responsibility, but required meeting time (e.g., physician's meetings, staffing, behavioral management consultation, emergency PSPAs). Again, at the time of this monitoring review, there were 211 individuals assigned to the psychiatric clinic. As medication reviews were being performed quarterly, this equated to 140.6 hours of consultation time per month, assuming that the consultation can be performed in two hours. The reason for this amount in allowable time was the fact that rather than being reviewed monthly, the facility was performing reviews quarterly. This also equated to 17.54 annual psychiatric evaluations per month. Allowing for three hours per re-evaluation, this equals 52.7 hours of clinical consultation time per month, assuming that the re-evaluation can be performed in three hours. Therefore, in the absence of the evaluation of new admissions, attendance at meetings (e.g., polypharmacy committee, behavior therapy committee, physician's meetings, behavior support planning), and/or any other clinical activity, 193.3 physician hours is consumed by clinical consultation. This indicated that 46.02 hours of physician time per week (or 1.2 FTE) are required for this activity (allowing for a total of 4.2 weeks per	Noncompliance

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		month). Given these basic considerations, and the need for improved coordination of psychiatric treatment with primary care, neurology, other medical consultants, pharmacy, and psychology, a minimum of 3.0 FTE physicians appears to be necessary at this facility. The monitoring team can be available to further discuss the determination of optimal FTEs if the state would like.	
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.	A review of the facility's current policy and procedure manual did not reveal a policy and procedure regarding the provision of psychiatric care. In response to a document request for all policies, protocols, procedures and guidelines that relate to the role of psychiatrist at the facility, the overarching DADS policy regarding Psychiatric Services, dated 7/20/10, was provided. As such, it appeared that the facility did not have a facility specific policy and procedure regarding psychiatric services. Nevertheless, the facility psychiatric staff were in the process of evaluating individuals treated in psychiatry clinic as per the requirements and outline of Appendix B. At the time of the monitoring review, there was documentation provided that six individuals had been evaluated per the outline of Appendix B. All of these were requested for review, and included the evaluations of Individual #170, Individual #91, Individual #57, Individual #249, Individual #131, and Individual #176. In general, the physicians followed the required format, however, there was marked variability in the quality of the evaluation, as the evaluations differed across physicians with regard to detail provided both in historical data and in the comprehensiveness of the case formulation and treatment plan (for additional information regarding this issue, please see the discussion under J13). This is an area that would be amenable to physician peer review and education. Per interviews with psychiatric clinic staff and psychiatric physicians, they planned to continue to perform comprehensive psychiatric evaluations per Appendix B for all individuals treated in psychiatry clinic. Given this goal, a more robust review of these assessments will be performed during future monitoring visits. During the onsite review, three psychiatric clinics were observed (for additional information regarding this please see the discussion regarding J8). In all three instances, the physician, along with the assigned psychologist, performed brief rounds at the individual's home, spending anywhere from 30 seconds to three minutes in either direct observation or conversation with the individual. The physician then relocated to a conference room where he or she spent anywhere from 20 to 40 minutes reviewing the individual's medical record and data, in discussion with the various team members, or dictating the note from the clinic into the medical record. In all three clinic observations, the physician appeared to be familiar with the	Noncompliance

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		individual's history, and had the medical record open, reviewing documents from the record during clinic. In all three clinic observations, other staff, including the nursing case manager, QMRP, psychology and direct care staff were in attendance. One issue observed during psychiatry clinic was the lack of integration of the psychiatrist into the team. For example, the psychiatrist was in one clinic was questioning the behavioral interventions that were being utilized with a particular individual. The physician was informed that "the team" had met regarding the interventions and that, per this meeting, decisions regarding the individual's management had been made. The monitoring team queried at that time what disciplines constituted the team, and numerous disciplines were listed, however, the psychiatrist was not included in this list. Another issue, observed in one of the three clinics, was the overall level of disorganization displayed by the team members. For example, in one of the three observations, staff were engaging in side conversations, debating the results of various medical testing that the physician was reviewing in order to make a decision regarding the individual's medication management. It was understandable that treatment team interactions at the facility were flat, in that there was no hierarchy of personnel with respect to input or decision-making. There needs to be one specified team member who is empowered to act as a parliamentarian, ensuring that conversations occur one at a time, that all input is heard and respected, and that the schedule is determined and followed. Otherwise, clinical interactions are hampered and time will be wasted. During the onsite review, two staff members were introduced as psychiatric assistants. Per discussions with them and the lead psychiatrist, it was planned for these staff members to assume the responsibility for the clinic schedule from psychology and provide other administrative assistance to the psychiatric physicians (e.g. informing them of scheduled and emergency PSP meetings). Observation of the psychiatric assistants during clinic revealed that they were an asset to the physician. They were organized, had the individual's medical record available, had gathered the most recent laboratory examinations, including MOSES and DISCUS results, and the most recent vital sign measures, and in some cases, had photographs of the individuals available for the physician to review (to ensure the physician had identified the correct individual).	
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	The Reiss screen is an instrument that was developed to identify individuals who may need a psychiatric evaluation. Per an interview with the director of psychology, the facility had performed Reiss Screens on all new admissions since January 2010. The director of psychology reported that newly admitted individuals were only referred for a psychiatric evaluation if they were prescribed psychotropic medication at the time of admission, if the Reiss screen was positive, or if an evaluation was clinically indicated per the initial psychological evaluation.	Noncompliance

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	each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	Per the documents requested for this monitoring review, there were six individuals admitted to the facility since 1/1/10, and all of these individuals were evaluated via the Reiss Screen. Given the way both the documentation was requested and reported, it was impossible to determine the results of said screen, or the outcome (e.g., was the individual referred for a psychiatric evaluation). Per the director of psychology, all individuals residing at the facility who were not currently being treated in psychiatry clinic were also screened via this instrument. Data regarding the number of individuals who were referred for a psychiatric evaluation following this screening were not available at the time this report was completed. Per a discussion with the director of psychology, there was no current decision as to the frequency with which the screen would be administered to individuals residing at the facility who were not currently receiving psychiatric services. Given the need for additional information in order to determine compliance with this provision and a review of the facility self-assessment, which indicated noncompliance with this provision, this provision will remain rated as being in noncompliance. Additional information regarding this provision will be requested during future monitoring reviews.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	The facility did not have a system to integrate pharmacological treatment with behavioral and other interventions. Review of the records did not reveal any collaborative or combined case assessments or diagnostic formulations. There were, however, signs of the beginnings of integration between psychiatry and psychology, specifically the attempts by psychiatry to attend some PSP meetings. There were also opportunities for interaction during psychiatry clinic; these were observed during three clinic observations performed during this monitoring review and were a base upon which to build integration. One area of integration that required attention was regarding the use of data. While some of the target data points were documented in the record as the impetus for medication adjustments, both psychiatry and psychology staff voiced concern regarding the accuracy of data collection, and the accuracy of the choice of individual target behaviors. It was also notable that, while there were graphs of data presented to the physician, these did not include other potential antecedents for changes in target behavior frequency, such as changes in the individual's life (e.g., change in preferred staff, death of a family member), social and situational factors (e.g., move to a new home, begin a new job), or health-related variables (e.g., illnesses, allergies). Data collection practices are also discussed in section K of this report.	Noncompliance

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		Medication decisions made during clinic observations conducted during this onsite monitoring review were based on brief observations of the individuals as well as the information provided during the time of the clinic. In all three of the clinic observations performed during this onsite review, the psychiatrists made rounds in the individual's home with the assigned psychologist. The physician spent anywhere from 30 seconds to three minutes with the individual. In some cases, the team's reluctance to bring the individual to clinic was understandable. For example, there were some individuals who reportedly became agitated if their daily schedule was disrupted. Even so, these individual's experienced a disruption in their schedule because they were kept at home specifically for psychiatry clinic when they were scheduled for an on campus activity. Staff interviewed agreed that it would be less intrusive for the individuals to continue with their planned activity and for the psychiatrist to go to the activity site in order to conduct the pre-clinic observation. In other cases, individuals who would clearly be amenable to presenting in psychiatry clinic and discussing their medication and treatment were also observed in the home setting, and decisions regarding their medication regimen were made in their absence. This was concerning, as individuals have the right to participate in team decisions regarding their treatment program. During the clinic meeting (including psychology, social work, direct care staff, and nursing), the team spent a significant amount of time discussing the individual's treatment regimen. There was some waste of time, however, as in every clinic observed, staff waited in the room while the psychiatrist dictated the progress note from the clinical encounter. A review of the psychological and psychiatric documentation for 21 individual records did not reveal case formulations that tied together the information regarding a particular individual's case. Psychology and psychiatry need to formulate diagnoses and plans for treatment as a team. There was no documentation located regarding objective assessment instruments being utilized to track specific symptoms related to a particular diagnosis. The use of objective instruments (i.e., rating scales and screeners) that are normed for this particular population would be useful to psychiatry and psychology in determining the presence of symptoms and in monitoring symptom response to targeted interventions.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two	Per interviews of psychiatrists and psychology staff, psychiatry was not currently involved in the PBSP process. It is generally accepted that the individual's psychiatric physician participate in the formulation of the behavior support plan via providing input	Noncompliance

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	years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	or collaborating with the author of the plan with regard to target behaviors for monitoring, symptom monitoring, and the behavioral-pharmacological hypothesis for the individual's clinical presentation. The physician may also be a valuable resource for development of novel approaches for behavioral intervention for specific individuals. This would allow for collaboration with regard to the identification and definition of target symptoms for monitoring. It may also serve to decrease the reliance on psychotropic medication. Psychiatrists were aware that in many cases, the behavioral interventions, behaviors being monitored and tracked, and the behaviors that were the focus of positive behavioral supports were not coordinated with the psychiatric diagnosis or psychotropic medications. A review of the PBSP documentation provided in the records of 21 individuals available for offsite review, there was not a signature line included in the PBSP document for the treating psychiatrist. This was concerning, because participation of the individual's actual treating psychiatrist is the generally accepted professional standard of care. While it is not necessary for the psychiatric physician to participate in all meetings regarding the PBSP, there must be some participation/collaboration and documentation of this participation/collaboration in the process in order to satisfy the requirements of this provision item. Psychiatrists were aware that in many cases, the behavioral interventions, behaviors being monitored and tracked, and the behaviors that were the focus of positive behavior supports were not coordinated with the psychiatric diagnosis or psychotropic medications. In all of the above records reviewed, psychotropic medication was being prescribed. It was difficult from the data reported to discern the benefits of the medication with regard to the target symptoms identified for monitoring. The psychology staff had begun to utilize graphs for the reporting of data trends over time. For psychiatry, these graphs would be most useful if they included specific time markers (e.g. start dates of medication, stop dates of medication, dosage adjustments, specific life stressors that may affect behavior) and if they included data up to the date of the psychiatric review. For example, during a psychiatric clinic observed during the monitoring review, the psychiatrist had added a medication to Individual #563's regimen and requested that individual return to clinic in two weeks. During the week of the monitoring review, the individual returned to clinic for the two-week review. Unfortunately, data were not reported in a timely fashion and, therefore, the physician was unable to determine the benefit of the medication at the two-week return. This information would allow the physician to determine if ongoing treatment with the particular medication is worth the potential risk.	

#	Provision	Assessment of Status	Compliance
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	A review of the records of 21 individuals at the facility who were prescribed various psychotropic medications did not reveal documentation by the psychiatric physician of an individualized specific risk/benefit analysis with regard to treatment with medication as required by this provision item. There were comments included in the positive behavioral support plans, however, these did not satisfy the requirements of this provision item. For example: • Individual #488 was prescribed psychotropic medications including Seroquel, Trilafon, Remeron, and Klonopin. Some side effects of these medications were included in the document dated 11/1/09, however, these were incomplete. For example, weight gain and other metabolic side effects were not included in the side effect list for Seroquel. The documentation included comments regarding the criteria to increase or decrease the medication burden "If Individual #488 displays a 50% reduction or increase in aggressive or self abusive behaviors over the three months between quarterly psychiatric reviews." There was no documentation regarding other alternative strategies that had been considered in lieu of medication. • Individual #426 was prescribed psychotropic medications including Seroquel, Trazodone, Depakote, and Inderal. As in the example noted above, the list of side effects noted in the PBSP dated 1/22/10 was incomplete. There was no notation regarding the less restrictive measures attempted and/or the risk analysis. • Individual #587 was prescribed psychotropic medications including Risperdal. As in the examples noted above, the PBSP dated 2/10/10 included an incomplete list of side effects, and did not note the less restrictive measures and/or the specific risk analysis. What was curious was that the risk/benefit/alternatives to medication were being authored and presented to the individuals or their legally authorized representative by psychology staff. This is akin to the issue discussed in provision item J10, where psychology staff, psychiatric assistants, or social work staff were responsible for obtaining consent to treatment with psychotropic medication. The above illustrated the need for improved assessment of whether the harmful effects of the individual's mental illness outweighed the possible harmful effects of psychotropic medication, and whether reasonable alternative treatment strategies were likely to be less effective, or potentially more dangerous, than the medications. The success of this process will require a collaborative approach from the individual's treatment team inclusive of the psychiatrist, primary care physician, and nurse. It will	Noncompliance

#	Provision	Assessment of Status	Compliance
		also require that appropriate data regarding the individual's target symptom monitoring is provided to the physician, that these data are presented in a manner that is useful to the physician, that the physician review said data, and that this information is utilized in the risk/benefit analysis. The input of the various disciplines must be documented in order for the facility to meet the requirements of this provision item.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	Per the document request submitted prior to the monitoring review, the facility was to provide data regarding a list of individuals prescribed intra-class polypharmacy, including the names of the medications prescribed and the medication's start date, as well as facility-wide data regarding polypharmacy, including intra-class polypharmacy. A review of the documentation regarding individuals prescribed intraclass polypharmacy revealed a list of 12 individuals. Of these, nine were classified as being prescribed polypharmacy as a result of a prescription of two (eight individuals) or three (one individual) antipsychotic medications. The remaining three individuals were prescribed two anxiolytic medications (one individual), two mood stabilizers (one individual) or two antidepressant medications (one individual). A review of the documentation provided in response to the request for facility-wide data regarding polypharmacy revealed a listing of individuals residing at the facility who were prescribed psychotropic medication. Per this listing, there were individuals who met criteria for polypharmacy per the current definition (prescription of two or more psychotropic medications within the same class, or the prescription of three or more medications regardless of class). There were 90 individuals prescribed three or more medications. Of these, there were 21 individuals prescribed four psychotropic medications and 10 individuals prescribed five psychotropic medications. Per interviews with the lead psychiatrist and the clinical pharmacist, facility level review of polypharmacy was in the early stages. The pharmacist indicated that only recently (8/18/10 per a review of the pharmacy and therapeutics committee meeting minutes) had the facility adopted the correct definition for the determination of polypharmacy. Per the 8/18/10 pharmacy and therapeutics committee meeting minutes, "Future Plan: Will need to form a committee to address polypharmacy and record minutes of the meeting." The minutes of the first "Quarterly Psychotropic Polypharmacy Committee Meeting" were requested and reviewed. Per this document, the committee planned to meet every six months and the first meting was held on 9/1/10. Given the interviews and document review noted above, the facility was in the early stages of development with regard to a facility-level review to monitor polypharmacy. In discussions with the clinical pharmacist, it was noted that in order to meet the requirements of the Settlement Agreement, the facility level review would need to occur	Noncompliance

#	Provision	Assessment of Status	Compliance
		monthly, and include a review of the medication regimen for individuals determined to meet criteria for polypharmacy, so that clinical justification for each regimen can be determined and documented in the individual record. A review of the records of 21 individuals prescribed psychotropic medication revealed that in each record, there was a quarterly medication review document authored by the facility pharmacist. The current clinical pharmacist reported that she had begun performing the quarterly drug regimen reviews in early September 2010, however, previous reviews were located in the charts (quarterly for the prior year). She also reported that the psychiatrists did provide justification for polypharmacy in their dictations, which are stored "on the S drive." A review of the quarterly drug regimen reviews revealed that these were generally well done with respect to identification of laboratory and/or physical examination requirements due to treatment with a particular medication. They also provided good information regarding potential medication interactions. The acknowledgement of the quarterly drug regimen review by the prescribing psychiatrist was variable (judged by the lack of the psychiatrist's signature on the document). Additionally, a review of the quarterly psychiatric review dated immediately following a pharmacy review did not generally note review of the pharmacy document. A review of the quarterly psychiatric reviews revealed justifications for polypharmacy that were unsatisfactory. A more robust discussion regarding the rationale for the utilization of a particular regimen was necessary. Polypharmacy was routinely noted in Health Status Team Recommendations. Team members, including the primary care provider signed these documents. The HST recommendations reviewed in the 21 records requested for offsite review did not generally include the signature of a psychiatrist. These documents were confusing because they did not reveal how a certain risk level was determined. During this monitoring review, the psychiatrist was present in Health Status Team (HST), and it was reported that the psychiatrists had only recently begun attending this particular meeting. An observation of this meeting by the monitoring team revealed that it was not so much a review of the individual's risk, but more of a paper exercise. It would be beneficial for the meeting to expand (with the presence of the psychiatrist) in order to review, in depth, the individual's specific risk as a result of polypharmacy. For example: • Individual #21 was prescribed psychotropic medications, including Cogentin, Perphenazine, Quetiapine, Sertraline, and Valproic Acid. Per the HST, this individual was low risk for polypharmacy. The justification for the regimen, per psychiatry, was that she was "stable on this combination." • Individual #426 was prescribed psychotropic medications, including Seroquel,	

#	Provision	Assessment of Status	Compliance
		Trazodone, Depakote, and Inderal. Per the quarterly psychiatric review, dated 4/8/10, the justification for polypharmacy read, "Not applicable." The individual was also judged to be at low risk for polypharmacy per HST. • Individual #406 was prescribed psychotropic medications, including Zyprexa, Lexapro, and Topamax. Per the quarterly psychiatric review, dated 7/22/10, the justification for polypharmacy read, "Not applicable." This individual was also judged to be at low risk for polypharmacy per HST. • Individual #417 was prescribed psychotropic medications including Zoloft, Tegretol, and Klonopin. The quarterly psychiatric review, dated 7/22/10, was blank in the section where justification for polypharmacy was designated. This individual was judged to be at low risk for polypharmacy per HST (the HST sign in sheet for this individual noted the presence of a psychiatrist, but the signature was illegible). From a review of the discussion above, it was apparent that the determination of polypharmacy via the review committee, pharmacy, and the physicians must be coordinated. Also, there must be justification for polypharmacy (i.e., the rationale for the current regimen) included in the individual's record. Additionally, the Health Status Team must review the individual's medication regimen and appropriately determine risk of the regimen.	
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 review of a sample of 21 records revealed documentation that the Monitoring of Side Effects Scale (MOSES) and Dyskinesia Identification System: Condensed User Scale (DISCUS) were being performed by the Nurse Case Manager. The facility also had a tracking system for documentation of completion of these items entitled "Big Master Tracker." MOSES scales were being performed in the months of January and July. DISCUS scales were being performed every three months according an individualized schedule. Per a review of the "Big Master Tracker," there were 11 individuals who were not designated as "complete" with regard to their most recently scheduled DISCUS examinations. Review of the newly instituted comprehensive psychiatric assessments performed per Appendix B revealed no documentation of the physician's review of the MOSES or DISCUS results. A review of the quarterly psychotropic medication reviews revealed that the results of the scales were included as part of the document format. Also, the psychiatrist had, in most cases, signed off on the actual forms used to rate both MOSES and DISCUS and in approximately 50% of the signed examples available for review, the physician had completed the attached box indicating what his or her opinion was as to the reported results. In one clinic observation performed during this monitoring review, the psychiatrist questioned the rating scale results because the data were significantly	Noncompliance

#	Provision	Assessment of Status	Compliance
		different from one measuring period to the next. The physician requested that the scales be repeated prior to the next clinic visit. Further review of the quarterly psychotropic medication reviews revealed no documentation regarding how the MOSES and DISCUS information would be utilized or incorporated into the clinical decision making process for the particular individual. In an effort to address the need for documentation of data review and the impact of said data in clinical decision making, the facility could consider physician education regarding documentation requirements, quality assurance monitoring with ongoing corrective action, or a peer review process utilizing physician reviewers from another DADS facility.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	At the time of the onsite monitoring review, the facility psychiatrists were reportedly participating in some PSP activities. Per staff interviews, the psychiatrists "come when they can." The psychiatrists, however, had contact with other members of the treatment team during psychiatric clinic. There was not a separate treatment planning document regarding psychotropic medications. Instead, this was done via the quarterly medication reviews, according to staff interviews. There were references to psychotropic medications in some of the PSP documents reviewed. Even so, this was insufficient to meet the requirements of this provision item. A review of the PST attendance-tracking document requested during the onsite review, there had been a total of 497 PST meetings between the dates of 8/2/10 and 9/30/10. Of these meetings, psychiatry was noted to be present in 42 meetings. This indicated that the physicians had attended 8.4% of the meetings. It was recommended during the onsite review that physicians increase their attendance at PST meetings, however, in an effort to conserve resources, they should make an effort to attend those meetings that are specific to medication/side effects/behavioral challenges. In review of the psychiatric documentation from the records of 21 individuals, the information contained in the quarterly psychotropic medication reviews regarding the case formulation, diagnostic impression, and psychiatric treatment planning varied from record to record. For those individuals whose initial psychiatric evaluation had been completed according to the requirements of Appendix B (six individuals), the historical documentation was overall better, however, there remained marked variability and an overall need for improvement with regard to the case formulations to include the justification of the individual's diagnosis, the behavioral-pharmacological hypothesis, and the objective psychiatric symptoms or behavioral characteristics that should be monitored to assess the efficacy of a prescribed treatment regimen. The following examples were taken from the six records where comprehensive psychiatric evaluations	Noncompliance

#	Provision	Assessment of Status	Compliance
		per Appendix B were performed: • Individual #170 had diagnoses, including Psychosis, not otherwise specified; Impulse Control Disorder, not otherwise specified; and Attention Deficit Hyperactivity Disorder. The Case formulation, dated 10/12/10, for this individual stated, "It is felt that by asking him to complete tasks rather than telling him to do so. Have patience if he is agitated and reduce demands. Praise him when he cooperates, completes his tasks offered to him and interacts in an appropriate manner. I have seen Individual #170 several times this quarter due to his increased irritability and destructive episodes. His medications have been adjusted. There were meetings with medical and other team members to review and discuss his medication and treatment efforts. At this time he is more stable. Restraint use has decreased. He has not been seen talking to himself. His affect has improved greatly." This case formulation did not provide enough information to justify the diagnoses. The treatment was not specified, and there was no identification of the specific target symptoms for treatment with medication. Additionally, it was not clear as to what were the behavioral interventions were and what was the hypothesis guiding either the behavioral or pharmacologic treatment. • Individual #57 had diagnoses, including Bipolar Disorder, not otherwise specified; Impulse Control Disorder, not otherwise specified; Personality change due to general medical condition-Cerebral Palsy; and History of Attention Deficit Hyperactivity Disorder. The formulation for this individual, dated 9/8/10, stated, "Biological factors include his Cerebral Palsy, Seizure disorder and history of Pervasive Developmental Disorder. He is unable to function in a less restrictive environment at this time…being considered for Topamax to address his irritability and increased psychomotor activity…needed his mood regulated through Topamax…has been some improvement but his current rage episodes are a concern…has a history of seizure disorder…has not had a seizure in quite some time…noted by the neurologist that the antiepileptic medication might could help with his mood as well as be seizure protective." This case formulation did not provide information regarding the individual's diagnoses. While there was discussion regarding irritability and mood instability as target symptoms for treatment with Topamax, this individual was also prescribed the antidepressant medication Trazodone and the antipsychotic medication Thorazine. • Individual #91 had diagnoses, including Autistic Disorder and Profound Mental Retardation. She was prescribed medication, including the antidepressant medication Lexapro, the mood stabilizer Lithium, the anxiolytic medication Lorazepam, the atypical antipsychotic medication Seroquel, and the antidepressant medication Trazodone. The case formulation, dated 10/5/10,	

#	Provision	Assessment of Status	Compliance
		read, "It's unclear if this patient has the ability to abstract information that would have nay profound effect on her spiritual needs. The social history reports religion as Baptist." There was no information regarding the individual's diagnosis, the target symptoms for treatment with medication, or the goals of treatment. • Individual #176 had diagnoses including Schizoaffective Disorder, bipolar type, and Mild Mental Retardation. She was prescribed the antipsychotic medication Clozaril, the anxiolytic medication Ativan, and a mood stabilizer Lithium. The case formulation, dated 10/12/10, read, "The patient gets angry when she is not able to get her way, and sometimes…due to the great difficulty in communication…she gets frustrated. The reinforcements that the treatment plan has is to acknowledge her accomplishments and weekly opportunities to shop for desired items, and also reinforce each week that she goes without displaying a target behavior with her choice of makeup, jewelry, or nail polish…Interventions will continue to include problem solving, redirection and reengagement strategies…" There was no information regarding the justification for the individual's diagnosis, the target symptoms for treatment with the psychotropic medication, or the specific goals of treatment included. • Individual #249 had a diagnosis of Bipolar Disorder, most recent episode hypomanic. She was prescribed Celexa and Topamax. The case formulation, per the assessment performed 8/24/10, read, "Information not available at this time." Per the treatment recommendations, it read, "…on Celexa 20 mg daily and on Topamax gradually being increased to Topamax 50 mg twice a day to address her increase [sic] psychomotor activity and restlessness and irritability." The case formulation and justification of diagnosis were not completed, however, there were target symptoms identified for treatment with the medication Topamax. Further review of the psychiatric documentation revealed that in approximately 75% of the 21 cases reviewed, there was a connection between the medication prescribed and the diagnosis. There were, however, 15 of the 21 records where target symptoms identified for monitoring did not correspond to the diagnosis or medication prescribed. It was this, in conjunction with the case formulation deficits noted above (i.e., documentation of diagnostic formulation, rationale regarding psychotropic medication regimen complete with plans regarding regimen alteration, and corresponding behavioral hypothesis and data collection), that resulted in challenges related to the facility's performance in meeting this provision item. For example: • Individual #57 was seen for quarterly psychiatric review on 6/22/10. At that time, diagnoses included Personality Change due to Cerebral Palsy, impulsive aggressive type, and History of Attention Deficit Hyperactivity Disorder. Target	

#	Provision	Assessment of Status	Compliance
		symptoms for monitoring were inappropriate sexual behavior, compliance, and agitation. He was prescribed medication, including Trazodone and Thorazine at this time. He was next seen 9/8/10 and his diagnoses were changed to reflect additional diagnoses of Bipolar Disorder, not otherwise specified, and Impulse Control Disorder, not otherwise specified. There was no description of the rationale for the change of diagnoses, nor were specific target symptoms for monitoring these diagnoses documented. • Individual #33 was diagnosed with Dysthymic Disorder. She was prescribed the antidepressant medication Trazodone and the antipsychotic medication Risperdal. The target symptoms for monitoring included agitated behavior, stripping, and self-injurious behavior. While agitation and self-injury can be components of a mood disorder, monitoring for other mood symptoms could be beneficial. The above examples illustrated the need for medication treatment plans that outlined a justification for a diagnosis as well as a thoughtful planned approach to psychopharmacological interventions and the monitoring of specific target symptoms to determine the efficacy of the prescribed medication. Dosage adjustments should be done thoughtfully, one medication at a time, so that based on the individual's response via a clinical encounter with the individual and a review of appropriate target data (both pre and post the medication adjustment), the physician can determine the benefit, or lack thereof, of a medication adjustment.	
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.	In response to the monitoring team's document request regarding a listing of all facility-wide policy and procedures, the facility provided a listing of policies including one entitled, "Legally Adequate Consent/Authorization for Treatment" with an effective date of 7/17/08. There was an update to this policy created April 2010. Per the policy update, it was the responsibility of the social worker to complete the "Consent/Authorization for Treatment with Psychotropic Medication" form for individuals with a legally authorized representative, and it was the responsibility of the psychiatrist or psychiatric assistant to complete the form for individuals without a legally authorized representative. This policy update referenced the Texas Administrative Code Title 40 Part 1, Chapter 8, Subchapter I. An internet search revealed that, per this Code, "The treating physician or his/her designee will discuss the administration of psychotropic medication with all persons for whom such medication has been prescribed, will provide to them the information required for informed consent." Review of similarly titled policy and procedure at other DADS facilities revealed the use of a reference to Texas	Noncompliance

#	Provision	Assessment of Status	Compliance
		Administrative Code Title 25, Part I, Chapter 414 Subchapter I as delineating procedures regarding consent to treatment with psychotropic medications. An internet search revealed that, per this Code, "the treating physician, registered nurse, licensed vocational nurse, physician's assistant, or registered pharmacist" was responsible for obtaining informed consent for treatment with psychotropic medications. The policy further stated, that if the information was not provided by the treating physician, the physician must "confirm the explanation with the patient and the patient's legally authorized representative, within two working days." Per interviews with facility staff, including the CNE, the facility pharmacist, the Director of Psychology, and the facility psychiatrists, as well as review of facility medical records, psychology and/or social work staff were responsible for completing the consent form for medication and presenting same to the individual or his or her legally authorized representative for signature. The staff also reported that psychiatry had been involved in some consent process, however, due to manpower shortages, they were unable to continue this involvement. The two full-time psychiatrists interviewed were aware of the need for them to actively perform the informed consent discussion with individuals and their legally authorized representative, however, they further stated that current available clinical consultation hours did not permit this involvement. A review of 21 individual records (all of whom were prescribed psychotropic medication) selected for offsite review revealed that in 12 records, there was no documentation of informed consent. Whether this was an error in the document submission process or an actual lack of documentation in the record was unknown. In four cases, there were forms entitled, "Consent/Authorization for Treatment with Psychotropic Medications." Examples of these included: • Individual #308 - The form, dated 9/17/10, was signed by the legally authorized representative and by a facility social worker designated as the "person giving explanation" for treatment with the atypical antipsychotic Seroquel. • Individual #176 - The form, dated 9/1/10, documented consent for three different medications: the antipsychotic medication Clozaril, the mood stabilization medication Lithium, and the anxiolytic medication Ativan. The individual's legally authorized representative signed this form, however, there was no signature designating the person giving the explanation. • Individual #57 – The form, dated 9/28/10, documented consent for two different medications: the atypical antipsychotic medication Risperdal, and the side effect medication Cogentin. The facility director signed this form and the person documented as giving the explanation was a psychiatry assistant. • Individual #562 – The form, dated 8/25/10, documented consent for two different medications: the anxiolytic medication Valium, and the atypical	

#	Provision	Assessment of Status	Compliance
		antipsychotic medication Geodon. The facility director signed this form and the person documented as giving the explanation was a psychiatry assistant. In only one of the above four examples were any specific risks, benefits, or side effects related to treatment with a particular medication documented. The remaining five records (Individual #148, Individual #417, Individual #33, Individual #392, Individual #52) included consent for treatment with psychotropic medications as part of a document entitled, "Guardian Consent for Positive Behavior Support Plan & Medications." These documents included a smattering of side effects, but overall were incomplete with respect to documenting potential risks. For example, the document in the record of Individual #148 regarding consent for treatment with the atypical antipsychotic medication Risperdal noted, "Potential side effects included autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, impaired thinking and motor skills, abnormal gait, involuntary muscles spasms), weight gain, increased pigmentation." This information did not mention other serious side effects (e.g. Neuroleptic Malignant Syndrome, Tardive Dyskinesia, elevation of prolactin levels, metabolic syndrome). The document in the record of Individual #33 offered more information regarding treatment with Risperdal, but was still incomplete. An additional five examples of consent for psychotropic medications were requested during the onsite review. Of these, the individual, the legally authorized representative, or the facility director signed all. The psychiatric assistant in all five examples signed as the person giving the explanation. In no cases reviewed, was there any documentation of the prescribing psychiatrist actively participating in the informed consent process. The informed consent process at the facility was not consistent with generally accepted professional standards of care that require that the prescribing practitioner disclose to the individual the risks, benefits, side effects, alternatives to treatment, potential consequences for lack of treatment, as well as give the individual or his or her legally authorized representative the opportunity to ask questions in order to ensure his or her understanding of the information. This process must be documented in the individual's record. To delegate this responsibility to psychology staff, social work staff, or psychiatric assistants (i.e., to those who do not have prescriptive authority and would not be able to respond to specific questions an individual or legally authorized representative may have regarding the specific medication) was inappropriate. In an effort to address the deficit in these informed consent practices, it was recommended that the facility consult with the state office who, in turn, may want to consider a statewide policy and procedure outlining appropriate informed consent practices that comply with Texas state law and generally accepted practice.	

#	Provision	Assessment of Status	Compliance
		In a separate but related issue, review of the medical records revealed information regarding the individual and his or her guardianship status, however, this information was not included in the psychiatric annual evaluations or progress notes. Easy identification of an individual's guardianship status for the purposes of consent is necessary. Inclusion of this information in the demographic data located in the beginning of the psychiatric evaluations/progress notes may assist in this regard. Also see section U of this report.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	Per an interview with the facility lead psychiatrist, the coordination of treatment between neurology and psychiatry was in the beginning stages. Neurology reportedly conducted a clinic at the facility one time per month. Psychiatry reportedly participated in these clinical encounters if the individual was prescribed medication to address both a seizure diagnosis and a psychiatric indication, or if the psychiatrist had a question for the neurologist. Documentation of collaboration was noted in the record of Individual #488. Per the neurological consultation performed 8/25/10, "we did discuss this case with the psychologist and also with [treating psychiatrist] in detail. My impression was in talking with them that it does not appear that the seizures are causing his behavior issues, but rather the behavior issues are from his organic brain syndrome." There were no psychiatric progress notes available for review since this consultation. Per the facility medical director, individuals can also receive neurology consultation in the community, "if they need to be seen sooner than the monthly clinic is scheduled…we send them into town…it is better when it is done onsite though…because we [indicating the facility physicians] can interact with the neurologist…and the psychiatrists can consult with them then too." It was good to see that this option existed for individuals, however, it remained a concern that there was little communication between neurology consultation and the facility. At the time of this monitoring review, per the list of all individuals being treated for seizure disorder provided by the facility, there were 190 individuals with a current diagnosis of seizure disorder. Of these, 79 (42%) were also receiving psychiatric services/medication. A review of the list of medications prescribed to the individuals, as well as the indications for said medication, revealed that 211 individuals were prescribed psychotropic medication and that 79 of these individuals (37%) were also prescribed medication for seizure disorder. While this would indicate the need for clinical consultation, there were other neurological disorders diagnosed that would have been amenable to close clinical	Noncompliance

#	Provision	Assessment of Status	Compliance
		contact between neurology and psychiatry (e.g., headache, EPS, tremors, various syndromes). Per interviews and observation of medical staff, there were obvious attempts at coordination of care occurring specifically between primary care and psychiatry. The physicians met together daily to review cases (regarding individuals who were currently in the facility infirmary, hospitalized, or who were experiencing difficulties or challenges). While these attempts at communication were laudable, the risk was for transmission of non-emergent information to be hindered by the indirect contact between psychiatry and neurology. A review of records chosen for review due to comorbid diagnoses of psychiatric illness and seizure disorder where seizure medications were reportedly being utilized for a dual purpose (e.g., seizure diagnosis and psychiatric diagnosis) revealed various challenges that were likely attributable to the lack of sufficient neurological consultation and collaboration. For example: • Individual #417 was last seen by the neurologist 11/11/09. At that time, the neurologist recommended, "she is currently on Carbamazepine 200 mg TID and she takes Lyrica 75 mg BID…she seems to be doing fine…maintain her on the current treatment program…could consider just placing her on one medication either Tegretol or Lyrica. If we are gong to use Lyrica, then we could simply bump up the dosage to about 100 to 150 mg BID. Alternately, we could just simply leave her alone and see how she does." This individual was seen by psychiatry 1/21/10. There was no documentation of the psychiatrist's review of the neurological consultation. The psychiatrist did review a Tegretol level dated 1/15/10, which was 5.9 (4 – 12). Per the most recent list of the individual's medication, dated 6/15/10, the dosages of both Carbamazepine and Lyrica remain unchanged. While the alteration of the medication dosage was an option per the neurologist's documentation, it is unclear whether this occurred due to his recommendation, or by chance. • Individual #460 has a history of seizure disorder. She was seen by psychiatry 7/2/10 and the antiepileptic medication Topamax was prescribed for impulsive behavior and agitation. Per the Quarterly Drug Regimen Review dated 9/1/10, the individual's blood levels for the antiepileptic medication Tegretol had been consistently sub-therapeutic. The individual was seen by the nurse practitioner 9/14/10 and, at that time, a taper of Tegretol was started. There was no documentation of a discussion of this medication change with the psychiatrist. It would be important for changes in the dosage of this particular medication to be reported because this medication affects the metabolism of other medications prescribed by psychiatry. Additionally, the psychiatric progress notes for this	

#	Provision	Assessment of Status	Compliance
		individual revealed a history of impulsivity and behavioral challenges that were likely partially addressed via treatment with Tegretol. There was no neurological consultation noted or documented in the individual's record. In an effort to better address the requirements of this provision item, it would be beneficial to determine the amount of clinical neurology time needed via an examination of the number of individuals in need of neurology (including those not prescribed concomitant psychotropic medication) consultation and the recommended follow up frequency. It was apparent that, in some cases, the burden for review of medications specifically prescribed for seizure disorder diagnoses fell upon the primary care physician. The facility may want to consider options for improving neurologic consultation availability, specifically increasing the contract with the current provider, exploring consultation with local medical schools and clinics, and considering telemedicine consultation with providers currently contracted in other DADS facilities.	

Recommendations:

1. Integrate psychiatry into the overall treatment program at the facility. This would include involving the psychiatrists in discussions regarding treatment planning and behavioral support planning.

2. Review those individuals requiring pretreatment sedation for medical and dental clinic and prepare individualized desensitization plans for them.

3. Ensure that psychiatry is aware of when an individual requires pretreatment sedation and documents this knowledge in his or her progress notes.

4. Integrate the psychiatric physician into the individual's team.

5. Ensure that the target behaviors/diagnoses/psychopharmacology for all individuals prescribed psychotropic medication are appropriate. This must include a detailed case formulation and discussion that is collaborative with other team members. In addition, there should be a detailed psychopharmacological treatment plan. When diagnoses or medications are changed, there should documentation of what symptoms or criteria were met in order to justify an alteration of diagnosis. When a medication is added, or a dosage is changed, there should also be documentation regarding potential difficulties that may occur and symptoms that are being targeted with these changes.

6. Draft and implement policy and procedure governing psychiatric clinic at the facility to include requirements of the Settlement Agreement, Appendix B, and the overarching DADS policy.

7. Complete annual psychiatric evaluations following the requirements of the Settlement Agreement Appendix B. These must include detailed case formulations and treatment plans for psychotropic medication.

8. Examine the scheduling process of psychiatric clinic at the facility. This should include the arrangements for individuals to actively participate in the psychiatric clinic process.

9. If the Reiss screen is completed, document the outcome of the screen and the referral's made as a result.

10. Generally accepted professional standards of care indicate that individual's have the right to participate in psychiatric clinic as a participant in team decisions regarding their treatment. It seemed that many individuals at the facility could actively participate.

11. Review the target symptoms and data points currently being collected for individuals prescribed psychotropic medication. Make adjustments to the data collection process (i.e., specific data points) that will assist psychiatry in making informed decisions regarding psychotropic medications. This data must be presented in a manner that is useful to the physician (i.e., in graph form, with medication adjustments, identified antecedents, and specific stressors identified).

12. Formalization of the PSP process to review risk/benefit ratios for the prescription of psychotropic medications that are authored either by psychiatry or at a minimum in collaboration with psychiatry.

13. Formalize the facility level review of polypharmacy.

14. Review the method of reporting polypharmacy data for accuracy and completeness.

15. Increase the frequency of the pharmacy quarterly drug regimen reviews to monthly in order to meet the requirements of the Settlement Agreement.

16. Improve physician documentation of the rationale for the prescription of specific medications as well as for the rationale and potential interactions when polypharmacy is implemented.

17. Improve documentation of psychiatric review and clinical use of DISCUS and MOSES examination results.

18. Improve psychiatric documentation to include a diagnostic formulation and justification for each specific diagnosis.

19. Review the target behavioral data for each individual to determine if appropriate data points are being collected. In order for the data to be usable, it should be graphed with medication information (i.e., start dates of medication, stop dates of medication, and dosage adjustments) included.

20. Ensure that the indications for specific medications correspond to the purported diagnosis, and that appropriate defined behavioral/symptom data points are being monitored.

21. Individualize the process for Informed Consent.

22. Develop a statewide Informed Consent Policy and Procedure that is consistent with Texas law and generally accepted practices in medicine.

23. Explore options to increase the availability of neurology consultation.

The following are offered as additional suggestions to the facility:

24. Consider monitoring the psychiatrist's workload in order to objectively determine the need for additional clinical contact hours. This can better be performed once a baseline is established for meetings/clinical coordination with other disciplines.

25. Develop a recruitment/retention plan for psychiatry. The facility should consider the development of a "pearls of wisdom" book. This would be an information book for psychiatry that outlines information that is specific to the practice of psychiatry within the facility, and ease the transition for both the physician and staff.

26. Consider the utilization of scales and screeners normed for this population in an effort to obtain objective data regarding symptoms as well as to monitor symptom response to targeted interventions.

27. Consider the designation of a "parliamentarian" for psychiatric clinic.

28. Consider making the identification of the individual's legal status and the identify/contact information of their legally authorized representative (if any) part of the regular demographic information included in the psychiatric assessment and progress notes. This will make the informed consent process and the regular contact of families/legal representatives during treatment a simpler process.

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Positive Behavior Support Plans (PBSPs) for: • Individual #519, Individual #60, Individual #170, Individual #90, Individual #498, Individual #328, Individual #166, Individual #333, Individual #79, Individual #440, Individual #375, Individual #203, Individual #392, Individual #297, Individual #36, Individual #417, Individual #176, Individual #102, Individual #507, Individual #426, Individual #475, Individual #221, Individual #557, Individual #145, Individual #131, Individual #476, Individual #345, Individual #9, Individual #12, Individual #600, Individual #134, Individual #249 o Functional Assessments for: • Individual #333, Individual #79, Individual #440, Individual #375, Individual #203, Individual #392, Individual #297, Individual #36, Individual #417, Individual #176, Individual #102, Individual #507, Individual #426, Individual #475, Individual #221, Individual #557, Individual #145, Individual #131, Individual #476, Individual #345, Individual #9, Individual #112, Individual #488, Individual #468, Individual #480, Individual #600, Individual #31, Individual #93, Individual #134, Individual #249 o Psychological Evaluations for: • Individual #333, Individual #79, Individual #440, Individual #375, Individual #203, Individual #392, Individual #297, Individual #36, Individual #417, Individual #176, Individual #102, Individual #507, Individual #426, Individual #475, Individual #221, Individual #557, Individual #145, Individual #131, Individual #476, Individual #345, Individual #9, Individual #112, Individual #488, Individual #468, Individual #480, Individual #600, Individual #31, Individual #93, Individual #134 o PBSP monthly notes • Individual #581, Individual #276, Individual #480, Individual #31, Individual #557, Individual #203, Individual #79, Individual #476, Individual #60, Individual #90, Individual #498, Individual #134, Individual #36, Individual #166, Individual #145, Individual #221, Individual #417, Individual #426, Individual #297, Individual #9, Individual #440 o Form used by supervisors to review PBSPs, undated o Quarterly Psychiatric Medication Review for Individual #Individual #161, dated 10/21/10 o Peer/Behavior Review Committee meeting minutes, dated 8/24/10, 8/17/10, 8/10/10, 8/3/10, 7/27/10, 7/22/10 o Format for Psychological Evaluations/Functional Assessments &Positive Behavior Support Plan, dated 8/10 o Structural/Functional Behavioral Assessment (SFBA) and Positive Behavior Support Plan (PBSP)

	Evaluation Tool dated, 9/10/10 o Spreadsheet documenting each individuals dates of functional assessments, Positive Behavior Support Plans, and Psychological Evaluations, undated o Psychology Department Roster, dated 9/1/10 o Spreadsheet tracking licenses, certifications, BCBA coursework completed, and BCBA supervision for each member of the psychology department <u>Interviews and Meetings Held</u>: o Sylvia Middlebrook, Ph.D., Director of Psychology o Marvin Stewart, M.A, Program Compliance Monitor o Edward Hutchison, M.A., BCBA consultant o Julie Bradbury, M.S., Associate Psychologist III; Veron Wiggins, M.A., Associate Psychologist III; Keri Leggett-Bush, M.Ed., Associate Psychologist III o Psychology meeting: • Staff Present: Sylvia Middlebrook, Ph.D., Director of Psychology; David Milem, M.A., Associate Psychologist V; Martha Thomas, M.S., Associate Psychologist, V; Robin McKnight, M.A., Associate Psychologist V; Mike Fowler, M.A., Associate Psychologist V; Marvin Stewart, M.A., QA/PCM; Julie Bradbury, M.S., Associate Psychologist III; Veron Wiggins, M.A., Associate Psychologist III; Keri Leggett-Bush, M.Ed., Associate Psychologist III, Jackie Price, M.Ed., Associate Psychologist III; Ranleigh McAdams, M.A., Associate Psychologist III; Richard Mendola, M.A., Associate Psychologist III; Charles Motes, M.A., Associate Psychologist III; Emily Havard, M.A., Associate Psychologist III; Jessica Decker, Psychology Assistant; Troy Finch, Psychology Assistant; Jillian Harris, Psychology Assistant; Rosie Christian, Psychology Assistant <u>Observations Conducted</u>: o Psychiatry meeting • Staff present: Mark Janes, Psychiatry; Julie Bradbury, Associate Psychologist; Marvin Stewart, QA/Program Compliance; Abimbola Furinde, Clinical Pharmacist; Maria Garcia, RN; Sydney Breneman, DCP; Shanta Scott, QMRP • Individuals presented - Individual #566, Individual #123, Individual #410 o Psychiatry meeting • Staff present: Dr. Buckingham, Psychiatrist; Robin McKnight, Associate Psychologist; Rosie Christian, Psychology Assistant; Linda Thompson, DCP • Individuals presented - Individual #161, Individual #131 o Psychology Peer Review Meeting • Staff Present: Sylvia Middlebrook, , Ph.D., Director of Psychology; David Milem, M.A., Associate Psychologist V; Martha Thomas, M.S., Associate Psychologist, V; Robin McKnight, M.A., Associate Psychologist V; Mike Fowler, M.A., Associate Psychologist V; Marvin Stewart, QA/PCM; Julie Bradbury, M.S., Associate Psychologist III; Veron Wiggins, M.A.,

	Associate Psychologist III; Keri Leggett-Bush, M.Ed., Associate Psychologist III, Jackie Price, M.Ed., Associate Psychologist III; Ranleigh McAdams, M.A., Associate Psychologist III; Richard Mendola, M.A., Associate Psychologist III; Charles Motes, M.A., Associate Psychologist III; Emily Havard, M.A., Associate Psychologist III; Jessica Decker, Psychology Assistant; Troy Finch, Psychology Assistant; Jillian Harris, Psychology Assistant; Rosie Christian, Psychology Assistant • Individual Presented: - Individual #392 o Psychology V meeting • Staff present: Sylvia Middlebrook, Ph.D., Director of Psychology; David Milem, M.A., Associate Psychologist V; Martha Thomas, M.S., Associate Psychologist, V; Robin McKnight, M.A., Associate Psychologist V; Mike Fowler, M.A., Associate Psychologist V • Individuals Presented: - Individual #333, Individual #102, Individual #9, Individual #557, Individual #221, Individual #57, Individual #507, Individual #475, Individual #375 o Observations occurred in various day programs and residences at LSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals including, for example: • Assisting with daily care routines (e.g., ambulation, eating, dressing), • Participating in educational, recreational and leisure activities, • Providing training (e.g., skill acquisition programs, vocational training), and • Implementation of behavior support plans
	Facility Self-Assessment: LSSLC's Plan of Improvement (POI) indicated noncompliance for each item of this settlement provision. The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the facility's POI findings of noncompliance in all areas. The only exception was provision item K2 (qualified director of psychology) that the monitoring team determined was in substantial compliance with the Settlement Agreement. The POI established long-term goals for compliance with each item of this provision. Because many of the items of this provision require considerable change to occur in the way psychology services are provided, and because it will likely take some time for LSSLC to make these changes, it may be useful for the facility to also establish short-term goals (e.g., for the next six months), so that the psychology staff can better mark their progress toward substantial compliance.
	Summary of Monitor's Assessment: Although only one of the items in this provision was found to be in substantial compliance with the Settlement Agreement, there was however, progress in several items. Areas of improvement noted since

	the baseline review were: • A substantial increase in the number of psychologists enrolled in coursework toward the Board Certified Behavior Analyst (BCBA) certification (K1) • Addition of a qualified director of psychology (K2) • The establishment of internal peer review (K3) • Additional flexibility in the data system (K4) • The inclusion of a new psychological evaluation format that included a personal history, standardized cognitive assessment, standardized assessment of adaptive ability, a screening for psychopathology (e.g., Assessment for Dual Diagnosis, Reiss Screen for Maladaptive Behavior) and emotional/behavioral issues (i.e., functional assessment, Questions About Behavioral Function), and an assessment of each individual's medical status (K5) • Establishment of a standardized format combining psychological evaluation, functional assessments, and Positive Behavior Support Plans (PBSPs) in one simplified document (K5, K9, K11) • Improvements in the overall quality of Positive Behavior Support Plans (K9) There were also areas that the monitoring team believes require immediate attention. Those areas include: • A plan needs to be developed to ensure that those psychologists not enrolled in BCBA coursework, or eligible to sit for the exam, either receive the training and experience necessary to write effective positive behavior support plans, or are reassigned to duties that do not include the writing of PBSPs (K1) • More closely manage peer review meetings to increase the number of individuals discussed at each meeting (K3) • Modify current ABC data system (K4) • Target and replacement behaviors should be graphed at increments sufficient to make data-based treatment decisions (K4)

#	Provision	Assessment of Status	Compliance
K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development,	This provision item was rated as being in noncompliance because the psychologists at LSSLC were not yet demonstrably competent in applied behavior analysis (ABA), as evidenced by the absence of professional certification, and inconsistency in the quality of the positive behavior support plans (see K9). At the time of the onsite review, 10 of the facility's 13 psychologists, and the director of psychology, were enrolled in course work toward becoming board certified behavior analysts (BCBA). This represented a substantial increase from the baseline review when only two psychologists were enrolled in the BCBA coursework. In addition, one psychologist at LSSLC was seeking eligibility to sit for the BCBA exam based on training and experience.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Additionally, a consultant with expertise in ABA and certified as a BCBA was recently hired two days a week to assist in the development of PBSPs, and to provide supervision of psychologists enrolled in the BCBA program. LSSLC and DADS are to be commended for their efforts to recruit and to train staff to meet the requirements of this provision item. The facility had developed a spreadsheet to track each psychologist's BCBA training and credentials. It is recommended that the facility develop a plan to ensure that the remaining psychologists attain BCBA certification or are reassigned to duties that do not include the writing of Positive Behavior Support Plans (PBSPs).	
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 attained substantial compliance with this provision item. A director of psychology (Dr. Middlebrook) with a Ph.D., licensed as a psychologist in Texas, and 11 years of experience working with individuals with intellectual disabilities was hired on 5/1/10. Additionally, Dr. Middlebrook had enrolled to take the BCBA coursework. Supervisees interviewed indicated they had positive professional interactions with, and received professional support from, the new director of psychology. Finally, under Dr. Middlebrook's leadership, several initiatives had begun (e.g., increased number of psychologists enrolled in BCBA coursework, establishment of internal peer review, modifications to psychological evaluations) leading toward the attainment of substantial compliance with other items of this provision.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	This item was rated as being in noncompliance because there was no external peer review and because further work needed to be done with the format of the new peer review system. The facility had made substantial progress on this provision item of the Settlement Agreement by recently adding the opportunity to present cases that were not progressing as expected at the internal peer review meeting. The facility's BCBA consultant chaired this meeting, but because he was contracted to be at the facility two days a week and because he assisted in the development of PBSPs, the monitoring team viewed this meeting as internal peer review. Review of available minutes of peer review meetings suggested that the internal peer review meeting occurred weekly, with regular attendance among all of the psychologists. During the meeting observed by the monitoring team, there was active participation among the psychologists and there were several examples of staff sharing strategies and suggestions to improve functional assessments and PBSPs. Only one individual, however, was presented at each two hour meeting. The monitoring team believes that the number of individuals presented could be substantially increased (and therefore	Noncompliance

#	Provision	Assessment of Status	Compliance
		increasing the positive impact of the meeting) without sacrificing the clinical and educational benefits of the meeting by better focusing and managing the content of the presentations. It is recommended that internal peer review meetings be more directly focused and managed so that several individuals can be presented at each meeting, thereby, increasing the opportunities for facility psychologists to present and receive feedback on their cases. At the time of the onsite review there was no evidence that the facility was conducting external peer review. The monitoring team recommends that peer review be extended by adding monthly external peer review meetings consisting of, at minimum, other Texas DADS, BCBAs and supervisors (perhaps by teleconference) that are not directly involved in the development of the facilities PBSPs. Operating procedures for both internal and external peer review committees will need to be established.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	The data collection methodology used at LSSLC did not conform to ABA generally accepted professional standards and, therefore, this provision item has been rated as being in noncompliance. Since the baseline review, the facility had improved its data collection by introducing individual data books (that included each individual's PBSP and data sheets) that followed each individual throughout the day. The advantage of this system for data collection was that it should improve the reliability of data collection by allowing direct care professionals (DCPs) to record data immediately after it occurs, rather than waiting to return to the location of the data sheets before recording individual data and potentially forgetting the details of the behavior that occurred. The monitoring team, however, found that the data books were in locked rooms in home 524, requiring DCPs to wait until the end of their shift to record data. It is recommended that the data books be readily available to DCPs, and data be recorded as soon as possible after it occurs. Another improvement in the data system since the baseline review was an increase in the flexibility of the data system. The majority of homes during the onsite review collected frequency data using a system where antecedents, the target behavior, and consequences (also known as an ABC data system) for each target behavior were recorded. The data for the ABC system were recorded on cards or sheets kept in each individual's personal data book. Some of the homes (e.g., 506, 561A, 561B) used a data system that consisted of DCPs recording the frequency of target behaviors and their times of occurrence. The plan was for all homes to use the ABC system for frequency data collection.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In addition to the frequency measure, a duration measure was noted for some individuals (e.g., Individual #131), and staff reported the use of time-sample measures for some individual's data collection systems. The monitoring team encourages the facility to continue to expand its data system to ensure that it is flexible enough to be sensitive to each individual's needs. It is suggested, however, that the facility consider a simpler alternative to the ABC system for routine frequency recording. The ABC system is typically used, and is well suited, for direct descriptive assessments to better understand the antecedents and functions of target behaviors (see K5). Its routine use as a frequency measure, however, can result in poor data collection integrity and confusion from DCPs. For example, Individual #328's PBSP specified that he be given a choice following physical aggression. The consequences on his ABC data sheet were generic and did not include offering a choice. Therefore, it was impossible for the DCP to accurately record Individual #328's data. A data collection system needs to be collected by DCPs with integrity. The most direct method for assessing and improving the integrity with which data are collected is to regularly measure inter-observer agreement (IOA). It may be that some data systems are too complex (e.g., ABC systems that require the collection of multiple antecedents and consequences for each target and replacement behavior) for some DCPs to collect data reliably. Under those conditions, the data system may need to modified (e.g., use of fewer target behaviors, move to a less complex time-sampling procedure) to ensure that the data are reliably collected. At the time of the onsite review of LSSLC, data reliability (i.e., IOA) was not collected. It is recommended that the facility ensure that IOA for all target behaviors (including replacement behaviors) is consistently collected in each home and day/vocational site. Additionally, specific IOA goals should be established, and staff retrained or data systems modified, if scores fall below those goals. None of the DCPs interviewed indicated that they had input in the establishment of data collection systems. It is recommended that DCP input in data system development be sought and documented. Target behaviors were analyzed individually. The data system at LSSLC did not, however, consistently include the collection of replacement behaviors. It is recommended that replacement behaviors be added to each individual's data sheet. Target behaviors were not consistently graphed at LSSLC. Of 21 monthly progress notes reviewed, only seven contained graphed data. It is recommended that all target and replacement behaviors be graphed to improve the ability to make accurate data-based treatment decisions. The PBSP target behaviors that were graphed were all in monthly increments. That is, each datum point represented one month of data. Some target and	

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		replacement behaviors, however, need to be graphed more frequently to ensure sufficient data-based decision-making. For example, the monitoring team observed a psychiatry clinic in which the psychiatrist had recently prescribed a medication to Individual #131 and wanted to know if it was beginning to work. Because the target behaviors were graphed in monthly increments, he could not make data-based decisions, and instead had to rely on staff opinions (which varied widely across team members) of whether her behavior had improved in the last two weeks. If the psychologist had graphed the data showing Individual #131's daily behavior, the psychiatrist would likely have been better able to evaluate if the medication was affecting her behavior, thereby increasing the likelihood that Individual #131 received the most efficient medication and dosage. The monitoring team identified some examples of PBSPs modified prior to the annual review due to an increase in target behaviors (e.g., Individual #466, and Individual #600). The majority of PBSP data reviewed however indicated an increase (e.g., Individual #498, Individual #60, Individual #392) or no change (e.g., Individual #426, Individual #276, Individual #221) in target behaviors such as physical aggression, with no modification in the PBSPs prior to the annual review. It is important that when individuals' data trends in an undesirable direction (or continues with no improvement), that hypotheses be developed, changes are made to the PBSP, and that these changes be documented in the progress notes. A criterion for revision of the plan was not included in the PBSPs. A specific and individualized criterion for review of each PBSP should be established, and the decision to revise should be based upon the data.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	This provision item was rated as being in noncompliance due to the absence of psychological assessments for all individuals, and the absence of functional assessments for those individuals whose records indicated a behavioral disturbance. <u>Psychological Assessments</u> All of the 29 psychological evaluations reviewed included a personal history, standardized cognitive assessment, standardized assessment of adaptive ability, a screening for psychopathology (e.g., Assessment for Dual Diagnosis, Reiss Screen for Maladaptive Behavior) and emotional/behavioral issues (i.e., functional assessment, Questions About Behavioral Function), and an assessment of each individual's medical status. The facility had substantially increased the number of psychological evaluations completed since the baseline review, however, a spreadsheet documenting psychological evaluations indicated that 31 individuals did not have a psychological evaluation at the time of the onsite review.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Each individual's record should contain a psychological evaluation that consists of an assessment of intellectual and adaptive ability, screening for psychopathology, review of personal history, and assessment of medical status. <u>Functional Assessments</u> A spreadsheet of all individuals with a PBSP provided to the monitoring team indicated that approximately 211 individuals at LSSLC had a PBSP. Thirty-five of those individuals, however, did not have a functional assessment. All individuals whose records indicate a behavioral disturbance should have a functional assessment of the variable or variables affecting the individual's target behaviors. The facility recently introduced a new format combining psychological evaluations, PBSPs, and functional assessments that included all of the components commonly identified as necessary for an effective functional assessment. The quality of some of these components, however, appeared insufficient for the functional assessments to be as effective as they could be. For example, although all 30 functional assessments reviewed contained both indirect and direct measures of the functions of target behaviors, some examples of direct assessments were incomplete. The following examples were typical: • Individual #468's and Individual #417's descriptive assessments did not describe the direct observation of antecedents and consequences of their target behaviors. Instead, their direct assessments simply described the frequencies of their target behaviors over the last year. The direct assessments of several functional assessments sampled (e.g., Individual #176), however, were based on direct observation and clearly identified antecedents and consequences of target behaviors that were potentially useful for better understanding the undesirable behavior, and writing an effective PBSP. All functional assessments should include a direct assessment that includes direct observations of target behaviors and relevant environmental variables. All of the functional assessments reviewed identified potential functions of the undesired behavior. Some of the identified functions, however, were not operationally defined and, therefore, not useful for understanding the variables maintaining the behavior. For example: • Individual #131's functional assessment concluded that her maladaptive behavior was a result of her mental illness and diagnosis of schizophrenia. • Individual #375's target behaviors were hypothesized to be a function of her Intermittent Explosive Disorder.	

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		Although these individual's target behaviors may be related to their psychiatric diagnoses, in order to better understand the functions of their target behaviors, it would be important to focus on the effect the target behaviors have on the environment (e.g., provide attention, access to desirable objects, and/or avoidance or escape from undesired activities). All hypothesized functions of the target behavior identified in a functional assessment should be operationally defined. Several of the functional assessments reviewed identified several possible functions of undesired behavior. Typically, however, no attempt to summarize the multiple functions into a clear statement of the most important variables affecting the target behavior was apparent. The following examples were typical: • The indirect and direct measures of Individual #57's functional assessment failed to identify any consistent function of his target behaviors. Therefore, the functional assessment discussed several functions (e.g., control of the environment, creation of excitement, escape from boredom, gain attention, escape undesired tasks and routines) that resulted in a complex discussion that did not appear to result in a better understanding of the function of Individual #57's undesired behavior. • Individual #145's functional assessment indicated that her physical aggression was a function of gaining tangible items, attention from staff, a means for getting peers to leave her alone, a way to express dislikes, and means to express being homesick. Clearly when comprehensive functional assessments are conducted there are going to be some variables identified that are determined to not be important in affecting the individual's target behaviors. An effective functional assessment needs to integrate these ideas and observations from various sources into a comprehensive plan (i.e., a conclusion or summary statement) that will guide the development of the PBSP. Although many of the functional assessments reviewed were comprehensive, typically, they did not attempt to integrate the information into a summary statement identifying the variables (both antecedent and consequent) that were hypothesized to affect the behavior. All functional assessments should include a summary statement (e.g., in the treatment hypothesis and rationale section of the functional assessment) that integrates the results of the various assessments into a comprehensive statement of the variables affecting the target behaviors. All functional assessments reviewed included a list of preferences and reinforcers for each individual. These preferences and reinforcers, however, were not consistently used therapeutically. For example, the conclusions of Individual #488's functional assessment suggested that his interest in music and singing had the potential of getting him involved in more activities. Music and singing, however, were not included as Individual #488's	

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		preferences. The identification of preferences and potent reinforcers is an important component of functional assessments. If preferences are identified, they should be listed in the preference/reinforcers section. If staff surveys do not identify practical and potent reinforcers, a systematic preference assessment should be conducted. All of the functional assessments reviewed (except Individual #57) contained replacement behaviors. Replacement behaviors should be functional. That is, they should represent desired behaviors that serve the same function as the undesired behavior. Many functional assessments reviewed contained functional replacement behaviors (e.g., Individual #392, Individual #9, and Individual #333). For example Individual #392's targeted behaviors were hypothesized to be maintained by positive attention and to escape undesirable events. Her replacement behavior was appropriate communication of wants and needs. This was a good example of a functionally equivalent replacement behavior because it provided the same reinforcers (i.e., attention from staff, escape from undesired events) as hypothesized to be maintaining the target behavior. Many of the replacement behaviors reviewed, however, did not appear to be related to the function of the target behavior. For example: • Individual #93's replacement behaviors consisted of participation in programming. This may represent important skills and activities for Individual #93, however, it was not functionally equivalent to the purposed function of his target behaviors: escaping undesired situations. • The replacement behavior for Individual #60 was making choices. This alternative behavior, however did not appear to be functionally related to her target behaviors that were hypothesized to be maintained by automatic motivation (i.e., no identified social functions). None of the functional assessments or PBSPs reviewed included specific instructions for how to train replacement behaviors. Some of the replacement behaviors were not operationally defined and it likely would be difficult for DCPs to teach the behaviors without additional instruction. For example, Individual #345's replacement behavior was identified as "increased reality orientation and psychiatric stability." Examples were included, however, some examples would not likely be interpreted by all DCPs the same way, resulting in inconsistent implementation of the replacement behavior. It is recommended that all replacement behaviors include specific skill acquisition plans for training. Moreover, these plans should be integrated into the current methodology, data system, and schedule of implementation for other skill acquisition plans at the facility. These plans should be based upon a task analysis (when appropriate), have behavioral objectives, contain a detailed description of teaching conditions, and include specific instructions for how to conduct the training and collect data (see section S1 of this report).	

#	Provision	Assessment of Status	Compliance
		There was no evidence that functional assessments at LSSLC were reviewed and modified when an individual did not meet treatment expectations. It is recommended that when new information is learned concerning the variables affecting an individual's target behaviors, that it be included in a revision of the functional assessment. Additionally, functional assessments should be reviewed at least annually to ensure accuracy.	
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.	LSSLC's psychological assessments were not based on current, accurate, and complete clinical and behavioral data (see K7) and, therefore, this provision item was rated as being in noncompliance. Seventeen of the 29 standardized assessments of intellectual ability reviewed were at least 10 years old. Four were more than 20 years old, and one intellectual assessment (Individual #102) was 38 years old.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	As indicated in K5, psychological assessments were not completed for every individual at LSSLC and, therefore, this provision item was rated as being in noncompliance. The facility should conduct psychological assessments as needed, and at least every five years, for each individual residing at the facility. Additionally, the monitoring team recommends that each individual at the facility receive an annual psychological assessment update. The purpose of the annual update would be to note/screen for changes in psychopathology, behavior, and adaptive skill functioning. Thus, the annual psychological assessment update would comment on (a) reasons why a full assessment was not needed at this time, (b) changes in psychopathology or behavior, if any, (c) changes in adaptive functioning, if any, and (d) recommendations for an individual's personal support team for the upcoming year. A review of the spreadsheet of individuals and psychological evaluations indicated that the two most recent admissions, Individual #103 and Individual #256 did not have psychological assessments. Psychological assessments should be conducted with 30 days for newly admitted individuals.	Noncompliance
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be	Psychological services, other than PBSPs, were provided at LSSLC, however, more work is needed to be done before this provision item can be considered to be in substantial compliance. Psychological assessments reviewed did not document the need for psychological services other than PBSPs. It is recommended that needed services be documented in the psychological assessments.	Noncompliance

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	measured to determine the efficacy of treatment.	At the time of the onsite review, eight individuals participated in counseling/psychotherapy. As was the case during the baseline review, however, it was not apparent that these services were goal directed with measureable objectives and treatment expectations. Eight individuals were reported to receive counseling/psychotherapy. When the monitoring team requested copies of current treatment plans and objectives, the monitoring team was told by the facility that they did not exist. It is recommended that all psychological services other PBSPs contain the following: • A treatment plan that includes an initial analysis of problem or intervention target • Services that are goal directed with measurable objectives and treatment expectations • Services that reflect evidence-based practices • Services that include documentation and review of progress • A service plan that includes a "fail criteria"— that is, a criteria that will trigger review and revision of intervention • A service plan that includes procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on	This item was rated as being in noncompliance because the quality of the content of some of the PBSPs reviewed was insufficient, and because many of the interventions were not based on functional assessment results and ongoing individual behavior. The monitoring team noted, however, that overall the PBSPs were improved relative to the baseline review. All of the PBSPs reviewed had the necessary consents and approvals. There are several important components that should be included in every PBSP. Because the PBSPs and functional assessments were all presented together, the monitoring team looked at both of these documents to determine if the following components were present. All of PBSPs and/or functional assessments reviewed included: • Rationale for selection of the proposed intervention. • History of prior intervention strategies and outcomes. • Consideration of medical, psychiatric and healthcare issues. • Operational definitions of target behaviors. • Operational definitions of replacement behaviors. • Description of potential function(s) of behavior. • Use of positive reinforcement sufficient for strengthening desired behavior. • Strategies addressing setting event and motivating operation issues.	Noncompliance

#	Provision	Assessment of Status	Compliance
	extraordinary circumstances.	• Strategies addressing antecedent issues. • Strategies that include the teaching of desired replacement behaviors. • Strategies to weaken undesired behavior. • Description of data collection procedures. • Baseline or comparison data. • Signature of individual responsible for developing the PBSP. Although present in all PBSPs/functional assessments reviewed, the quality of some of the above components appeared insufficient for the plans to be as effective as they could be. Several PBSPs had insufficient operational definitions of target behaviors. For example: • Some operational definitions of target behaviors were not clear or operational. For example Individual #488's physical aggression was defined as "…hitting, grabbing, slapping, scratching, and property destruction." This definition was not complete. It left too much interpretation of what aggression was to the DCP recording the behavior. One DCP, for example might interpret grabbing as putting his hand on another individual, whereas another DCP might interpret grabbing as a more forceful pulling at another individual. Additionally, Individual #488's PBSP included property destruction as a separate target behavior. It was unclear if this property destruction was operationally different from the property destruction included in Individual #488's definition of physical aggression. Some operational definitions required the reader to determine the individual's intentions. For example, Individual #31's target behavior of physical aggression was defined as "Any behavior meant to cause harm to another…" This definition of aggression required the reader to infer the intent of the individual. Operational definitions should not require the reader to infer intent; they should consist of objective behaviors that are clear and complete. Although all PBSPs reviewed included strategies for weakening undesired behaviors, many appeared likely to have the opposite effect. For example: • Individual #112's PBSP indicated that her undesirable behavior was a function of her attempting to communicate discomfort or unhappiness. The intervention following undesired behavior, however, directed staff to attempt to discover what was bothering her, and attempt to resolve it. If the function of the behavior was in fact to communicate her discomfort, then this intervention would likely increase the target behavior because it encouraged Individual #112 to reduce her discomfort/unhappiness by engaging in an the undesired behavior. On the other hand, a potential intervention based on these functional assessment results might include teaching Individual #112 an appropriate way to	

#	Provision	Assessment of Status	Compliance
		communicate her needs, and ensuring that staff address her discomfort only when she appropriately communicates her discomfort. • Individual #507's PBSP indicated that aggression was maintained by gaining access to desirable items. The intervention included staff redirecting her attention to preferred items and activities following physical aggression. Again, if the functional assessment was accurate and her aggression was maintained by gaining access to desired items, then this procedure would serve to increase her disruptive behavior by providing potentially desirable items following the undesired behavior. • Individual #333's PBSP to decrease self-injurious behavior (SIB) included attempting to redirect her by offering her the use of her preferred items, or redirecting her to a different activity, following the targeted behavior. Individual #333's functional assessment, however, indicated that the function of her SIB was escape of undesired activities. Therefore, offering other activities following SIB (i.e., allowing her to escape the undesired activity) would likely result in an increase, rather than a decrease, in her SIB. An intervention more directly associated with her functional assessment results might include having her return to the previous activity (i.e., not allowing her to escape the undesired event) following SIB. Additionally, if practical, the PBSP could allow her to get breaks from, or avoid, selected undesirable activities by indicating (in a more socially acceptable manner than aggression) that she did not want to engage in the activity. It is recommended that the facility attempt to ensure that all strategies for weakening undesired behaviors are consistent with functional assessment results. Finally some PBSPs reviewed appeared very general and not related to functional assessment results. For example: • Individual #249's intervention for physical aggression (i.e., tell him to stop, block aggression, try problem solving strategies, intervene with the least amount of physical force) appeared very general and not related to functional assessment results. • Individual #93's intervention for disruptive behavior consisted of ignore, verbally prompt, redirect, and problem solve. None of these interventions were clearly related to the hypnotized function of the behavior: escape from undesirable activities. • Individual #170's intervention for physical aggression consisted of, tell him to stop, separate him from the person is aggressing, use the least amount of physical intervention necessary.	

#	Provision	Assessment of Status	Compliance
		As discussed in K4, although some PBSPs reviewed showed evidence of data-based modifications, many PBSPs were not modified based on ongoing individual behavior (see K4). It should be noted that approximately 20% of the PBSPs reviewed were very good (e.g., Individual #221, Individual #36, and Individual #297). The monitoring team was encouraged by the generally improved quality of the PBSPs, and the efforts of the facility to continue to improve the PBSPs. The monitoring team observed several meetings specifically designed to improve the quality of PBSPs (e.g., peer review meeting, and the psychology director's meeting with the supervising psychologists). Additionally, the facility's BCBA consultant has developed a tool, consistent with the components discussed above, to objectively assess and provide feedback on each psychologist's PBSP.	
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.	Interobserver agreement measures were not collected for target and replacement behaviors at the time of the onsite review (see K4). A system to regularly assess the accuracy of PBSP data is a necessary requirement for determining the efficacy of treatment and for meeting the requirement of this provision item. PBSP data were not consistently graphed at LSSLC (e.g., Individual #468, Individual #426, and Individual #440). All PBSP data should be graphed. As discussed in K4, these data should be graphed and presented in increments that would be sensitive to individual needs and situations (e.g., daily or weekly graphed data to assess the changes associated with a change in medication or target behaviors). The graphs reviewed contained horizontal and vertical axes and labels, condition change lines and label, data points, and a data path. They did not contain clear demarcation of changes in medication, health status, or other relevant events.	Noncompliance
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.	This provision item was rated as being in noncompliance because the facility, at the time of the onsite review, did not track treatment integrity data. All staff interviewed indicated that they understood each individual's PBSP. Additionally, observations of DCPs implementing PBSPs also appeared to be consistent with written plans. For example, Individual #519's PBSP specified that following SIB, staff should block the behavior, talk to him about the SIB, and if the SIB continued, take him to his room to lie down on his bed. The monitoring team observed Individual #519 engaging in SIB, and the staff followed all the steps of the PBSP as written. The DCP working with Individual #519, however, indicated that going to his room was a preferred activity and he generally calmed after being brought to his room. If in fact laying down on his bed was a desirable activity for Individual #519, then this plan, although implemented with integrity by the DCP, was likely to increase his SIB rather than decrease it (see K9 for	Noncompliance

#	Provision	Assessment of Status	Compliance
		additional examples of PBSPs that were designed to weaken target behaviors but likely would have the opposite effect). Nevertheless, the only way to ensure that PBSPs are implemented as written is to implement a system to systematically monitor treatment integrity. It is recommended that a treatment integrity system be developed, data regularly tracked, and minimal acceptable integrity measures be established. Since the baseline review, LSSLC has begun a process of reviewing each PBSP (see K9), attempting to eliminate unnecessary target behaviors, and simplifying the interventions. It appeared to the monitoring team that this process had resulted in more practical and useful PBSPs that were more likely to be implemented with integrity by DCPs.	
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.	Each psychologist maintained logs documenting DCP training on each individual's PBSP. The trainings were conducted by psychologists and psychology assistants prior to PBSP implementation and whenever plans changed. The trainings, however, were not standardized and did not include a competency-based component. Additionally, there was no system in place to ensure that all staff (including relief staff) had been trained. Finally, there was no systematic way to identify all of the staff who required remedial training. Therefore, this item is rated as being in noncompliance. In order to meet the requirements of this provision item, it is recommended that the staff training procedures include a competency-based component, and the development of a centralized system to ensure that all staff are trained in the implementation of each individual's PBSP.	Noncompliance
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.	This provision item specifies that the facility must maintain an average of one BCBA to every 30 individuals, and one psychology assistant for every two BCBAs. At the time of the onsite review, LSSLC had a census of 400 individuals and employed 13 psychologists and seven psychology assistants. None of the psychologists, however, had obtained BCBA certification (see K1). In order to achieve compliance with this provision item, the facility must have 10 psychologists with BCBAs.	Noncompliance

Recommendations:

1. Continue with training and supervision of psychology staff towards obtaining the BCBA certification.

2. The facility should develop a plan to ensure that the remaining psychologists attain BCBA certification.

3. It is recommended that internal peer review meetings be more directly focused and managed so that several individuals can be presented at each meeting.

4. The facility should provide monthly external peer review meetings.

5. Operating procedures for both internal and external peer review committees will need to be established.

6. The data books should be readily available to DCPs, and data should be recorded as soon after it occurs as is possible.

7. The facility should continue to investigate the use of data systems that are flexible enough to be sensitive to individual needs.

8. It is recommended that the facility ensure that IOA for all target behaviors (including replacement behaviors) is consistently collected in each home and day/vocational site. Additionally, specific IOA goals should be established, and staff retrained or data systems modified, if scores fall below those goals.

9. DCP input in data system development should be solicited and documented.

10. Replacement behaviors should be added to each individual's data sheet.

11. All target and replacement behaviors should be graphed.

12. It is recommended that target and replacement behaviors be graphed at increments sufficient to make data-based treatment decisions.

13. When individuals' data trends in an undesirable direction (or continues with no improvement), hypotheses should be developed, and changes should made to the PBSP.

14. A specific and individualized criterion for review of each PBSP should be established, and the decision to revise should be based upon the data.

15. Each individual at LSSLC should have a psychological evaluation.

16. All individuals whose records indicate a behavioral disturbance should have a functional assessment of the variable or variables affecting the individual's target behaviors.

17. All functional assessments should include a direct assessment that includes direct observations of target behaviors and relevant environmental variables.

18. All hypothesized functions of the target behavior identified in a functional assessment should be operationally defined.

19. Functional assessments should include a summary statement (e.g., in the treatment hypothesis and rationale section of the functional

assessment) that integrates the results of the various assessments into a comprehensive statement of the variable or variables affecting the target behaviors.

20. If preferences are identified, they should be listed in the reinforcers section. If staff surveys do not identify practical and potent reinforcers, a systematic preference assessment should be conducted.

21. All replacement behaviors should be functional.

22. All replacement behaviors should include specific skill acquisition plans for training. Moreover, these plans should be integrated into the current methodology, data system, and schedule of implementation for other skill acquisition plans at the facility.

23. It is recommended that when new information is learned concerning the variables affecting an individual's target behaviors, that it be included in a revision of the functional assessment. Additionally, functional assessments should be reviewed at least annually to ensure accuracy.

24. The facility should conduct psychological assessments as needed, and at least every five years, for each individual residing at the facility.

25. Psychological assessments should be conducted with 30 days for newly admitted individuals.

26. It is recommended that needed services be documented in the psychological assessments.

27. It is recommended that all psychological services other PBSPs contain the following:
    - A treatment plan that includes an initial analysis of problem or intervention target
    - Services that are goal directed with measurable objectives and treatment expectations
    - Services that reflect evidence-based practices
    - Services that include documentation and review of progress
    - A service plan that includes a "fail criteria"— that is, a criteria that will trigger review and revision of intervention
    - A service plan that includes procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings

28. All PBSPs should contain operational definitions of target behaviors, replacement behaviors and potential functions.

29. It is recommended that the facility attempt to ensure that all strategies for weakening undesired behaviors are consistent with functional assessment results.

30. All PBSP data should be graphed.

31. It is recommended that a treatment integrity system be developed, data regularly tracked, and minimal acceptable integrity measures be established.

32. Staff training procedures should include a competency-based component. Additionally a centralized system to ensure that all staff are trained in the implementation of each individual's PBSP should be developed.

The following are offered as additional suggestions to the facility:

33. In addition to the long-term POI goals, it may be useful for the psychology department to establish short-term goals (e.g., for the next six months) so that the psychology staff can better mark their progress toward substantial compliance.

34. It is suggested that the facility consider a simpler alternative to the ABC system for routine frequency recording.

35. It is suggested that all graphs contain clear demarcation of changes in medication, health status, or other relevant events.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #009: Medical Care, dated 7/20/10 o DADS Policy#006: At Risk Individuals, dated 10/5/09 o DADS Policy#09-001: Clinical Death Review, dated 3/09 o DADS Policy #09-002: Administrative Death Review, dated 3/09 o DADS Policy #044: Medical Emergency Response, dated 7/21/10 o Safety and Health Council Meeting minutes, 3/17/19 and 7/21/10 o LSSLC Trend Analysis for Emergency Response Drills, 3/10 – 8/10 o Emergency Response Training Curriculum, Response to Hazards and Emergencies o Mortality Reviews provided onsite for individuals who died between 2/10 and 6/10 o Listing, Individuals with seizure disorder o Listing, Individuals diagnosed with pneumonia o Listing, Individuals with diabetes mellitus o Listing, Individuals hospitalized and sent to emergency department in 2010 o Records of the following individuals: • Individual #454, Individual #147 Individual #431, Individual #321, Individual #492, Individual #485, Individual #352, Individual #135, Individual #468, Individual #551, Individual #172, Individual #,507 Individual #283, Individual #288, Individual #361, Individual #173, Individual #472, Individual #165, Individual #56, Individual #517, Individual #306, Individual #538, Individual #469, Individual #423 o Physician caseloads Interviews and Meetings Held: o Brian Carlin, M.D., Medical Director o Ronald Corley, M.D., Primary Care Physician o Nai Kwei Chang, MD, Primary Care Physician o Dickson Odero, M.D., Primary Care Physician o Nelda Johnson, R.N., C.F.N.P., Nurse Practitioner o Mary Bowers, R.N., Chief Nursing Executive Observations Conducted: o Daily medical staff meetings o Infirmary rounds o Health Risk Screening Meeting o Cottages and dorms o Day services areas o Infirmary rounds

	Facility Self-Assessment: Observations, interviews, attendance at facility meetings, review of policies, procedures, and multiple documents, including the active records of individuals have resulted in the monitoring team's finding being congruent with the facility's self-assessment ratings of noncompliance with all provisions items.
	Summary of Monitor's Assessment: The medical department had made little progress in addressing the provisions of the Settlement Agreement. The medical director reported that the facility had been waiting on guidance from state office. Since the DADS policy on medical was released in July 2010, the facility had greater clarity on how to proceed. The medical department was in the process of implementing the Health Care Guidelines. The most notable need for improvement was seen in physician assessments, follow-up of acute and chronic medical problems, and post-hospital evaluations. No external review of medical services had been completed and there was no formal medical quality program in place. The medical director had developed some audit tools to assess compliance with standards of care. He provided a copy of the diabetes audit tool that assessed compliance with the American Diabetes Associations guidelines for care. No aggregate data resulting from these audits were available. Policies and procedures based on state issued medical policy and the Health Care Guidelines had not been developed. The medical director reported that the medical manual was outdated. The medical director was confident that, with a recent reduction in his caseload, he would have time to devote to addressing the provisions of the Settlement Agreement.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance	The medical staff was comprised of three primary care physicians, a medical director, and one family nurse practitioner. The medical director had been employed at the facility for 20 years, serving in the capacity of medical director for the last five years. All of the primary care practitioners were employees of the facility. The facility also had psychiatric services provided by two full-time psychiatrist and two part-time psychiatrists. The daily routine of the medical staff began each day around 8:00 with the daily staff meeting. Attendees included the medical director, all primary care physicians, psychiatry staff, chief nurse executive, the infection control nurse, and the hospital coordinator. This meeting included discussions related to events occurring since the previous day's close of business and lasted approximately 30 minutes. It was immediately followed by rounds in the infirmary.	Noncompliance

#	Provision	Assessment of Status	Compliance
	with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Individuals requiring acute care were transferred to local hospitals in Lufkin for evaluation and/or admission. The facility maintained informal agreements with local practitioners who agreed to admit individuals from the facility. Neurology clinic was conducted for approximately two hours each month. The clinic was held onsite which allowed for participation by the psychiatrists. An onsite ENT clinic was also conducted monthly. The facility maintained a hospital liaison program through nursing services. The nurse liaison visited the hospitals on a daily basis and provided status updates to the PST members via email. Labs were drawn at the facility and sent to Austin Sate Hospital. Labs were sent to local hospitals when stat results were needed. X-rays were done onsite and sent to Memorial Hospital for radiology interpretation. X-rays of extremities were read onsite by a primary care physician whose specialty was orthopedics. **General Medical Care and Documentation** A sample of records, listed above in the Steps Taken section of this report was reviewed. <u>Annual Assessments</u> Annual assessments (medical evaluations) were completed based on a standardized format. This format did not align with the requirements of the Health Care Guidelines and did not provide an accurate or comprehensive description of the medical events for individuals. All of the medical evaluations included a listing of the active diagnoses, but the majority of the records reviewed had an active diagnosis list that was incomplete and in many cases lacked important diagnoses. There was no plan of care to correspond with the active diagnoses as required in the Health Care Guidelines. <u>Active Problem List</u> The records reviewed contained a formal Active Problem List. The lists were generally not accurate and, in most cases, were not updated. <u>Integrated Progress Notes</u> Physician entries were noted in the integrated progress notes. With the exception of one primary care physician, most physicians had very limited documentation in the progress notes. The notes were written in SOAP format, but the documentation did not meet requirements of the Health Care Guidelines. Very often, each component of the SOAP note contained only one to two words. In addition, abnormal labs and diagnostics were rarely documented in the progress notes, resulting in difficulty in determining if the	

#	Provision	Assessment of Status	Compliance
		abnormalities were being appropriately addressed. Notes frequently lacked times. Primary care physicians did not complete quarterly summaries. Physician Orders Physician orders included the appropriate information and were dated, timed, and signed. **Routine and Preventive Care** In the sample of records reviewed, there was evidence that some elements of preventive care were consistently being provided. Preventive Care Flow Sheets were included in the records reviewed, but the guidelines, such as those for mammography, were dated and were not consistent with the Health Care Guidelines. Screenings • Audiology evaluations and vision assessments were consistently documented in the records reviewed. • Cervical and ovarian cancer screenings were completed for two of eight of the women whose records were reviewed. Only one record included a rationale for deferring the pelvic exam. • Mammography was completed for four of six women who met criteria for testing. • Screening for colorectal cancer was being completed and colonoscopies were being requested for individuals over the age of 50. • PSAs were consistently documented for men who met criteria for screening. Immunizations • Influenza, H1N1, and pneumococcal vaccinations were administered to all of the individuals in the sample reviewed. • There was evidence of vaccination and/or immunity to Hepatitis B for all of the individuals in the sample reviewed. Risk Identification • The Preventive Care Flow Sheet contained a risk assessment for osteoporosis. The risk assessment was not comprehensive and excluded many well known risk factors for osteoporosis. There was no other comprehensive assessment of risk by physicians documented in the records. Bowel Management • The facility did not have a bowel management program or provide any specific	

#	Provision	Assessment of Status	Compliance
		clinical guidelines to physicians on management of chronic constipation. None of the records reviewed for individuals with chronic constipation documented any diagnostic work-ups for constipation. Examples of problems with bowel management are provided in the discussion on medical management below. **Medical Management** While the primary care providers appeared to adequately address some elements of preventive care, such as immunizations, lipid, and vision and hearing screenings, there were significant issues related to acute and routine care. Examples of delays in diagnosis, lack of follow-up, lack of appropriate response to a change in clinical status, and failure to address abnormal lab values were noted in the records reviewed. It was obvious, however, that the primary care providers were attempting to address many issues. Documentation to substantiate actions taken by the providers was frequently absent in the records. The documentation that was present, at many times, did not provide adequate information for the interdisciplinary team. Notes such as "New onset seizure – start work-up" provided no information to the team related to possible etiologies for the new onset of seizures and gave no indication of the next steps required to provide adequate care. Per the Health Care Guidelines, "All entries will be legible, accurate and clearly written to facilitate effective interdisciplinary communication and as a means of assessing and evaluating individual care." Integration of medical services into the team process requires that the primary provider have the responsibility to present to the team information regarding medical issues (including treatment and medication plans) in a manner relevant to health and well-being, goal setting, opportunities, barriers, and the case formulation for the individual. <u>Management of acute and chronic problems</u> The following are examples that demonstrated issues related to a lack of clinical follow-up, delays in treatment and/or diagnosis, and absence of clinical interventions. Individual #507 • The individual had a screening mammogram performed on 8/17/09 that showed microcalcifications deep in the left breast that warranted further evaluation. On 9/10/09, the consulting oncologist indicated that the guardians at the SSLC were notified of the need for a biopsy. The lumpectomy was completed on 3/24/10 and was positive for ductal carcinoma in situ. The individual subsequently underwent a mastectomy. There was a six month delay from the time there was recognition of the need for a biopsy to the actual	

#	Provision	Assessment of Status	Compliance
		procedure being completed. • The individual had a true choking episode on 10/14/09 and was admitted to the infirmary. The physician orders indicated that the same medical orders were to be continued. The first medical documentation in the progress notes was dated 10/18/09 and did not include any discussion of interventions or a plan of care to prevent further episodes of choking. • A modified barium swallow study was completed on 11/23/09 and indicated no change in diet texture was needed. • The individual experienced another true choking episode on 6/17/10 that required the Heimlich maneuver. Physician orders dated 6/18/10 indicated that previous orders were to be continued. The physician progress note dated 6/18/10 did not include any documentation of a plan of care for this individual who had two choking episodes within eight months. • The annual medical evaluation completed in 7/10 did not list breast cancer as an active diagnosis. The evaluation did not address the choking episodes and what measures were being taken to mitigate risks and minimize the probability of future occurrences. Individual #551 • The requested progress notes were not included in the documents received. Observation notes were provided in lieu of integrated progress notes. • The individual had multiple medical problems, including seizure disorder, hypothyroidism, and chronic constipation. • The annual medical evaluation and problem list did not include the diagnoses of hypertension, anemia, constipation, and anorexia. The individual received multiple medications associated with these conditions. • The individual received daily polyethylene glycol and bisacodyl for treatment of constipation. The records documented abdominal films on 10/6/10, 8/25/10, and 1/10/10. The indications were abdominal distention and constipation. The reports of each of these studies documented large amounts of stool in the colon without evidence of obstruction. The annual medical evaluation included no discussion of this significant chronic medical problem, why the individual was at risk for bowel obstruction, how the risk would be mitigated, or what plan of care was implemented to manage the risk. • The individual was treated with ferrous sulfate for anemia, yet anemia was listed as an inactive problem and there was no documentation of the etiology of the iron deficiency anemia. • The individual was reported to have irregular menses, but there was no evidence that a recent pelvic exam was completed or if this contributed to anemia. There was no documentation in the annual evaluation or progress notes of iron	

#	Provision	Assessment of Status	Compliance
		deficiency that would warrant use of this constipating medication. • The individual was also treated for hypertension. The regimen consisted of a clonidine patch and prn metoprolol XL. This was documented to be effective but there was no explanation for why a long acting medication would be given prn to control hypertension. • The individual had multiple hospital admissions for uncontrolled seizures with sub-therapeutic drug levels, pancreatitis, and cholecystitis. The individual was also admitted to the hospital in 12/09 with mental status changes and sodium of 157. o Progress notes were not available to determine physician response to these issues. • Although the seizure disorder was documented as difficult to control, neurology evaluations were completed on an annual basis. The neurology records did not indicate the level of seizure control in the past or consideration of more aggressive interventions, such as VNS placement. The individual had a dilantin level of 7.5 in 3/10, but there were no changes made in the medication regimen. The neurologist noted the sub-therapeutic dilantin level in 6/10 (three months later), and recommended that the dose be increased and that the individual return to clinic in one year. Individual #454 • The individual had a microcytic anemia documented for several months. An endocrine consult in 2/10 noted that there was a microcytic anemia and that no work-up was completed. The consultant recommended that iron studies be completed. The studies were not obtained until July 2010 at which time true iron deficiency anemia was documented: o A 51-year-old non-menstruating female must have the etiology of iron deficiency anemia determined. Potential etiologies include GI blood loss. o This individual also had a diagnosis of hypertension and valvular heart disease. The problem list did not include these diagnoses, although both were significant and required a plan of care. Individual #431 • The individual was reported to have two seizures while at the workshop. This individual had no history of seizures. There was no documentation in the nursing assessments of physician notification. The individual was placed on sick call the next day. • The MD assessment on 3/5/10 (not timed) consisted of a four line note: o S – 2 seizures	

#	Provision	Assessment of Status	Compliance
		o O- No hx seizures o A – start w/u o Plan – Keppra • This note did not provide documentation of an appropriate assessment of the individual, did not provide any information to the PST on possible etiologies of the seizures, or include or refer to the actual plan of care. The individual was eventually diagnosed with a brain cyst. • Progress notes dated 10/23/09 – 10/ 21/10 were reviewed. There was only one other physician note present in the chart. It was dated 6/10/10 and documented, " Annual PE done." Individual #492 • This was a chronically ill individual requiring renal replacement therapy. Physician documentation was infrequent and, when present, usually consisted of four-line SOAP notes. • On 10/22/09, the individual reported that a filling fell out of a tooth. The LVN documented that the RN was notified and there would be an attempt to get a dental appointment the next day. There was no actual nursing assessment documented in the progress notes and no documentation of physician notification of the event. The individual was seen in dental clinic on 10/28/09 and treatment provided. • Labs in 9/10 indicated positive Hepatitis C antibody. This finding was not documented in the progress notes or any other documents reviewed. There was no plan of care associated with this finding. Individual #321 • The individual had x-rays done multiple times that showed an ileus: o 2/09 – impaction o 4/09 – ileus o 11/09 – ileus o 1/10 – high grade ileus without obstruction • The annual medical evaluation did not list constipation as a problem and, therefore, did not address the issue of bowel management. The individual received docusate sodium, senna, polyethylene glycol, and bisacodyl for management of constipation. There was no documentation of any work-up related to chronic constipation. The individual had a screening colonoscopy completed in 2008. • The individual had a Nissen fundoplication in March 2010, but GERD was not listed as an active diagnosis.	

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		Individual #288 • The individual had a diagnosis of COPD, bronchiectasis, and chronic constipation. The following are examples of medical problems and evaluations completed related to those problems: o MD assessment on 3/3/10: S – cough O- no rales A – chronic bronchitis P – Levaquin o Evaluated again on 3/10/10 for complaints of lower abdominal pain. o MD assessment on 3/23: S – fever at home (during home visit) O - no sx A - exam neg P - Rocephin, chest x-ray • Nursing documentation on 3/24/10 documented that the direct care professionals reported a temperature of 101. Tylenol was given, but MD was not notified. • Nursing documentation on 3/30/10 indicated that the individual's mother was concerned about antibiotics being discontinued. • MD assessment on 3/30/10 indicated that antibiotics were completed. • Individual complained of abdominal pain on 4/8/10 and was put on sick call to be checked prior to going for a home visit. The individual was cleared for the visit. • Individual complained of abdominal pain on 4/15 /10 and was sent to the emergency department for evaluation. She was admitted with a diagnosis of abdominal pain and ileus and was discharged on 4/20/10. The records did not document MD follow-up until 5/8/10. • The individual was seen by the MD on 5/11/10 and 5/17/10. Notes were difficult to read. • On 5/18/10, the individual was sent to the emergency department for evaluation of a temperature of 102. A CT of the abdomen showed fecal impaction with distention of the proximal bowel. Enemas were administered in the emergency department. • On 6/19/10, the individual was admitted to the hospital with a diagnosis of left lower lobe pneumonia. • In spite of serious medical issues, multiple emergency department visits and hospitalizations during a three month period, there was no evidence that the medical staff conducted a comprehensive assessment of this individual, including assessment of continued risk for recurrent events and mitigation of risks. There	

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		were no appreciable changes in the plan of care in response to these events, nor was there any evidence that consideration was given to the how issues of fecal impaction, nausea, and vomiting impacted this individual's respiratory status. The limited documentation in the chart contained in the four-line SOAP format could not provide adequate information to the PST. <u>Management of Emergent Problems</u> The chief nurse executive reported that the state issued a new policy on medical emergency response in July 2010. In September 2010, the facility increased the number of drills to one per home per shift each month. All drill instructors recently received competency-based training by the nurse educator. Drill checklists were forwarded to the safety director for inclusion in the agency safety meetings. Records of drills from 3/10 – 8/10 were reviewed. Of the drills conducted, one was rated as a fail. Appropriate corrective action was taken. The facility maintained six AEDS on campus. It was reported by the CNE that an AED could be in any area on campus within three minutes. When a code blue occurred, the CNE reported that a critical incident team meeting did not always occur. She reported that no issues had been identified with actual code blues. The Health and Safety Council Committee meeting minutes reviewed did not contain any discussion related to the medical emergency response system. In the records reviewed, individuals who were noted to be in extremis received prompt care with rapid transfer to acute care facilities. **Seizure Management** The facility did not have a comprehensive seizure management program, nor did it have adequate mechanisms to track the overall quality of care provided to individuals with seizure disorder. A spreadsheet was provided to the monitoring team that contained all individuals with a diagnosis of seizure disorder and their drug regimens. Individual records contained seizure reports. There was no active tracking of the number of individuals on two, three, four, or five drugs. There was also no tracking of the number of individuals with intractable seizure disorder and how many of those individuals had been referred for evaluation for VNS implantation. Approximately 199 individual were diagnosed with seizure disorder. Thirty eight percent of the individuals with seizure disorder were receiving the "older" and more toxic drugs, such as dilantin and phenobarbital. The facility conducted onsite neurology	

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		clinics. Individuals with seizure disorder and a psychiatric diagnosis were seen simultaneously by the neurologist and psychiatrist. The records of nine individuals with a diagnosis of seizure disorder were reviewed. There was documentation of evaluation by neurology in all nine records. The notes did not follow a standardized format and the content varied. Issues related to quality of life, such as an individual's cognitive ability, ability for self care, communication use, social skills, and motor skills were seldom documented in the records reviewed. The notes often lacked a rationale for maintaining an individual on multiple drugs in the absence of seizures for many years and for maintaining an individual on the older more toxic drugs. Individual #485 • The individual had a history of seizure disorder treated with valproic acid. On 9/25/09, the individual experienced 14 seizures over a period of 45 minutes requiring the use of diastat. The individual was admitted to the infirmary for observation. • By definition, this individual experienced status epilepticus if there was a failure to return to full consciousness between the seizures or if there was continuous seizure activity for 30 minutes. This is a medical emergency and preparation for transfer to an acute care facility should have begun around five minutes into the event. • There was documentation by the physician on 9/28/10, but not again until 10/14/10. • On 9/8/10, the individual was seen in neurology clinic. The neurologist noted seizures were well controlled with a very low valproic acid level. The recommendation was to d/c valproic acid and return to clinic in one year. The events of 9/25/09 did not appear in the consult and it was not clear if that information was made available. That information could have potentially impacted the decision to d/c the valproic acid. Individual #321 • The individual had been seizure free since 2005 and maintained on valproic acid. The individual was seen in neurology clinic on 9/10/09 and 10/6/10. It was documented that the individual was on Depakote and had been seizure free since 2005. The neurology clinic notes did not contain any discussion related to consideration of tapering the drugs to extinction. Individual #283	

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		• The individual was seen in neurology clinic on 8/25/10 primarily for evaluation of a essential benign tremor. Carbamazepine was prescribed for a diagnosis of seizure disorder. It was documented that the last seizure was in 2003. The clinic note did not contain any discussion of tapering the drug to extinction given that the individual had been seizure free for seven yeas. Individual #551 • Individual was treated with dilantin for seizure disorder. The clinic note dated 6/10 noted that the dilantin level was low and that the dose should be increased to 100 mg tid or perhaps 350 mg. The individual was to return to clinic in one year. Seizure disorder had been fairly controlled. Individual #172 • Individual was seen in clinic in 3/08 and scheduled to return in one year. The individual was seen on 10/09 and was noted to being doing well. Recommendation was to check dilantin level, since none was done recently.	
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 facility had not established a general medical review system. One type of medical review in place was the mortality review and these reviews were completed for all deaths in the year 2010. The system involved three action steps per policy: 1. Within five working days of notification of death, the physician completes a death summary for the record. 2. Within 14 working days of notification of death (45 with autopsy) the clinical death review committee meets. 3. Within 21 calendar days of completion of review by the clinical death committee (52 with autopsy) the clinical death review committee will forward a report to the administrative death review committee. The goal of the mortality review, as stated in DADS policy, was to provide a comprehensive review of clinical care and operational procedures that may have affected the overall care of the individual. Recommendations for correction actions were to be made when appropriate. Each review committee required the participation of an external representative. A physician formerly employed by LSSLC participated in the mortality reviews. Eleven deaths occurred from September 2009 – September 2010, representing a mortality rate of approximately 3%. The causes of death were documented as: • Aspiration pneumonia (3)	Noncompliance

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		• Metastatic ovarian cancer (1) • Respiratory failure (2) • Renal failure (1) • CVA (1) • Alzheimer's (1) • Ventricular fibrillation (1) • Myocardial infarction (1) The autopsy report for the death attributed to ventricular fibrillation showed evidence of heart failure and dilated cardiomyopathy, but also showed an acute right lower lobe bronchopneumonia. Six deaths have occurred in 2010. The average age of death was 61.5 years. The mortality reviews for the first four deaths were made available for review during the onsite visit. The causes of death were documented as: • Aspiration pneumonia • Respiratory failure • Metastatic ovarian cancer • Ventricular fibrillation (acute bronchopneumonia) The clinical and administrative death reviews completed by the facility resulted in no recommendations related to the four deaths. One autopsy was completed among the four deaths reviewed. Three of the 11 deaths in 2010 were attributed to pneumonia. A fourth individual had an acute bronchopneumonia at autopsy, although the cause of death was listed as ventricular fibrillation. Pneumonia was involved in 36% of the 2010 deaths to date. The facility must ensure that appropriate processes are in place to identify persons at risk for pneumonia, so that effective interventions can be implemented.	
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	The facility did not have a formal medical quality improvement process in place at the time of the review. The medical director indicated that the facility was awaiting guidance from state office. He provided a template used to monitor the provision of diabetes care to individuals living at the facility. This information was used for individual corrective action.	Noncompliance

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	action; and monitors to ensure that remedies are achieved.		
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.	This provision item referred to the Health Care Guidelines that provided the framework for the standards of medical care to be provided by the facility. DADS Policy #009: Medical Care was issued in July 2010. While the medical department was in receipt of this policy, there had not been any development of facility policy and procedure based on these guidelines. The medical director reported that the Health Care Guidelines were in the process of being implemented and that all primary care providers had been advised of the guidelines. There was no system in place to monitor compliance with the guidelines (also see section E above).	Noncompliance

Recommendations:

1. Facility-specific policies and procedures must be developed to guide the provision of medical care. Clinical guidelines and protocols are needed to ensure adequate provision of care. The most immediate need appears to be protocols related to management of persons with pneumonia and chronic constipation.

2. The annual assessments should be revised to align with the requirements of the annual plan of care specified in the Health Care Guidelines. Problem lists should be updated with changes as specified in the Health Care Guidelines.

3. Quarterly summaries of each individual's status should be done. These summaries should be standardized and provide a concise summary of the events.

4. Primary providers must provide adequate documentation in interval progress notes, quarterly notes, and annual summaries. The primary providers must be cognizant of the fact that the role of the PCP in the interdisciplinary process extends beyond that of direct care. Integration into the team process requires the PCP to present to the team information regarding medical issues (including treatment and medication plans) in a manner relevant to health and wellbeing, goal setting, opportunities, barriers, and the case formulation for that individual.

5. Preventive care flow sheets should be revised to be consistent with the Health Care Guidelines. It would be helpful if the preventive care flow sheets had the criteria for testing, such as the age a particular screening should start.

6. Disease management flow sheets should be implemented and available in the records. The focus should be on common conditions as well as conditions commonly seen in persons with developmental disabilities.

7. The medical director should consider tracking key elements of the preventive flow sheet, such as mammograms, pap smears, dexa scans, and PSAs. Primary care providers can be advised of deficiencies so that corrective action can be taken. The assessments and recommendations should be individualized. For example, not every woman in the sample was considered to need breast and cervical cancer screening. For example, a 75-year-old woman who did not have a cervical cancer screening would not be considered out of compliance with the guidelines. There should be a documented rationale for the decision not to perform screening exams that may include age or risk status. The rationale and/or risk/benefit assessment was not evident in the records.

8. Guidelines need to be implemented and enforced on the follow-up of individuals with acute medical problems and those returning from the hospital. Individuals with acute medical problems, or those returning from the hospital, should receive daily medical evaluation until stable or until the problem is resolved.

9. A qualified radiologist should interpret all radiographs completed at the facility.

10. A comprehensive seizure management policy should be developed. This policy should include the requirements for medical management, documentation in the clinic notes, training, and response to seizures and status epilepticus.
    a. Consideration should be given to the development of drug protocols that specify the labs and other diagnostics that must be monitored as well as the frequency of the monitoring.
    b. The facility should track essential data related to seizure management, such as polypharmacy and individuals with intractable seizures.
    c. These data should be included as part of the medical quality review system, as well as the facility's quality program.

11. A medical quality improvement program is needed. Measures of medical quality must be determined and should include process and outcome measures that are appropriate for the individuals being supported. Once determined, data should be collected and analyzed, and corrective actions taken when necessary. This process should integrate into the facility's quality improvement program.

12. The facility should ensure that an external physician with no current or previous ties to the facility participate in the mortality reviews. This is needed in order to benefit from an objective opinion.

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o LSSLC Organizational Chart o Map of LSSLC o DADS State Supported Living Center Policy: Nursing Services (1/31/10) o DADS State Supported Living Center Policy: Guidelines for Comprehensive Nursing Assessment (July 2010) and Comprehensive Nursing Assessment form (June 2010) o DADS State Supported Living Center Policy: At Risk Individuals including exhibits A through H o DADS State Supported Living Center Policy: Use of Restraint, Restraint Checklist, and Restraint Documentation Guidelines o DADS State Supported Living Center Nursing protocol: Post Anesthesia Care, 6/10 o LSSLC Facility Operational Procedures Manual, Medical 14, Dental/Medical Sedation and Restraint dated 07/16/10 o LSSLC Nursing Policy and Procedure Manual, Medication Administration procedure .0310, revised 3/10 o LSSLC Nursing Policy and Procedure Manual, Seizure Management procedure .0810, revised 7/10 o LSSLC Nursing Policy and Procedure Manual, Documentation procedure .0910, revised 9/10 o LSSLC Operational Procedures Manual, Injury to Individuals procedure 02, revised 8/18//10 o LSSLC Nursing Policy and Procedure Manual, Gastrostomy or Jejunostomy Tube-Nutrition/Hydration/Medication .0709, rev. 7/09 o LSSLC Nursing Policy and Procedure Manual, Nursing Assessment Guidelines procedure .0710, revised 7/10 o LSSLC Facility Operational Procedures Manual, Medical 103 Medical Emergency Response and Drills, rev. 7/21/10 o Seizure Management form, new 6/1/10 o Alphabetical list of individuals with current PSP, annual nursing assessment, and quarterly nursing assessment (due) dates o Alphabetical list of individuals by residence with health risk assessment ratings by rating area, 9/10 o List of admissions since 4/1/10 o List of Infirmary admissions 4/1/10 – 10/15/10 o List of Emergency Room Visits 4/1/10 – 10/15/10 o List of Incidents and Injuries since 1/1/10 o List of Hospitalizations 4/1/10 – 10/15/10 o List of expired individuals since 4/1/10 o List of Pneumonia Diagnoses since 1/1/10 o List of individuals and weights with BMI > 30 o List of individuals with weights with BMI < 20 o List of individuals with unplanned weight loss at six months of <u>≥</u> 10%

	o List of individuals with pica as of 9/8/10 o List of individuals who received nutrition enterally o List of individuals' oral hygiene assessment ratings by dental staff o List of choking incidents since 1/1/10 including a summary of interventions for each episode o The last six months, minutes from Weekly Nursing Management Meetings o The last six months Nursing Quality Enhancement reports o Licensed Nurse Competency/Skill Assessment, LSSLC o Licensed Nurse Competency Exam, LSSLC o Medication Station Orientation List o Infection control monitoring tools o Infection Control Committee Meeting minutes 4/8/10 through 9/9/10 o Infection incidence list o Medication Administration Observation checklist form and completed checklists from 4/6/10 to 8/2/10 by the nursing department and 4/27/10 through 9/7/10 by the QA Nurse o Texas Health Monitoring Instrument, Medication Administration Observation section, completed July 2010 by the nursing department and by the QA Nurse o LSSLC Bi-weekly Medication Errors Meeting minutes 3/10/10 through 6/16/10 o Nursing Department Medication Error graphs and charts 4/21/10 through 9/2/10 o Medication Errors FY 2010 and the Medication Error Synopses through September 2010 o Emergency competency checklist o Nutritional Management Team Reports for last six months, 3/10-8/10 o Unusual Incident Reports for the last six months, 3/10-8/10 o Mortality and death reviews since 4/10 o Current Medication Administration and Treatment Records for 18 individuals residing on homes 559A and 559B o Occupational and Physical Therapy Evaluation Staffing notes since 6/1/10 o LSSLC Self-Assessment: POIs 5/17/10 and Supplemental POI September 2010 o LSSLC Meeting Schedule for 10/18/10, updated o Records including at least physician's orders, IPNs, nursing assessments and health data, HMPs and progress reports on HMPs, Health Risk Ratings and HST reviews, hospital discharge summaries, and MARs of: • Individual #288, Individual #11, Individual #191, Individual #96, Individual #146, Individual #440, Individual #106, Individual #215, Individual #60, Individual #600, Individual #385, Individual #103, Individual #444, Individual #296, Individual #389, Individual #172, Individual #174, Individual #131, Individual #387, Individual #298 o Selected portions of records for: • Individual #519: current MAR • Individual #345: IPNs and nursing records related to 10/19/10 hospital admission <u>Interviews and Meetings Held</u>: o Opening meeting and power point presentation on LSSLC progress held 10/18/10 o Chief Nurse Executive, Mary Bowers

	o Nursing Operations Officer, Laura Flowers o Quality Enhancement Nurse, Gena Hanner o Nurse Hospital Liaison, Janet Montes o Nurse Managers, Jackie Lindsay and Lisa Proctor o Case Managers, Joyce Adams (549A), Carmen MacDonald (561A and B), Amy Clary, Clinton Hook (557A), Bobby Duke (561B), and Mayra Guzman (559) o Infirmary RN, Gwen McKinley o Workshop RTT1, Teresa Sniders o Respiratory Therapist, Melissa Crawford o Home Managers, Nicci Derbonne (561A) o LVNs, Kathy Rogers (549A), Erin Manley (557A), Tammy Kenner (549B), Beverly McCarthy (549A) and Garie White (559A) o RNs, Joy Tarver (559B), Susie Johnson (549) o Home 549A, Gabriel Bizzel and Erica Harris, MRAs o Home 563A, Patricia Rusher, MRA3 o Home 559B, Lance Porter, Nurse3 o Home 557A, Georgia Walker, MRA o Home 561B, Latrease Johnson, MRA2, Sinequia Roberson, MRA2 o Home 561A, Amy Wallace, MRA1 o Home 563A, Patricia Rusher, MRA3 o Home 506, Vera Blake, MRA3, Isabella Wade, MRA2 o Home 520B, Laquita Jones, MRA1, Adelric Daniel, MRA1 o Home 539, Brittany Richard, MRA2 o Weekly Nurse Management Meeting 10/19/10 o Meeting with Pharmacist, Medical Director, and Chief Nurse Executive 10/19/10 <u>Observations Conducted</u>: o Medication pass on Thursday, 8/19/10 at 7:00 am in homes 559A and 559B o Nebulizing treatment (539) o Enteral nutrition (549A, 549B, 557A and 557B) o Glucometer blood glucose checks and insulin administration (557A) o QA Nurse meeting 10/20/10 o HST meeting 10/20/10
	Facility Self-Assessment: The facility's self-assessment for section M rated noncompliance for all items with many initiatives in the early or initial stages of development. Other needed initiatives were awaiting further direction through policy and procedure development and revision at the state level before proceeding. The monitoring team concurred with these self-ratings

	Summary of Monitor's Assessment: Although LSSLC had been undergoing significant change and faced almost daily challenges in communicating and enforcing expectations for performance improvement, the nursing staff members were dedicated to providing quality care and individualized supports and services. During the conduct of this review, 20 individuals were visited, and their records were reviewed. In general, recordkeeping practices were improved from the baseline monitoring review. There was ample evidence across the 20 individuals reviewed that the individuals' physicians were generally notified of significant changes in their health status and needs, and/or when they needed to be seen, usually within less than 24 hours, by their physician or nurse practitioner. Observations of medication administration including enteral administration were conducted. During all observations, nurses properly washed and disinfected their hands prior to medication administration and between individuals; they identified the individuals receiving medications; appropriately thickened liquids; and, they did not initial medications on the MAR prior to the individuals' receipt of the medications. There were several areas of medication administration practice that did not meet acceptable professional standards, such as timely administration and appropriate follow-up for response to treatment with PRN medications. The administration of medication and the management of the medication administration system at LSSLC had undergone numerous changes since the baseline review including changes made during the week of this review when a new distribution system was initiated on 10/20/10. The effectiveness of these initial and recent changes to a system identified as highly flawed at the time of the baseline review will require further review and evaluation. Nurses continued to check each individual order against the week's supply and handwrite any variance onto the physician's order on the MAR. All 20 individuals reviewed had annual and quarterly nursing assessments filed in their records. The assessments were conducted by RN case managers, and all but one were completed in a timely manner. Notwithstanding these positive findings, problems were noted with the conduct of nursing assessment, diagnosis, planning, implementation of planned interventions, and evaluation of plans. Comprehensive documentation in the individuals' records of their significant changes in health status from identification to resolution was inconsistent and incomplete. The 20 individuals reviewed had some or all of their health needs and risks referenced by Health Management Plans (HMPs) and Acute Health Care Plans (ACPs). These plans were established by their RN case manager in response to identified health needs, risks, and/or significant changes in health status. The plans were generally generic and more appropriate for acute episodes than for individualized long term management of a health risk or problem. The forms, processes, and plans in place at the time of this review, however, were in need of review and revision in order to promote progress toward the achievement of this provision of the Settlement Agreement. It was clear that a large part of the issues with HMPs and ACPs were associated with the inadequate and incomplete nursing assessments and nurses' incomplete and inconsistent identification and follow-up to significant changes in individuals' health status

	and needs. At LSSLC, there were a number of monitoring and training efforts underway within the Nursing Department and across the facility. These included a new Program Compliance Coordinator position in the nursing department to address monitoring and follow-up for targeted areas addressed in the Texas Health Monitoring Tools that were related to nursing services. Adequate nursing staffing to meet the needs of an aging population of individuals with more frequent and severe chronic health problems and associated acute episodes remained a significant issue. Additionally, there was the issue of maintaining an adequate level of appropriately trained staff. Training nurses to meet the new requirements was intense, but carry over into actual nursing practice remained an even greater challenge.

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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.	As was noted in the baseline review, the Nursing Operations Officer (NOO) supervised and/or participated in most facility processes that impacted on functioning of the individual units, including individualized health care management. These functions included some of the following: • Infirmary rounds where decisions and transition plans were made regarding the movement of individuals to and from the hospital and the regular living units. This included deciding what had to be done to get ready to readmit persons to the facility from acute care or infirmary settings. • Twenty-four hour per day nursing crisis management in the facility in terms of staffing and emergencies including supply management. • The Master Tracking list to monitor the status of Case Management requirements, such as MOSES and DISCUS, Quarterly and Annual Nursing Assessments, Acute and Chronic Care Plans, or any recurring Nurse Case Manager responsibility. H Sheets in use for the last year allowed the nurse managers to document the status of all health care plans and other recurring assessment requirements. This tool also tracked the status of Health Management Plan reviews as well as the type of health management plans being developed (e.g., seizures, UTI, risk of aspiration, impaired skin integrity, hypertension). The focus should now be shifting to the quality and individuality of plan interventions as well as documentation that the plan was implemented as planned, with supporting data adequately summarized and analyzed. • Acuity levels were increasing as the population aged and experienced more health care issues with the acuity levels and demands on nursing services increasing again since the baseline review. Medication and treatment administration responsibilities had been increasing in terms of numbers and complexity, particularly for individuals who were non-ambulatory and fed by	Noncompliance

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		other than oral means. As of 10/20/10 there were 55 individuals with gastrostomy tubes and two with G/J tubes, an increase of 16.66% since 4/09. The current age range of the LSSLC population was from 10 to 83 years of age, with the majority at the upper end of the range. With the initial implementation of many new systems and procedures, LSSLC was making some progress towards meeting this provision, but consistent and functional implementation was not yet occurring. There continued to be a pattern of frequent and regular absence of consistent identification of health care problems, implementation of appropriate and individualized interventions, and appropriate follow-up to resolution. During the onsite monitoring review, 20 individuals were visited, and their records were reviewed. Records were organized, and nurses' notes were usually in the DAP (Data, Analysis, Plan) format. The emphasis in the DAP notes was most often on planning to the exclusion of appropriate and complete assessment data. They did not have an adequate feedback system, and were not documenting the assessment portion of the system correctly. Instead, they were most often writing actions. Further, the single most common entry under the plan section was that they will continue to monitor, however, there was no specification regarding what would be monitored, when that might happen, how they would complete that action, or the plan to notify the primary care practitioner. Documentation to resolution was difficult to track in the record. It was, however, a rare occurrence to find a nursing note in the IPNs that was illegible, improperly signed and dated, and/or not designated as a late entry, when needed. The time notes were written was not consistently present in the 20 records reviewed. There was ample evidence across the 20 individuals' reviewed that their physician was generally notified of significant changes in their health status and needs and/or when the individuals needed to be seen, usually within less than 24 hours, by their physician or nurse practitioner. The individuals' physician and/or nurse practitioner were usually notified of individuals with changes in seizure activity, mental status, behavior, injuries, and illnesses (e.g., vomiting, diarrhea, elevated temperature, other abnormal vital signs). Exceptions are described in sections M2 and M6 for Individual #146, Individual #11, Individual #96, Individual #444, Individual #385, and Individual #172. Comprehensive documentation in the individuals' records of significant changes in health status from identification to resolution was, at times, inconsistent and incomplete. Integrated Progress Notes (IPNs) and other health status tracking systems failed to document whether nurses were consistently assessing health care problems and changes in health status, adequately intervening, and appropriately providing follow up to problems once identified, as required by this provision item. Numerous examples from this sample indicated the seriousness of this problem at LSSLC and extended to all phases	

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		of the nursing process from assessment to evaluation of plan effectiveness. Examples below, and in sections M2 and M3 below, involved both problems that emerged primarily over the last quarter and existing problems that were reassessed using the new procedures during the last quarter. • Individual #11: She had HMPs, first to address seizures and potential associated injuries and, second, to address gastrostomy tube care to prevent aspiration. They were primarily generic in nature and a general restatement of facility and/or state policy and procedure. Interventions and actions that were not appropriate to this individual's needs were not removed from the plans, such as disinfecting procedures for individuals using cloth diapers. Other portions of her HMP, such as those to prevent constipation and maintain skin integrity had some individualized interventions. • Individual #146: This individual had chronic skin excoriations of the neck and ears, as well as other areas of the body associated with lichen simplex chronicus, a disorder that leads to chronic itching and scratching. This individual had every-12-hour orders for medical restraints since at least 9/9/10 while in the infirmary for neck lesions (strep/staph) and contact isolation. She was readmitted to her dorm from the infirmary on 10/12/10. Her post Infirmary Nursing Assessment and IPNs since that time did not include a complete description/assessment of the open lesions to her left and posterior neck. There were not consistent documented ongoing assessments by nursing staff on the status of her lesions or the condition of her hands and their release for range of motion. The condition of the sites of treatment (i.e., her neck lesions) were not documented on 10/14/10 and 10/15/10 when sterile pads were used to pat moisture from the lesions, or consistently documented when cleansing the neck wound daily with normal saline started 9/23/10. Observation of this individual by the monitoring team on 10/19/10, followed by restraint record review and 1:1 staff interview, provided no evidence of routine removal of her medical restraint, bilateral mittens. A towel with yellow drainage was draped around the individual's neck. Circulation checks every 15 minutes were documented. The individual's 1:1 staff reported the mittens were removed in the morning, her hands were washed and dried, and freshly laundered mittens were applied. Her most recent annual nursing assessment completed 10/6/10 did not identify her recurrent impaired skin integrity and the prolonged use of mechanical restraints for medical purposes as a current nursing/health problem. There was no current appropriate HMP in place. Additionally, her skin integrity risk was identified as low and, during an HST meeting held 10/19/10 that was observed by the monitoring team, a recommendation of medium risk was made. The risk level was changed to high risk after intervention by the monitoring team and discussion with the HST regarding the long-term use of the medical restraints,	

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		status of her current acute episodes, and effectiveness of medical treatment for itching. • Individual #600: Despite recurrent documentation of medication and health monitoring (i.e., blood pressure, refusals and significant issues with more frequent requests by the individual asking for PRN pain medication, her history of polysubstance abuse, and current cigarette smoking status) her HMPs and accompanying interventions addressed only oral hygiene and hyperlipidemia. Her most recent nursing assessment and HMP review was 9/28/10. It was noted that physician's orders for Tramodal, an opiate agonist/analgesic for moderate pain, 50 mg, every six hours, as needed for headache, was being administered at this individual's request for headaches, one to two times daily, from at least 7/8/10 until 10/13/10. On 10/13/10, she had an order to discontinue the Tramodal and start, as needed, Tylenol/ acetaminophen for fever or pain. This was an abrupt discontinuation of a drug that can produce dependence and usually dosage is reduced gradually to avoid withdrawal symptoms. Challenging behavior issues presented by this individual were noted by the monitoring team to be occurring during this review period. • Individual #444: This individual's last quarterly nursing assessment and HMP review was 9/29/10. HMPs were initially developed and implemented 4/5/10. Regardless of weight gain, not loss, her HMP to address obesity had no change in interventions. She had no current HMP provided that addressed her insulin dependent diabetes mellitus given her need for sliding scale insulin for blood glucose levels over 400 mg/dl four to six times monthly and diabetic neuropathy. • Individual #172: Since 2/20/09, this individual had a physician's order to wear a wheelchair seat belt for safety, triggering development of what appeared to be an unnecessary HMP for risk of falls. He had been without falls. Direct support staff provided assistance with daily implementation that was documented and this could easily be monitored and checked during routine quarterly nursing assessments without the need for a HMP. • Individual #131: This individual had chronic episodes of hypothermia. She had a HMP developed and implemented 1/11/10 that was individualized with appropriate interventions specified for both direct support staff and nursing staff with the exception of the frequency of body temperature monitoring. At the time of this review, her body temperature was recorded each shift, but this was not included in her HMP. Six to eight shifts per month had not recorded her body temperature. • Individual #298: With the implementation of the new HMP format, this individual's HMPs were more generic and targeted acute episodes of the conditions rather than individualized prevention and maintenance interventions and strategies, such as for gastrointestinal bleeding and altered heart rhythm.	

#	Provision	Assessment of Status	Compliance
		He did have an individualized HMP to address chronically broken, excoriated skin around his ileostomy and gastrostomy stoma sites. Also see sections M2 and M6.	
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.	A revised comprehensive nursing assessment form and state policy and procedure on nursing assessment was initiated at LSSLC in June 2010. Timely nursing assessments were present in each individual's record reviewed with the exception of Individual #288. Nursing assessments had been updated and were generally comprehensive, however, several of the nursing assessments were not complete and a few were not comprehensive enough to address health issues that existed for individuals at the time. The first step of the nursing process that one would expect to find in a facility, such as LSSLC, is the nursing assessment. The nursing assessment is an ongoing and continuous process of collecting, evaluating, and communicating data and information regarding each and every individual's needs, regardless of the reason for the nursing encounter. Generally accepted professional standards of care indicate that nursing assessments must be complete, accurate, documented, and accessible to all members of the healthcare team. It is from the nurses' assessment that actual problems, high-risk potential problems, and nursing diagnoses are identified, and from which plans are developed to address and/or resolve problems. Moreover, the assessment records and summarizes pertinent health data against which change can be measured and goal achievement determined. Twenty individuals reviewed had annual and quarterly nursing assessments completed and filed in their records. All 20 had completed Braden Scales to rate skin integrity risk. The assessments were conducted by RN case managers. With the exception of Individual #96, nursing assessments completed since June 2010 included documentation of the actual completion date of the annual or quarterly assessment, the signature and title of the nurse completing the assessment, and the date the nurse signed the assessment. The use of a new comprehensive nursing assessment format had been initiated within the last quarter. It included items to gather more detailed health status data and facilitate analysis leading to more complete and appropriate diagnoses. The individual's medical diagnoses and current medication and treatment orders were items now included in the most recent version of the nursing assessment. Notwithstanding the positive findings, performance of nursing assessments failed to provide a complete and accurate review of each individual's health status. Annual and quarterly nursing assessments completed since June 2010 were often incomplete. They lacked the comprehensive health care data needed for analysis to identify changes, patterns and/or trends and provide a foundation for appropriate	Noncompliance

#	Provision	Assessment of Status	Compliance
		diagnosis and planning. There were also assessment items more frequently left blank. Examples of both are presented below. • Individual #288: The most recent quarterly nursing assessment provided for review was completed 2/24/10. • Individual #11: Her annual assessment was completed 8/18/10. All her current medications, including dosage, route, and corresponding diagnosis were not listed, including Trileptal, valproic acid, Prevacid, folic acid and glycolax, medications for seizure control, anemia, GERD, and constipation. • Individual #191: His most recent quarterly nursing assessment was completed 8/24/10. The Medication Section included medication changes, but not the frequency of his PRN medication use or his current medications and their corresponding diagnoses. Various assessment items were blank, including blood pressure, abdominal girth measurement, and the portion of the Immunization Section addressing MMR, Hepatitis A&B. The assessment item to indicate presence or absence of ulcers or wounds was not completed and this individual had a recent history of skin breakdown due to pressure. His assessment indicated he required a bowel management plan, but did not specify the plan. He had a history of chronic constipation and received two laxatives twice daily. • Individual #96: Her most recent quarterly nursing assessment was completed 9/7/10. The assessment was not signed and dated by the nurse completing the assessment. The portion of the Immunization Section addressing MMR, Hepatitis A&B, etc., and DNR status were blank. Her assessment indicated she required a bowel management plan, but did not specify the plan. She had a history of chronic constipation. • Individual #146: Her most recent annual nursing assessment was completed 10/6/10. The Medication Section included medication changes but not the frequency of her PRN medication use or her current medications and their corresponding diagnoses. A complete assessment and description of her skin lesions including sites, size, depth, color, and drainage was not included in the assessment. She had two lesions on her neck at the time and was wearing medical restraints, bilateral mittens, to prevent scratching the sites that had been positive for staph and strep. The EENT/Head and Neck Section of her assessment was also incomplete. • Individual #440: Her most recent annual nursing assessment was completed 9/27/10. The Medication Section included medication changes, but not the frequency of her PRN medication use or her current medications and their corresponding diagnoses. Various areas of the assessment were blank, including the portion of the Immunization Section addressing MMR, Hepatitis A&B; the Tympanic Membrane Section; and the usual number of hours of sleep item. There was also no indication her amenorrhea was secondary to a hysterectomy. • Individual #106: His most recent quarterly nursing assessment was completed	

#	Provision	Assessment of Status	Compliance
		8/25/10. The Medication Section included medication changes, but not the frequency of his PRN medication use or the diagnoses corresponding to his current medications. The portion of the Immunization Section addressing MMR, Hepatitis A&B, etc. was blank. The Tympanic Membrane Section of the assessment was blank. • Individual #60: The most recent quarterly nursing assessment was completed 8/17/10. The Medication Section included medication changes, but not the frequency of her PRN medication use or the diagnoses corresponding to her current medications. The Tympanic Membrane Section of the assessment was blank. • Individual #600: The most recent quarterly nursing assessment was completed 9/28/10. The Medications Section was blank for an individual who received multiple antipsychotic medications as well as had issues with pain and headache medications. • Individual #385: His most recent quarterly nursing assessment was completed 9/28/10. Various assessment items were blank, including abdominal girth measurement, bowel elimination pattern, and stoma condition. His identified health problems were recurrent excoriation at stoma site, hypertension, and constipation. • Individual #103: His most recent quarterly nursing assessment was completed 8/16/10. The Medication Section included medication changes, but not the frequency of her PRN medication use or the diagnoses corresponding to her current medications. The abdominal girth measurement item of the assessment was blank. • Individual #444: The most recent quarterly nursing assessment was completed 9/29/10. Various assessment items were blank, including abdominal girth measurement, tympanic membrane assessment, portions of her immunization status, and the genitourinary section. Given her colostomy, gastrostomy and diabetes, a baseline abdominal girth measurement would be indicated. • Individual #296: The most recent quarterly nursing assessment was completed 9/9/10. Abdominal girth measurement and tympanic membrane assessment items were blank. • Individual #389: The most recent quarterly nursing assessment was completed 7/26/10. The Medication Section included medication changes, but not the frequency of PRN medication use or his current medications and their corresponding diagnoses. He received multiple medications for bowel management, seizure control, and hypertension. Abdominal girth measurement and tympanic membrane assessment items were blank. • Individual #174: The most recent quarterly nursing assessment was completed 9/24/10. All his current medications, including dosage, route, and corresponding diagnosis were not listed including his antiepileptic medications.	

#	Provision	Assessment of Status	Compliance
		• Individual #387: The most recent quarterly nursing assessment was completed 9/14/10. The medical history section was incomplete without identifying Diabetes Mellitus Type II with insulin dependence, GERD, or osteopenia. Abdominal girth measurement and tympanic membrane assessment items were blank. • Individual #298: The most recent annual nursing assessment was completed 8/18/10. The abdominal girth measurement assessment item was blank. Monitoring his gastric residual and providing "serial measurements of abdominal girth if residual is difficult to measure" was an intervention in his HMP which would indicate the need for baseline abdominal girth measures on a quarterly basis per the comprehensive assessment. Several examples of other assessments that did not meet the nursing care needs of individuals include the following: • Individual #11: (1) On 6/11/10, she received an ordered soap suds enema "now" for constipation with no accompanying IPN documenting pre and post assessment results. On 9/13/10, at 1235H she received Miralax 17 gm in eight ounces of water per g-tube, a one-time administration, without documented follow-up assessment. The next IPN from nursing was on 9/15/10 without a time of entry documented. The Miralax order followed an ineffective enema administered on 9/12/10. Documentation of administration of the enema indicated it was her 3rd day without a bowel movement, but her bowel record indicated it was the 4th day. (2) Planned monitoring of a right ear otitis for three days post discharge from the infirmary was only documented for two days, 9/1/10 and 9/2/10, without documentation continued to resolution. (3) There was no IPN regarding nursing assessment and follow-up for this individual's 31-minute seizure on 7/8/10. The nursing portion of the seizure record on the same episode documented only vital signs and "Diastat 10 mg rectally." She was sent to the ER and was hospitalized until 7/13/10. (4) On 7/15/10, at 2110H, Benadryl, a one-time administration, was given for an extensive rash with a specified plan by nursing to re-assess in one hour. The next documented assessment was at 0400H. Resolution to the rash was not documented with the last related entry stating the rash had lessened. (5) Elevated body temperatures recorded and treated on 8/26/10 of 101.7 and 103.2 did not have results of further assessment such as accompanying pulse, respiration rate, lung sounds, or blood pressure. • Individual #191: In mid-September 2010, this individual had recurrent issues with meal refusals. Frequent refusals began 9/12/10, with several follow-up evaluations with his PCP, dental evaluation for possible mouth/tooth pain, and further PCP evaluation for constipation. Frequent refusals persisted through 9/19/10, when he was admitted to the hospital and treated with a craniotomy	

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		for a subdural hematoma. Despite persistent refusals from 9/12/10 through 9/19/10, there were no documented appropriate nursing assessments, including no abdominal assessment before or after the soap suds enema, vital signs, or a head to toe physical assessment. • Individual #96: (1) Weekly weights were not consistently recorded. (2) Her blood pressure and pulse were not consistently recorded every shift. (3) On 10/1/10, her blood pressure was 74/56 with no follow-up assessment. PRN medication, pseudoephedrine, prescribed for systolic blood pressure less than 90 were not administered for hypotension episodes on 10/2, 6-2 shift, 84/60; 10/14/10, 2-10 shift, 75/86; and 8/15/10, 6-2 shift, 89/54. There was no accompanying IPN or documentation of follow-up assessments for the four hypotensive episodes. • Individual #146: (1) This individual had every-12-hour orders for medical restraints and 1:1 staffing for at least two months, both while in the infirmary for neck lesions (strep/staph) and contact isolation, and after she was readmitted to her dorm on 10/12/10. As noted in section M1, she had chronic skin excoriations of the neck and ears that led to chronic itching and scratching. Her Post Infirmary Nursing Assessments and IPNs since that time did not include a complete description/assessment of the open lesions to her left and posterior neck. Her record contained inconsistent and incomplete assessments by nursing staff on the status of her lesions and the condition of her hands and their release for range of motion. The condition of the site of treatment (i.e., her neck lesions) was not consistently and completely documented. (2) On 8/20/10, she received acetaminophen at 2130H for a temperature of 102.4 without a follow-up assessment until 8/21/10 at 0500H. (3) Weekly weights were inconsistently recorded, although she was designated at medium risk due to overweight issues. • Individual #385: (1) A 10/17/10 IPN notation for this individual at 1045H of "red angry skin around g-tube stoma site" had no follow-up assessment documented until 10/18/10 at 0730H. (2) Another IPN on 10/16/10 documented a vomiting episode after medication administration with no description of vomitus characteristics or loss of medications. After another vomiting episode on 7/19/10, vital signs were assessed, but again, no estimated amount or characteristics of vomitus were recorded or abdominal assessment completed. • Individual #103: Weekly blood pressures were not consistently recorded. This individual had borderline hypertension with no HMP, but identified nursing plans to monitor his blood pressure weekly. • Individual #444: This individual with Insulin Dependent Diabetes Mellitus, who received routine and sliding scale insulin, had a blood glucose level of 440 on 8/8/10 at 1700H. Twelve units of regular insulin were administered and the physician was notified as prescribed. A recheck was planned for one hour later,	

#	Provision	Assessment of Status	Compliance
		but wasn't documented until 2100H. • Individual #172: (1) Planned per shift blood pressures and pulse rates were not consistently documented for this individual with hypertension and shunted hydrocephalus. There was no follow-up assessment of a blood pressure of 90/60 on 7/18/10, at the edge of ranges for both systolic and diastolic measures requiring prescribed treatment. (2) Planned monitoring for this individual, who was at risk for aspiration and had frequent aspiration pneumonia episodes, included weekly assessment of vital signs, respiratory effort, and auscultation of lung sounds. Documented assessments occurred inconsistently (e.g., once in 6/10, three times in 7/10, and twice in both 8/10 and 9/10). • Individual #174: Weekly weights and blood pressure measures were inconsistently documented since 9/2/10 for this individual who had a recent prolonged stay in the infirmary for nutritional status issues. • Individual #131: (1) This individual had blood pressure and/or pulse measure parameters for holding clonidine and/or metoprolol, both prescribed for hypertension. Her blood pressure and pulse measures were not consistently recorded in 9/10. (2) This individual experienced hypothermia episodes with no nursing order or planned action for frequent body temperature monitoring. Regardless, per shift temperatures were inconsistently documented. (3) No monthly weight and blood pressure measures were provided for review on the facility's Growth Record-Female form. • Individual #387: (1) Weekly weights were inconsistently documented for this individual with low body weight, diabetic gastroparesis, and multiple gastrointestinal disorders. (2) This individual had an order on 9/29/10 at 1315H for vital signs every shift for 72 hours, then temperature every shift, and vital signs weekly, for 182 days that were inconsistently documented. • Individual #298: (1) Weekly weights were inconsistently documented for this individual with low body weight, short bowel syndrome, and an ileostomy. (2) Documentation of assessment of his ileostomy stoma site at the times when the wafer and bag that were changed were not consistently recorded. • For all individuals receiving nebulizer treatments, pre and post treatment respiratory assessments were generally not present, including lung sounds and respiratory rate. These were from this sample that included Individual #172, Individual #288, Individual #96, and Individual #444. ▪ Baselines established regarding individuals' bowel elimination most often did not include prescribed routine laxatives and nutritional interventions necessary to maintain an adequate elimination pattern and eliminate or reduce acute constipation episodes (i.e., the bowel management plan). ▪ Although all 20 assessments included completed Braden Scales with total scores, the ratings based on the scores were not provided (i.e., the score key: 12 or less high risk, 13-15 moderate risk, $\geq$ 16 minimum risk).	

#	Provision	Assessment of Status	Compliance
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.	Basic health care needs were currently addressed in the Acute and Health Management (chronic) Plans. Nursing staff at LSSLC had initiated the new (July 2010) state policy on care plan development. The plans continued to need improvement as detailed below in order to meet the requirements of this provision item. There were Health Management Plans for each chronic problem identified in the nurses' assessments, but, for some individuals, their most significant health problems were not identified, therefore, HMPs were not developed. The "Big Master Tracker" that documented whether the plan was present, along with a number of other items, did not deal with the comprehensiveness of the HMP. For example, for many individuals, particularly those with respiratory, GI, and other issues where immobility and alignment were problematic, there was little evidence that the specific physical and nutritional management aspects of chronic care were evidenced in their health management plans. Early identification of chronic illness symptomatology was not addressed in the HMPs. Monitoring of the plans, however, was completed on a monthly basis by nursing. The facility was generally providing adequate care for the chronic conditions of diabetes, bowel management, and weight management. The facility was not providing adequate health management for the chronic conditions of GERD, incontinence, impaired skin integrity, and chronic respiratory illness particularly related to aspiration. These areas of service will need further development. As is noted in section M4, one of the steps that had been taken that would assist in addressing these issues, was the recently completed training on the "Physical and Nutritional Management Team: Identification of Risk and development of Interventions" by 51 nurses. GERD and aspiration were two closely related health care outcomes that demanded interdisciplinary collaboration to assure that at-risk individuals had positions that prevented the problem from occurring or worsening. GERD often leads to aspiration because the individual is in a position that prevents emptying of the stomach and facilitates reflux. Elevating the head of the bed is often not a functional intervention for a number of reasons. First, the individual should not be in the bed for more than eight to 10 hours at a time. Second, elevating the head of the bed must be combined with assuring the quality of the individual's position. For example, the order should state: "Assure that the individual is elevated at all times to at least 30-45 degrees with the head and trunk in alignment and the nose, naval, and knees pointing in the same direction." When sitting, the individual should be positioned with the pelvis in a slight anterior tilt, with support to the forearms, such that the head and trunk are elongated, and the head is in neutral or slight capital flexion. GERD and chronic anemia are two closely related health care outcomes that also demand	Noncompliance

#	Provision	Assessment of Status	Compliance
		interdisciplinary collaboration to assure that at risk individuals have appropriate preventative measures to address the GERD thus preventing the anemia. HMPs addressing anemia should have been directed at managing the GERD with monitoring and evaluation of signs and symptoms of anemia as data for monitoring success, that is, eliminating the complication of anemia resulting from chronic gastroesophageal reflux episodes. There was no evidence that the nurses consistently documented a full head to toe assessment in the presence of signs and symptoms of acute illness and injury. Also see section M2. Regarding infection control, staff were trained in hand washing and in standard infection control procedures. There was an Antibiotic Subcommittee, which met monthly and tracked use of antibiotics, type, locus of infection, and response to treatment. The long time Infection Control Nurse was retiring and in her final week of employment at the time of this review. The facility was beginning to address the risk management issues that would impact on reducing health risk for identified individuals, but was also waiting for further guidance from the state office in the form of revisions to the At-Risk Individuals policy. The following are continued examples of risk management issues: • From 4/1/10 until 10/15/10, there were 50 hospitalizations, and 118 ER visits. There were three additional ER visits for respiratory issues that did not result in hospitalization. Respiratory issues were the major cause of hospitalization, many of which were suspected to be aspiration. Only three individuals, however, were identified to be at high risk for aspiration and three for respiratory issues. This appeared to be inadequate, even after accounting for repeat hospitalizations of the same individual for respiratory issues. Individual #96 was rated as being at high risk for respiratory issues, but not aspiration, although she had had three hospitalizations for aspiration pneumonia in the last quarter. • There were eight individuals who had hospital discharge diagnoses of Urinary Tract Infections (UTI) and/or sepsis and required acute care, but no individuals were listed at high risk. There were 10 individuals at medium risk. • As in the baseline review, few health management plans for individuals who were either seen in the ER or admitted to acute care addressed the quality of positioning for intake and/or emptying. In a facility such as LSSLC, the health management plan and acute care plan are designed to promote health and/or prevent, reduce, or resolve the problems and risks that are	

#	Provision	Assessment of Status	Compliance
		identified via the nurses' assessment and nursing and medical diagnoses. The nursing interventions put forward in these plans should reference individual-specific, personalized activities and strategies designed to achieve individuals' desired goals and outcomes. The individuals' status, and the effectiveness of the plans, must be consistently implemented and continuously evaluated and modified as needed. All 20 individuals reviewed had some or all of their health needs and risks referenced in Health Management Plans (HMPs) and Acute Health Care Plans (ACPs). These plans were developed by their RN case managers in response to identified health needs, identified risks, and/or significant changes in health status. The forms, processes, and plans in place at the time of the review were in need of continued review and revision in order to promote progress toward the achievement of this provision item of the Settlement Agreement. Part of the problems noted in the HMPs and ACPs were due to the inadequate and incomplete health problem or nursing diagnosis identification. Other parts were due to the application of generic/standard plans or protocols to health problems that instead required individualized approaches and interventions. Some general comments are presented below. • HMPs and ACPs were in various forms, formats, and states of completion. • HMPs did not consistently address all of the health care needs of the individuals. • The interventions in the HMPs were the same across many of the individuals even though the individuals, as well as the precursors, nature, scope, and intensity of their problems, were very different. The majority of the newer HMPs were standard health care protocols generally more suitable for use in an acute care situation, such as management of a prolonged seizure or healing fracture. The protocols provided the nurse guidance in applying the nursing process to the presenting health problem or risk, making decisions regarding reporting and consultation with other health care professionals, and specifying follow-up plan criteria. With the addition of the individual's baseline data and a goal, each plan was essentially a generic health care protocol. The HMPs reviewed had more individualized interventions when utilizing the old, rather than the new, HMP formats. Some of the HMPs had not clearly identified nursing interventions from interventions to be taken by direct support staff. The frequency of monitoring and assessment as well as the frequency of other interventions were generally not specified. • Despite changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes, their HMPs and ACPs were not revised. • Timely reviews of HMPs were documented using H-sheets summarizing associated data. Even so, there was little evidence that the comprehensive	

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		review of the individuals' HMPs and ACPs ensured the plans were implemented as planned and continued to be appropriate and relevant to the individuals' health status based on a review and analysis of comprehensive health status data. • The objectives and expected outcomes referenced in the HMPs and ACPs were not consistently individualized, and they did not reflect the individuals' participation in their development or their desired health outcomes. Examples of HMPs and ACPs for specific individuals from the last quarter are presented below: • Individual #288: Interventions in her HMP were last updated 8/16/10. Her HMP addressing oral hygiene had interventions to brush four times daily (i.e., after each meal and bedtime) which was not occurring and was not consistent with her daily living and activity schedule. Her HMP to address chronic obstructive pulmonary disease (COPD) and recurrent upper respiratory infections included the intervention of teaching her controlled breathing techniques, but there was no documentation of implementation. Another intervention was assuring fluid intake of 2000 ml per day, but her fluid intake was not monitored and self-monitoring was not taught. • Individual #146: Interventions in her HMP were last updated 10/6/10. Acute Care Plans (ACPs) had been in place and then discontinued for open wounds and Herpes Zoster. A current HMP including individualized and specific interventions to address her skin integrity issues requiring medical restraints collaboration with the physician for medical treatment options to effectively control the itching, and other possible strategies to address the itching caused by her skin condition were not included. The facility's policy for use of medical restraints was reported to be in draft form dated 7/16/10, and called the Dental/Medical Sedation and Restraint procedure. After it was identified by the monitoring team that restraint release for exercise and range of motion was not consistently documented and the orders for frequency had not been specified, new orders were obtained and implemented. The new orders on 10/20/10 at 1430H specified range of motion every two hours. Documentation of restraint release and range of motion after this order on 10/20/10 were for 1815H, 2100H, 2200H, and 2400H. Most of this individual's HMPs were directed at stable health conditions treated medically and observed for change, most often not requiring a specific care plan, such as anemia, osteopenia, and hypothyrodism. • Individual #440: HMPs developed for her did not address nursing diagnoses or health problems with specific measureable goals and individual specific interventions appropriate to her health status and risks. For example: (1) She had an elaborate HMP to address her stable hypothyroidism, requiring primarily	

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		medical management already addressed in physician's orders and routine required health monitoring. (2) she had multiple diagnoses placing her at risk, including osteogenesis imperfecta (extremely fragile bones with high susceptibility to fractures) and osteoporosis with a history of fractures. Even so, her HMP did not address individual-specific prevention strategies. (3) She was rated at medium risk related to aspiration and choking and other medical concerns which were not addressed in HMPs. (4) Her HMP to address constipation was discontinued while she remained on three routine laxatives. • Individual #106: Although this individual had frequent pedal edema, peripheral vascular disease status post deep vein thrombosis, and a history of pulmonary embolism with current anticoagulant therapy, as well as an active seizure disorder (11 seizures in last reported quarter) and chronic obstructive pulmonary disease (COPD), he did not have HMPs to address these current nursing problems. He had a HMP to address obesity, without changes in actions or interventions despite overall weight gain for the last year and a HMP to address oral hygiene related to chronic gingivitis and severe periodontal disease. <u>Intervention for poor oral hygiene</u>: Of the 400 individuals at LSSLC, 104 had poor oral hygiene. Three of the individuals in the sample of 20 reviewed had oral hygiene that was poor. • Individual #444 had consistently poor oral hygiene. Poor oral hygiene leading to periodontal disease, increased her risk of negative effects on her diabetes. Her nursing assessment and health management plan generally addressed poor oral hygiene, including provision of education. No changes to his plan were made when she continued with poor oral hygiene. There were no identified changes in educational or alternative equipment strategies, such as additional education from the dental hygienist or use of a rotating electric toothbrush. • Individual #444, Individual #387, and Individual #600 had poor oral hygiene with recommendations for effective brushing and a routine care plan without individualized interventions to improve oral hygiene. The recommendation for effective brushing and presence of a routine care plan with non-specific interventions unchanged from quarter to quarter over long periods of time was generally true for each for these three individuals.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals	At LSSLC, nursing assessment and reporting protocols were in place, however, the presence of protocols was not sufficient to ensure that the health status of the individuals at LSSLC was consistently addressed. The facility's implementation of its nursing assessment and reporting protocols was in the early stage of implementation. As noted, there were numerous problems, described above in sections M1, M2, and M3. Thus, the anticipated positive outcomes for individuals due to the implementation of these	Noncompliance

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	served.	protocols were not yet evident in all the records reviewed. At LSSLC, the Chief Nurse Executive, Nursing Operations Officer, Nurse Educator, Hospital Liaison, Infection Control Nurse, Quality Enhancement Nurse, Campus Nurse Supervisors, Nurse Case Managers, and Nurse Managers all had a role and responsibility to ensure the implementation of nursing assessment and reporting to address the health status of the individuals. The nursing management team met on a weekly basis and included the Chief Nurse Executive, Nursing Operations Officer, Nurse Educator, Hospital Liaison, Infection Control Nurse, Nurse Recruiter, and Nurse Managers. A recent addition to the nursing management team was the hiring of a Program Compliance Coordinator to provide support in achieving this provision. The monitoring team attended the weekly Nurse Management meeting that was also attended by Valerie Kipfer, Nursing Services Coordinator from the DADS central state office. Meeting participants included the Chief Nurse Executive, Nursing Operations Officer, Nurse Educator, Hospital Liaison Nurse, Nurse Managers, Nurse Recruiter, Nurse Program Compliance Monitor, Immunizations and Employee Health Nurse, the Nursing Clerk, and the Quality Enhancement Nurse. A top priority discussed was staffing. This included nursing coverage of the infirmary with the loss of its Nurse Manager to occur the week of this review. The Infection Control Nurse was retiring on 10/22/10. There were also two other Nurse Manager and two RN Supervisor positions open as well as multiple LVN positions and other nurses on extended medical leave. The LSSLC nursing management staff were implementing various strategies to improve nurses' knowledge regarding the Texas Health Monitoring Instrument items and move towards full implementation. Efforts discussed at the weekly meeting included the LSSLC nursing department's annual nursing skills fair completed 10/10 with participation by all but 20 nurses out of 141. Nurse managers had been challenged to develop teaching and training strategies on their units to facilitate improving seizure recognition and management and presented their strategies. The Program Compliance Coordinator would be monitoring compliance on targeted areas and summarizing data for utilization review. Nursing administration was planning for collaboration with the QA Nurse and establishing inter-rater reliability across five identified areas from the monitoring tools: annual nursing assessments, quarterly nursing assessments, HMPs for GERD, documentation, and acute illness and injury. The LSSLC presentation on progress toward meeting the Settlement Agreement provisions provided to the monitoring team on 10/18/10 included progress in the nursing care provision presented by the Chief Nurse Executive. In addition to initial implementation of the new assessment and care planning procedures and forms, there was also implementation of new seizure observation forms and 30-day MARs. Fifty-one	

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		nurses received training on the "Physical and Nutritional Management Team: Identification of Risk and Development of Interventions." The expectation for adequate numbers of trained, competent, and capable nurses was clearly articulated by the Chief Nurse Executive and the Nursing Operations Officer. It was noted that future changes in nursing, as well as affiliated departments, needed to be monitored closely for the effects on even further demands for nursing time so that there is adequate staffing to meet the needs (e.g., a suggestion for future change was increasing the amount of time spent with each individual in the psychiatric clinic which may impact the amount of nursing time needed). The monitoring team did not meet with the Infection Control Nurse during the onsite review, but did review the infection control related documents and interview nursing staff regarding infection control issues and procedures. The Infection Control Nurse was reported to be directly involved in the daily process of nursing assessment and reporting. Her impending retirement was expressed as a great loss by many nursing staff interviewed. She attended the DCS shift reports to receive information about any new infections and the status of identified infections and infection control at the facility. She received information from the facility's Medical Director and Pharmacist related to antibiotic prescriptions and practices across the facility. All of the information related to identification, tracking and trending, and reporting of infections was recorded by the Infection Control Nurse who reported these data to the facility's Infection Control Committee. The Infection Control Nurse provided direct support staff with re-education and training in standard precautions and follow-up on individuals who were diagnosed with infections. The Infection Control Nurse was also reported to provide technical assistance to nurses working in the residences who had questions about specific infection control practices and procedures. The Hospital Liaison was directly involved in the daily process of nursing assessment and reports. She assured that all individuals who were hospitalized were visited, and that all pertinent information about their hospitalization was collected and reported to their caregivers at LSSLC. She communicated her assessment of individuals' hospital care/treatment and their response to treatment via verbal reports at morning (nursing) staff meetings and written reports, which were sent to the individuals' nurse case managers, physician, and DCS Supervisor, and were also filed in the individuals' records. The monitoring team met with Janet Montes, Hospital Liaison Nurse, to review complete and appropriate documentation related to and following the hospital admission on 10/19/10 of Individual #345. The Quality Assurance (QA) Nurse was not a member of the Nursing Department, but a member of the Quality Enhancement Department and reported to the Director of Quality	

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		Enhancement. The QA Nurse was a member of many of the facility's committees (e.g., Medication Error, Infection Control). As was noted above, there were plans for the Nursing Program Compliance Monitor and QA Nurse to collaborate to provide useful data and data analysis as a foundation for quality improvement in the five targeted monitoring areas. There were also routinely scheduled meetings between the nurse management team and the Quality Enhancement Nurse to review nursing QA monitoring findings. The meeting on 10/20/10 attended by the monitoring team discussed results of record audits related to use of the new Seizure Record, individualization of HMPs, and clarification of the monitoring tool on medication administration. The nursing assessment and reporting protocols and processes at LSSLC would not be complete without the role and responsibilities of the RN Case Managers, Nurse Supervisors, Direct Care RNs, and Nurse Managers. These were the nurses who were responsible for data gathering and direct observations of individuals, documentation, collection, aggregation, and interpretation of these observations/data, and communication of these observations and data through assessments (verbal and written) to members of the individuals' personal support team (PST). If there were problems at this level of actual nursing assessment and reporting, there were problems at each and every level as were referenced above in sections M1, M2, and M3 of this report. Nursing assessment and reporting protocols sufficient to address the health status of the individuals served relies on organized data conducive to analysis for identification of changes in health status, early identification of emerging health problems, and measures on which to base an evaluation of a plan's effectiveness. In addition to the need for consistent and appropriate documentation of adequate assessment, intervention implementation and response, as well as resolution of health problems described in M1, M2 and M3, there were other data systems related to individuals' health status that were not consistently and appropriately implemented. These included weights, pulse, blood pressure, bowel elimination, and respiratory assessment data as reported in section M2 and M3. For example, bowel elimination data were to be documented daily and monitored by nursing staff daily. The most recent records provided for the 20 individuals in the sample included for 7/10 and 9/10. Daily monitoring and appropriate follow-up action by nursing were not consistently implemented and/or bowel elimination records were incomplete for Individual #191, Individual #389 who was rated at medium risk for constipation, Individual #444, Individual #385, Individual #60, and Individual #298. Bowel and Bladder Record forms used through 9/10 did not provide adequate information indicating a daily monitoring by nursing staff including the codes for no action or to see the nursing notes for an explanation of action taken.	

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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.	LSSLC had implemented the state approved health risk assessment rating tool and held regular health status team meetings. The Health Risk Assessment Rating Tool was to assess and identify each individual's level of risk (low, medium, or high) across a number of particular areas: seizures, aspiration, choking, medical, cardiac, constipation, dehydration, diabetes, GI concerns, hypothermia, osteoporosis, polypharmacy, respiratory, skin integrity, UTIs, weight, injuries, and their overall risk level. Additional rating tools were completed for risks associated with dental status. The rating tools were completed in conjunction with representative members of the individuals' PST. Health Status Team (HST) meetings were held to review and assign health risk ratings. Individuals' PSTs were not identifying and prioritizing health risks as a foundation for appropriate and consistent management. All 20 individuals whose records were reviewed were also reviewed in a timely manner by the HST with the coordination of the HST Coordinator, Nellie Matthews. All 20 individuals reviewed had multiple risks related to their health and/or behavior. Several written HST reviews completed more recently were more comprehensive with more realistic ratings of risk. Planning for and making changes and modifications to the system of identifying and tracking health risks for individuals at LSSLC as described in the baseline review were awaiting revisions to the state policy and procedure that were in process at the time of this review. Health risk ratings, as identified in the baseline review, were not consistently revised when significant changes in individuals' health status and needs occurred. Examples included the following : • Individual #96 had three hospitalizations since July 2010 related to significant respiratory problems most often aspiration pneumonia: 9/15/10-9/24/10 left lower lobe pneumonia, 8/8/10-8/13/10 bilateral aspiration pneumonia, and 7/14/10-7/23/10 aspiration pneumonia. Prior to these episodes, she was hospitalized with aspiration pneumonia twice in 8/09 and pneumonia and respiratory failure in 4/10. Her health risk rating for respiratory was assigned "high," but her risk rating level for aspiration remained low. She had had several Medical Care Plans requiring 24-hour nursing related to aspiration pneumonia and risk of aspiration. • Individual #146 had spent weeks in medical restraints, bilateral mittens, due to open lesions secondary to a chronic skin condition. Her health risk rating for skin integrity remained low. • Individual #440 had an HST review 7/22/10 with recommendations to assess whether her three routine and one PRN medication for constipation were required for management. There was no evidence of this follow-up assessment. Her health risk rating for constipation remained low. The medical concerns area was rated medium for the same reason injury and osteoporosis were rated medium, due to a fracture and fragile bones secondary to osteogenesis imperfecta.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Individual #215 was rated low for weight. His BMI was 32.3, he was 38 pounds overweight, and had lost one pound over the last year while on a 1200 calorie diet. • Individual #60 had a medium rating for medical concerns due to a hospitalization for severe symptomatic constipation and dehydration, yet the ratings in the areas of constipation and dehydration remained low. Her rating for weight was low despite a BMI of 33.9, weight of 214 pounds, 56 pounds above the upper end of her body weight range, a 1500-calorie diet, and a weight loss of only three pounds over the past year. She also had no HMP addressing her overweight condition, but did have one for hypertension. Her HST review 8/13/10 did not include listing her multiple medications for Intermittent Explosive Disorder, which were lithium, quetiapine, lorazepam, trazadone, and buspirone. Her rating for polypharmacy was low, but high for behavior challenges. • Individual #385 was reviewed by the HST 9/13/10 with all low ratings assigned. He had previously had medium ratings for aspiration, injury, osteoporosis, and challenging behavior. His seizure rating and polypharmacy rating remained low despite treatment with three antiepileptic medications and experiencing seven seizures for the year. The pharmacy had recommended a medium rating that was not accepted by the HST as a whole. • Individual #600 was reviewed by the HST 5/17/10 and her polypharmacy for schizoaffective disorder was not specified in the review (both olanzapine and oxcarbazepine). • Individual #172 was reviewed by the HST 8/24/10 and his polypharmacy for a seizure disorder was not specified in the review (phenobarbital and gabapentin). • Individual #387 had a medium rating for medical concerns specified in his review of 7/21/10 due to pain related to a fracture and presence of a g-tube, yet aspiration and respiratory were rated low even given the six pneumonias he experienced since 2/09, including two since 5/10, as were noted in his HST review. Please also see section I of this report.	
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	The administration of medication and the management of the medication administration system at LSSLC had undergone numerous changes since the baseline review including changes made during the week of this review when a new distribution system was initiated midweek on 10/20/10. The Pharmacy had been moved to a larger location. The implementation of a monthly	Noncompliance

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	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.	MAR instead of a weekly one had begun in September 2010. Pharmacy staff received additional training regarding the WORx system and improvements to the WORx system had been made. Also see section N Pharmacy Services below in this report. The effectiveness of these initial and recent changes to a system identified as "highly flawed" at the time of baseline will require further review and evaluation. The following comments from the baseline report continued to apply to the flawed nature of the medication administration system at LSSLC and the vast amounts of nursing effort and time that continued to be spent on maintaining this problematic system. • Nurses continued to check each individual order against the week's supply and handwrite any variance onto the physician's order on the MAR. In auditing the MARs for the sample of 20 individuals reviewed, the likelihood of a variance in the number of pills to complete a dose continued to be likely to change for at least one or two medications per individual at least 30% of the time. • One dose could be anywhere between one and 14 pills per dose. For instance, Dilantin was only stocked in 100 mg pills. If the person had an order for 400 mg, four pills would be required for a single dose. The number of pills per dosage had to be handwritten on the MAR each week by the nurse because the number of pills per dose could also vary from week to week. In nursing practice, whenever the number of pills or capsules required to administer a dose is more than two pills, the likelihood of medication errors increases substantially. The fact is that the number of pills needed to administer a dose at LSSLC not only frequently exceeded this total, but it was likely to change from week to week. Administration of additional numbers of pills also increases the risk of choking and aspiration for a large segment of the LSSLC population. • Orders for weekly weights, blood pressures, pulses, and any other data needed related to physicians orders had to be hand-printed on the MARs. Individuals who received sliding scale insulin based on blood sugars also had these individual orders hand printed on the MARs. Variance in the method and approach to recording this health data led to documentation that was often illegible and difficult to analyze for patterns or trends. This could contribute to errors and was an antiquated way of conducting this procedure. • More than 7,600 doses of medication per day were counted for two shifts by two nurses, and a third shift count occurred on four residences in Long Pine and in the Infirmary. The nursing practice standard of narcotic counts, which were done each shift by the outgoing and oncoming shift nurse, required 10 minutes per nurse. To count the cart to prepare for an administration, it took an hour to prepare (e.g., counting the number of drugs in each bin) before the nurse could	

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		administer the first medication. During the bin exchange, which was a separate weekly activity, nurses had to hand write instructions for the number of pills per person, and as was noted above, the vital signs (e.g., "take pulse before administering, if below 60, do not administer") on each individual MAR. • In a sample of 20 sets of MARs from the most recent quarter, each individual had medication orders requiring handwritten instructions. This monitoring team did not count them. • Despite improvements to the WORx system, the pharmacy continued to generate orders without the parallel instructions electronically so that a large amount of hand work was required. When electronic instructions were provided, there continued to be discrepancies from one individual's MAR to another, such as noting to give Actonel 30 minutes before a meal on one individual's MAR and not providing the instruction on another. As was identified in the baseline review, a modern system of medication administration, such as Pyxis, would eliminate individuals getting inaccurate doses of medication, which was happening at too high a frequency during the onsite monitoring review. According to the staff interviewed, pharmacy had the capacity to include instructions to replace the ones written by hand on the MAR by the nurses each week. This type of system would also eliminate the wrong medications being dispensed. In some cases, doses of 50 mg were mixed in with 25 mg pills. The system was not working and nurses were being set up to fail because the system was flawed. Nurses shouldn't have to count every pill in every drawer once every shift. The current system resulted in some of the following outcomes: • Nurses were spending hours per shift doing tasks that should be done electronically. • Nurses had a history of taking short cuts (e.g., setting up for the 4:00 pm and 8:00 pm medication passes in advance). One short cut was taken during this review (pre-pouring stock medications) that was strictly not in compliance with facility policy. • Serious and frequent errors were occurring that would most probably not be an issue if a modern system of dispensing both medications and comprehensive Medication and Treatment records was available to the facility. Eight of the last 10 reported medication errors were related to pharmacy system issues. As indicated in more detail below, there were areas of the medication administration management system found to be inconsistent with generally accepted professional standards of care. These areas will require additional analysis and intervention including proper completion of the MARs, appropriate administration and management	

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		of the medications (routine and PRN) by the nurses, and in the oversight of medication errors. The nursing department had implemented a system for routine monitoring of the MARs by RNs. A review of 20 individuals' medication administration records (MARs) and treatment administration records for July 2010 through September 2010, and for some individuals' MARs through 10/15/10, was completed. There was generally appropriate and accurate documentation of administrations as indicated by the nurse's initials in the appropriate space of the MAR or reason for not charting was present (i.e., without omissions, "holes," or "blanks"). The following omissions, however, were found during this onsite review: • Individual #288: 10/14/10 1200H Vitamin B complex, 8/25/10 1200H Primidone, 8/25/10 1200H Sucralfate, 8/18/10 1200H Vitamin B complex, 8/19/10 1200H Vitamin B complex, 7/29/101200H Sucralfate, and 7/22/10 2100 Calcium/Vitamin D • Individual #11: 8/30/10 1200H Calcium/Vitamin D, metoclopramide, and valproic acid, and 8/7/10 2100H oxcarbazapine • Individual #191: 10/3/10 0700H Calcium/Vitamin D, lactulose, and levothyroxine, 10/10/10 and 10/11/10 2100H Lanolin/oxyquinal ointment to g-tube stoma, 8/1/10 2100H Calcium/Vitamin D, lactulose, phenobarbital, ranitidine, semosides, and simvastatin, 8/1/10 and 8/2/10 1200H valproic acid, 8/2/10 0700H and 2100H Lanolin/oxyquinal ointment to g-tube stoma, and 7/710 2100H Lanolin/oxyquinal ointment to g-tube stoma • Individual #96: 10/12/10 Duoderm to ears bilaterally to be changed every three days, 9/19/10 1200H sucralfate, and 9/2/10 and 9/3/10 0730H and 9/5/10 2100H Albuterol/Ipratropium • Individual #146: 10/14/10 2100H lactulose, 9/9/10 2100H lactulose, 9/9/10 Bactroban ointment to moist area back of neck, and 7/2/10 0700H risedronate; and blanks on 10/14/10 2-10 shift, and 10/15/10 2-10 and 6-2 shifts to "avoid moisture to left neck wound. Pat dry with sterile 2x2 or 4x4 if site moist" • Individual #440: 10/13/10 2100H Colyte and sennosides • Individual #106: 9/29/10 1700H Coumadin • Individual #60: 9/26/10 2100H Tretinoin gel 0.01% topical, 8/11/10 0700H lactulose and levothyroxine, and 8/2/10 2100H buspirone and Calcium/Vitamin D • Individual #385: 7/26/10 1700H Diltiazem HCl and 7/19/10 and 7/20/10 2100H valproic acid • Individual #600: 10/11/10 0730H and 2100H Trileptal, 9/27/10 2100H olanzapine, 9/14/10 2100H docusate sodium and 9/1/10 2100H docusate	

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		sodium and olanzapine • Individual #444: 10/12/10 1700H Vitamin D, 10/9/10 1800H Insulin Glargine 100U vial, 4U, subcutaneous injection, 10/8/10 1200H Natural tears ophthalmic drops, 10/1/10 and 9/22/10 2100H Timolol/dorzolamide ophthalmic drops, and 7/28/10 2100H Pregabaline for neuropathic pain • Individual #296: 9/10/10 1200H Calcium/Vitamin D • Individual #389: 10/15/10 2100H cholecalciferol, 10/15/10 lacosamide and lactulose at 1700H and 2100H as well as his remaining 10/15/10 medications too numerous to list on the MAR dated 9/15/10 to 10/16/10, 10/1/10 sodium chloride tab 1200H, and 9/24/10 0700H pantoprazole • Individual #172: 9/28/10 1700H chlorpheniramine maleate, 9/28/10 1200H metoclopramide, 9/6/10 0730H and 9/28/10 2100H phenytoin sodium extended release, 9/19/10 and 9/30/10 1200H lanolin/oxyquinal ointment, and mineral oil ophthalmic drops on 9/28/10 2100H and 9/2/10 1700H and 2100H • Individual #174: 9/1/10 1200H sucralfate, 8/18/10 2100 choleccalciferol and ferrous gluconate, and 8/18/10 0700H antifungal cream to stoma • Individual #131: 10/12/10 1700H clonidine and metoprolol, 10/2/10 2100H risperidone, 8/26/10 0730H multi-vitamin, 7/15/10 0730H cholecalciferol, and 7/8/10 1700H clonidine, 9/21/10 2100H Benadryl, and 9/16/10 1700H metoprolol • Individual #387: 8/18/10 2100H tipiramate and 7/19/10 1200H simethicone and Januvia • Individual #298: 10/14/10 0730H Garamycin ointment, 9/18/10 0700H and 9/12/10 0730H pantoprazole The medication administration records (MARs) and treatment administration records reviewed did not contain adequate documentation of PRN (as needed) medication administration with potentially negative consequences to the individuals receiving and/or not receiving PRN treatment as prescribed. There were several examples of PRN medications being administered without a clear notation of the individual's complaint or condition that led to administration (i.e., not documented on the MAR or in an IPN), including assessment data appropriate to the presenting problem. Examples of medications given on specific dates without documentation of the reason for administration included: • Individual #288: Antacid oral suspension prescribed for indigestion, given 7/31/10 • Individual #191:Acetaminophen prescribed for pain or elevated temperature, given 10/12/10 0830H • Individual #106: Acetaminophen prescribed for pain or elevated temperature, given 10/3/10 1025H and 7/28/10 0830H; and, Triple antibiotic topical	

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		ointment, administered on 7/27/10 • Individual #60: Gentamicin topical ointment administered on 9/5/10, and acetaminophen prescribed for pain or elevated temperature, given 8/1/10 0715H and 1245H • Individual #385: Acetaminophen prescribed for pain or elevated temperature, given 9/21/10 2130H, Mycolog cream for g-tube stoma irritation administered on 9/19/10 1340H, and promethazine HCl rectal suppository given for vomiting 9/21/10 2130H • Individual #600: Acetaminophen prescribed for pain or elevated temperature, given 10/13/10 1625H and 10/14/10 1625H; multiple administrations of Tramadol prescribed for headache pain including 14 administrations in October 2010, eight in September 2010, seven in August 2010, and eight in July 2010 • Individual #444: Triple antibiotic topical ointment administered on 8/22/10 and 8/17/10 • Individual #389: promethazine HCl rectal suppository prescribed for vomiting administered on 8/5/10 at 0900H and on 7/26/10 at 1340H and loperamide prescribed for diarrhea given 8/2/10 1435H and 7/23/10 2335H • Individual #174: Acetaminophen prescribed for pain or elevated temperature, given 8/25/10 0700H, 8/12/10 2300H, and 8/8/10 0100H, and promethazine HCl rectal suppository prescribed for nausea/vomiting administered 8/12/10 • Individual #298: Vitamin A&D ointment for stoma inflammation for seven administrations 8/11/10 through 8/16/10 In the following examples from the same 20 records, documentation of administration of PRN (as needed) medications did not provide a clear notation of the individual's response to treatment, including the date and time of an appropriate follow-up assessment for effectiveness. No response or follow-up assessment for effectiveness was documented for: • Individual #288: Antacid oral suspension prescribed for indigestion, given 7/31/10; acetaminophen prescribed for pain or elevated temperature, given for elevated temperature 9/29/10 0745H • Individual #11: Fleet enema for no bowel movement in three days administered rectally 8/28/10 0420H • Individual #191: Acetaminophen prescribed for pain or elevated temperature, given for a headache on 10/12/10 1015H • Individual #440: Acetaminophen prescribed for pain or elevated temperature, given 10/12/10 0830H • Individual #106: Acetaminophen prescribed for pain or elevated temperature, given 10/3/10 1025H and 7/28/10 0830H; and triple antibiotic topical ointment administered on 7/27/10	

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		• Individual #60: Gentamicin topical ointment administered on 9/5/10; acetaminophen prescribed for pain or elevated temperature, given 8/1/10 0715H and 1245H • Individual #385: Acetaminophen prescribed for pain or elevated temperature, given 9/21/10 2130H, Mycolog cream for g-tube stoma irritation administered on 9/19/10 1340H, and promethazine HCl rectal suppository given for vomiting 9/21/10 2130H; acetaminophen rectal suppository was administered on 10/11/10 1515H for a temperature of 101.5 F with follow-up assessment at 1830H with his temperature remaining at 101.5F and O2Sats of 96% and the next follow-up assessment was not until 10/12/10 at 0530H with stable vital signs noted. • Individual #600: Acetaminophen prescribed for pain or elevated temperature, given 10/13/10 1625H and 10/14/10 1625H; multiple administrations of Tramadol prescribed for headache pain, including 14 administrations in October 2010, eight in September 2010, seven in August 2010, and eight in July 2010 • Individual #444: Triple antibiotic topical ointment administered on 8/22/10 and 8/17/10 • Individual #389: promethazine HCl rectal suppository prescribed for vomiting administered 8/5/10 0900H and 7/26/10 1340H and loperamide prescribed for diarrhea given 8/2/10 1435H and 7/23/10 2335H • Individual #174: Acetaminophen prescribed for pain or elevated temperature, given 8/25/10 0700H, 8/12/10 2300H, and 8/8/10 0100H, promethazine HCl rectal suppository prescribed for nausea/vomiting administered 8/12/10 • Individual #298: Vitamin A&D ointment for stoma inflammation for seven administrations 8/11/10 through 8/16/10; Mi-acid liberally to ostomy site administered 9/26/10 for rash under colostomy wafer; and ostomy supply powder administered to colostomy site on 8/16/10 at 2300H for one and one-half inches of redness and irritation around stoma site Other examples of medication management and administration from the same 20 records that did not meet generally accepted professional standards of care included: • Individual #288: Acetaminophen prescribed for pain or a fever >100.5 F every four to six hours was given on 9/20/10 at 1750H for a fever of 101.5. Follow-up assessment at 2150H included a continued high temperature of 101.8 rectally without additional administration. The reason for, and response to, administrations of acetaminophen on 9/18/10 and 9/28/10 were not signed. • Individual #11: Her prescribed bowel management plan included a Fleet (Na Phosphate) enema for the third day without a bowel movement and magnesium hydroxide (Milk of Magnesia) oral suspension on the 4th day without a bowel movement. These orders were not consistently administered as prescribed. On	

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		9/4/10, the 5th day without a bowel movement, a Fleet enema was administered with large/soft results. On 9/9/10, an enema was administered in response to an assessment of a vomiting episode noting she had not had a bowel movement since the 9/4/10 enema results. The results of this administration were not charted. On 9/12/10, three days later, both a Fleet enema and magnesium hydroxide oral suspension were administered "without significant results." An IPN at the time documented "no bowel movement in 3 days." On 9/16/10 documentation on the MAR indicated another enema was administered for no bowel movement since 9/8/10 with very large results. There was no further documentation in the IPNs. On 9/20/10, she again received an enema for no bowel movement since 9/16/10, on the fourth day, not the third day, without a bowel movement. • Individual #96: She had orders for as needed/PRN pseudoephedrine for systolic blood pressure less than 90 (i.e., for hypotension/low blood pressure). On 10/1/10, her blood pressure was 74/56 with no follow-up assessment. There was no accompanying IPN or documentation of follow-up assessments. No administrations as prescribed were documented given on 10/2, 6-2 shift, 84/60, 10/14/10 2-10 shift, 75/86 and 8/15/10, 6-2 shift, 89/54. • Individual #215: Septra DS was prescribed twice daily for a UTI. His MAR documented administration of the medication three times daily 8/13/10 – 8/17/10. • Individual #385: He had physician's orders for Diltiazem HCl twice daily for hypertension. The medication was to be held for a diastolic blood pressure below 60 (i.e., <60) or a systolic blood pressure of less than 110 (i.e., <110), which was not consistently administered as prescribed. This order had been transcribed incorrectly to the MAR and printed out incorrectly on MARs repeatedly using a larger than symbol, ">", instead of a less than symbol, "<", that caused errors and could have caused harm to the individual. It did lead to his 8/19/10 1700H dose being inappropriately held for a B/P of 118/72. His Diltiazem HCl was not held as ordered for several administrations including 8/8/10 B/P 105/73, 8/9/10 B/P 102/70, 9/24/10 B/P 108/82, and 9/25/10 B/P 106/66. • Individual #600: A Milk of Magnesia for constipation administered 8/12/10 at 1200H was documented in her IPN, but not on the MAR. • Individual #444: She had insulin dependent Diabetes mellitus , Type 2, with physician's orders for regular insulin on a sliding scale, including administering 12 Units of regular insulin for blood glucose (i.e., blood sugar) levels over 400 and notifying the physician. Several times when her blood glucose was above 400 and 12 Units of insulin were given, there was no documentation of notification of the physician. These included 10/8/10 @2100H 450 blood sugar,	

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		9/29/10 @ 1200H 403 blood sugar, 9/24/10 @1700H 443 blood sugar, 9/19/10 @1700H 401 blood sugar, 8/14/10 @1700H 401, and 8/10/10 @1200H 440 blood sugar. • Individual #172: He had physician's orders for metoprolol tartrate twice daily for hypertension. The medication was to be held for a diastolic blood pressure below 60 (i.e., <60) or a systolic blood pressure of less than 110 (i.e., <110). His metoprolol tartrate was not held as ordered for the following administrations in September 2010: @0730H - 9/5/10 B/P 100/72, 9/9/10 B/P 98/67, 9/11/10 B/P 105/66, 9/15/10 B/P 100/64, 9/16/10 B/P 96/64, 9/21/10 B/P 104/75, 9/24/10 B/P 95/58, 9/25/10 B/P 97/59, 9/26/10 B/P 92/63, 9/29/10 B/P 97/56, and 9/30/10 B/P 106/70, and @2100H - 9/1/10 B/P 107/72, 9/2/10 B/P 100/?? (measure was illegible), 9/4/10 B/P 101/60, 9/6/10 B/P 107/79, 9/9/10 B/P 100/64, 9/10/10 B/P 108/70, 9/11/10 B/P 97/59, 9/14/10 B/P 100/74, 9/16/10 B/P 102/58, 9/17/10 B/P 108/60, 9/22/10 B/P 108/78, 9/29/10 B/P 92/56, and 9/30/10 B/P 106/70. A similar frequency of this type of error was noted for August 2010 as well. He also had orders for as needed/PRN pseudoephedrine for systolic blood pressure less than 90 (i.e., for hypotension/low blood pressure). On 8/7/10 his MAR documented two administrations for systolic blood pressure of 88/58 at 0715H and 88/60 at 1315H. There was no accompanying IPN or documentation of follow-up assessments. On 9/25/10 pseudoephedrine was administered for a blood pressure of 97/59 and metoprolol was not held, inconsistent with physician's orders for both medications. • Individual #174: An extra 90 mg dose of phenobarbital was administered to this individual on 10/5/10 at 2200H and stable vital signs were reported. His physician was notified and he was to be on sick call the next morning. Documentation of a follow-up assessment and vital signs was at 0215H on 10/6/10, four hours later. There was no consistent facility-wide method of documenting the verification of physician orders on medication and treatment records including 182-day orders. Transcription errors lead to medication administration and/or monitoring errors. As was noted earlier in this section of the report, there were also a large number of transcriptions and handwritten changes required to printed MARs with inadequate, incorrect or inconsistent electronic information. As was noted this practice also increases the risk of errors. Use of the new monthly MAR form to document PRN medication and treatment administration was initiated in September 2010. The forms were generally inadequately completed to meet the standard of documentation required for each administration,	

#	Provision	Assessment of Status	Compliance
		including the date and time of, and reason for, administration, and signature and title of the administering nurse. Documentation must also include the individual's response to treatment including the date, time, and type of follow-up assessment, as well as assessment results and the signature of the nurse evaluating response. The PRN medication portion of the form did not provide adequate writing space or directions on completion to include the date and time of follow-up assessments for response to as needed treatment. The observations of medication administration were conducted on Homes 559A, 559B, and 557A and for medications administered via the enteral route on Homes 549A and 549B. One nebulizer treatment was observed at Home 539 administered by the respiratory therapist. During all observations, nurses properly washed and disinfected their hands prior to medication administration and between individuals, they identified the individuals receiving medications, provided appropriately thickened liquids, and they did not initial medications on the MAR prior to the individuals' receipt of the medications. With one exception described below, nurses presented the medication as prescribed in the proper form, such as crushed and mixed with applesauce or pudding. Nebulizing treatments and associated documentation did not include appropriate pre and post treatment assessments, including vital signs, breath sounds, and PO2 Sats (oxygen levels) when indicated. Appropriate blood glucose testing using a glucometer and insulin administration were observed on 557A. For enteral administration of medications (549A and 549B), individuals' nurses checked their stoma sites and abdomens for signs of distension, pain, and skin breakdown, checked the positions of the individuals and their feeding tubes, appropriately flushed and clamped their feeding tubes, and properly administered the individuals' medications in accordance with their physician's orders and facility policy. Medications administered via gastrostomy tube were not administered with a 10cc flush between medications, per the Texas Health Monitoring Instrument. During the observations, medications were administered in the individual's room at bedside or with the individual, nurse, and medication cart surrounded, often precariously, by a portable screen set up in common living areas of the homes. The screens were inadvertently knocked over by other individuals in the environment several times on 559B and 557A. The monitoring team observed that this attempt at preserving privacy may present a greater potential for errors and accidents. Morning medication administration on 559A and 559B was reported by the nurses working in these residences to start at 7:00 am. Morning medication times had recently been changed in physicians' orders from 0700H to 0730H to facilitate more timely	

#	Provision	Assessment of Status	Compliance
		administration. It was noted by nursing staff and administration that the acuity of individuals and the number of medications received by individuals on this unit, including those given enterally, had increased over the past year. Five nurses were present, including four LVNs and one RN, to administer the medications. One of the LVNs administered medications to individuals who receive them enterally (via g-tube), utilizing a medication cart set up for that purpose. Medication administration began at 7:00 am. At the end of the monitoring team's observation at 0810H on 559B, at least 12 individuals had yet to receive their medications, increasing the likelihood of late administrations. During the medication passes observed, with the exception of one nurse, there was minimal to no interaction with the individuals regarding the medication, their health, or their general condition. Some individuals were given a choice of flavors, such as for vanilla or chocolate pudding to mix with medications. Other interactions with the individuals were primarily general instructions to "take this" or "finish this" while directing the individual to finish swallowing solid or liquid medications. It was generally not a person-centered process. The medication passes observed included several areas which were inconsistent with generally accepted professional standards of care as described below: • Many oral medications (tablets and/or capsules) were presented by the nurse together in a medicine cup and swallowed together in a single mouthful, presenting a choking risk to individuals. • During the observation on 559A one individual (Individual #519) was to receive Divalroex (Depakote) for seizures, an antiepileptic medication in delayed release tablet form. There were physician's orders and instructions on his MAR not to crush this medication. The administering nurse was stopped from crushing the medication by the monitoring team. The administering nurse had been previously crushing these medications and reported she was unsure if the individual could swallow the large whole tablets. The whole tablets were successfully presented in pudding and swallowed. • During the observation on 559B, one individual's (Individual #106) multiple vitamin and Vitamin D had been pre-poured. • During the observation on 557B at 1200H, the medication cart was observed to be left unattended with liquid medications on top of the cart, but the drawers of the cart were locked. The nurse had gone into an adjoining room to call for insulin dosage verification. Medication administration monitoring and observation by the nursing department included implementation of the Medication Administration Observation checklist. RNs	

#	Provision	Assessment of Status	Compliance
		periodically directly observed and monitored medication administration. Approximately 200 checklists completed from 4/6/10 through 8/2/10 were reviewed. There was no summary of the data. The form did not consistently indicate if the nurse was tenured or a new hire. Completed checklists did not indicate if a partial or complete medication pass was observed. Two observation checklists that were completed included a notation the observation was of an entire medication pass. The checklist did not include items related to cleanliness of the medication room, refrigerator, or cart. The checklists had an unclear scoring system that was inconsistently completed. The scoring system was inconsistent with the items, such that a total of the "Positive Items Scored" would not include positive actions on the part of the nurse (such as item #22: "If the person receiving a medication is on the DO NOT CRUSH list, did the nurse or CMA attempt to crush the med?)" The answer of "no" to this item was a positive and appropriate nursing action, but would not be included in the "Positive Items Scored." For the checklists reviewed, there were very few items checked as errors in administration. Comments to further explain errors were inconsistently and rarely provided. There was no summary or analysis of the data with documented follow-up as indicated. Several areas indicated for follow-up would be the eight nurses not providing stoma care, including observations on 7/21/10, 7/23/10, and 8/2/10. Six to seven nurses had not used a privacy screen or a privacy screen was not available to them during medication administration and/or had not communicated with individuals in a low voice in private (i.e., behind the privacy screen). Five observations of medication administration by LSSLC nurses were completed in July 2010 using the Texas Health Monitoring Instrument, Medication Administration Observation section. The two items scored "no" several times related to not administering 10cc of water between medications given via g-tube, and not informing direct support staff to keep the individual upright at least at 45 degrees after g-tube administration of medications. Additional medication administration observations were completed by the QA Nurse in July 2010 using the Texas Health Monitoring Instrument, Medication Administration Observation section, and from 4/27/10 through 9/7/10 using the Medication Administration Observation checklist. Results were similar to those described above with a small number of nurses not providing stoma care or flushes between medications given enterally. Identified medication errors were complicated by problematic pharmacy systems and inconsistent transcription methods. Graphic summaries of medication error data provided by the Chief Nurse Executive were reviewed, including Medication Errors from	

#	Provision	Assessment of Status	Compliance
		4/21/10 through 9/2/10. The most recent graphic error data was presented by the Chief Nurse Executive. Medication Error Committee meeting minutes from 4/27/10 through 8/11/10 were reviewed. For 7/1/10-7/31/10, nursing errors reviewed by the committee were generally related to administering the wrong dosage and omitting administrations. There were 19 wrong drug dosage administration errors, including administering more than prescribed of valproic acid, carbamazepine and divalproex (antiepileptics), and Septra (an antibiotic). There were 27 errors of omission in administering medications, including trazadone and Zoloft (antidepressants), Seroquel (an antipsychotic), and carbamazapine (an antiepileptic). For 6/1/10-6/30/10, errors reviewed by the committee were generally related to administering the wrong dosage and omitting administrations. There were 17 wrong drug dosage administration errors, including administering more than prescribed of phenytoin (an antiepileptic), risperdal (an antipsychotic), and megestrol acetate (Megace, for significant underweight condition). There were 14 errors of omission in administering medications, including lithium carbonate (mood stabilizer)and levetiracetam (Keppra, an antiepileptic). There were similar types and numbers of errors in May 2010. Another area identified in these reports related to administration to the wrong individual. There were 10 wrong person errors from 9/1/09 through 8/31/10 with two occurring in the most recent quarter. The most recent error analysis by the nursing department, dated 9/2/10, when compared to the 4/21/10 analysis, indicated a slight decrease in the percentage of these error types, but the frequency of both types of errors had risen. Further analysis, evaluation, and problem solving were needed. The analysis data provided also identified 231 pharmacy dispensing errors for the fiscal year and an increase in the percentage of errors by the pharmacy department from 4/21/10 at 27% to 9/2/10 at 55%.	

Recommendations:

1. The facility needs to provide a modern system of drug distribution, that is fully implemented and effectiveness evaluated. The facility should consider an electronic MAR with all individualized instructions printed on the document. This should be within the capabilities of the current system.

2. The facility should continue its efforts to develop the processes necessary for the generating data that can be accurately interpreted, analyzed, and are reflective of the practices being measured (i.e., quality assurance processes as they related to this provision of the Settlement Agreement).

3. The facility should re-evaluate the current healthcare planning approach including the reliance on standard plans. The facility's system for

health management plan development and implementation need to be revised to provide person-centered goals as well as individualized and specific interventions with a clear direction for data collection and analysis.

4. As required by Sections G and F of the Settlement Agreement, the Nursing Department should collaborate with other disciplines regarding care, so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in all treatment plans.

5. The facility should develop and implement clinically sound competency-based training for nursing assessment, health management planning, and documenting implementation. Once training is completed, the facility should provide ongoing proficiency monitoring and job coaching to nursing staff as required to ensure levels of performance that are consistent with professional standards of care and state policy.

6. As is recommended with regard to Section I of the Settlement Agreement, 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, teams need to conduct integrated team reviews, and develop appropriate proactive treatment plans to address identified areas of risk.

7. Documentation, particularly the DAP charting as specified in the Health Care Guidelines, needs to be trained and monitored until nurses are implementing this process more systematically. The facility should consider developing a process for unit nurses to review individual records for DAP charting and provide feedback to one another on the quality of that documentation

8. The facility should re-evaluate the medication administration process for inclusion of more person-centered approaches and more appropriate and safe methods of providing privacy.

9. The facility should revise and/or implement policies, procedures, and protocols with regard to medication administration monitoring to ensure current medication administration policies and procedures are fully and consistently implemented. The nursing department should provide observation of complete medication passes during implementation of the Medication Administration Competency Checklists. The data should be aggregated and analyzed to facilitate corrective action.

10. The facility should revise and/or implement policies, procedures, and protocols with regard to medication administration in order to ensure consistent administration of PRN medications, including appropriate and complete notations of the reason for and response to the medication given. Audits of PRN medication administration should be included in daily RN MAR audits.

11. The scoring key to the Braden Scale should be included on the nursing assessment form, the scoring key included next to the total score (i.e., 12 or less high risk, 13-15 moderate risk, $\geq$ 16 minimum risk).

12. The nursing department should continue efforts to coordinate and collaborate with the QA Department to best utilize the QA Nurse and Program Compliance Coordinator

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o LSSLC Nursing Policy and Procedure Manual, Medication Error Reporting, revised 11/11/09 o LSSLC Pharmacy Policy and Procedure Manual, date 7/00 o Medication Error Review Committee Summaries o Pharmacy and Therapeutics Committee Meeting Minutes, 6/14/10 and 8/18/10 o Texas Department of State Health Services, Medication Audit Criteria and Guidelines Revised April, 2010 o Texas Department of State Health Services, Drug Audit Checklist, Revised April 2010 o Quarterly Drug Regimen Reviews, MOSES and DISCUS forms for the following individuals: • Individual #454, Individual #147 Individual #431, Individual #321, Individual #492, Individual #485, Individual #352, Individual #135, Individual #468, Individual #551, Individual #172, Individual #507 Individual #283, Individual #288, Individual #361, o Drug Utilization Evaluations for the following drugs: • Risperidone • Lithium • Vitamin D • Benzodiazepines o Adverse Drug Reaction Report, dated 6/14/10 Interviews and Meetings Held: o David Leeves, R.Ph., Pharmacy Director o Abimbola Farinde, Pharm.D, Clinical Pharmacist o Brian Carlin, M.D., Medical Director o Mary Bowers, R.N., Chief Nursing Executive Observations Conducted: o Tour of pharmacy o Review of returned medications
	Facility Self-Assessment: The facility's self-assessment POI for section N found all items to be in noncompliance. Drug regimen reviews, adverse drug reaction reporting, and side effect monitoring tools were all implemented, but were lacking in clinical robustness.

	Based upon observations, interviews, facility touring, review of documents, the monitoring team finds the facility's self-assessment of noncompliance in all areas to be accurate.
	Summary of Monitor's Assessment: The facility demonstrated progress in several areas. Drug regimen reviews had been completed in a timely manner as well as the MOSES and DISCUS scales. Work was needed to improve the actual content of these tools in order for them to become even more clinically relevant. Primary care providers were not responding appropriately to information contained in these documents. The adverse drug reporting system was lacking tools to provide an objective determination of the occurrence of an adverse drug reaction. Only two reports were submitted over the span of a year and the system had not been fully developed. The pharmacy department appeared to complete all required components in the process of filling medication orders, but had no documentary evidence to support compliance. Medication errors were being reported and corrective actions were documented. The focus on the causes of errors was individual employees. Little attention had been given to how the current systems contribute to employee error. This resulted in multiple employees having similar types of errors.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed	The pharmacy was fully staffed with a pharmacy director, clinical pharmacist, pharmacist, and four pharmacy technicians. The pharmacy director described the following process for filling medication orders: 1. Orders were faxed to the pharmacy. 2. The technician would call the nurse to verify the order if there were problems with the order. 3. The technician entered the order into WORx. 4. The pharmacist received the order with the label and verified the order. 5. If there was a problem with the order, the pharmacist would contact the nurse for clarification, or the prescriber. The prescriber would be contacted if there was an issue such as a drug interaction. Clarification was documented on the order form by the pharmacy director. The physician order sheet was the only place that communication with the prescriber was documented. The pharmacy director and clinical pharmacist were both unfamiliar with the Single Patient Intervention Report and its use to document and track communication with practitioners, information provided, and responses. They	Noncompliance

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	dosage is not consistent with Facility policy or current drug literature.	reported receiving training on WORx but did not recall this capability.	
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.	Drug regimen reviews were completed quarterly by the clinical pharmacist. During discussions with the clinical pharmacist, pharmacy director, and medical director, the clinical pharmacist indicated that the scope of the drug regimen review was not clear. She had contacted other facilities and received examples of their DRRs and noted that the content of the DRRs varied among facilities. She indicated that more guidance was needed in order for the facility to comply with the requirements of the Settlement Agreement. Drug Regimen Reviews were consistently completed and recommendations were given related to therapeutic duplication, ordering of lab studies, dosage schedules, appropriateness of indications, and polypharmacy. Several concerns were identified in the records reviewed: • The format of the comments and recommendations made it difficult for the reader to differentiate between comments and actual recommendations. Each DRR was a continuation of the previous review. For example, the review of the 3rd quarter included all previous recommendations. This resulted in recognition of the most recent recommendation being difficult to determine. In many of the DRRs, the recommendations were presented as questions, such as "might a CMP be warranted?" • The information included in the DRRs was not consistent. In some cases, individuals receiving AEDs had drug levels listed. In other cases, the AED levels were not included in the DRRs. For those individuals who were seizure free for many years, there were no recommendations regarding consideration of tapering the drugs. • Sub-therapeutic drug levels were not always noted (e.g., Individual #551, Individual #361). • Important parameters for drug monitoring in certain drug classifications were not always included. Weights and BMI were not documented for persons receiving new generation antipsychotics. Monitoring for indications of metabolic acidosis was not documented for persons receiving Topamax. • Signatures of the pharmacist completing the review were absent on some documents (e.g., Individual #507, Individual #288, Individual #352, Individual #485). Prescriber response to recommendations was not always adequate. The inability to clearly distinguish the new recommendations may have contributed to this finding. The formatting of recommendations and lab values should allow the reader to clearly detect	Noncompliance

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		when values are abnormal and understand what recommendation is being made to address the abnormality.	
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.	The quarterly drug regimen reviews included information on the use of polypharmacy as well as the risks associated with use of the new generation antipsychotic medications. The pharmacy director, clinical pharmacist, and medical director reported that no stat drugs were used. Cholinergic burden was not addressed in the drug regimen reviews. The DRR worksheet provided instructions to use facility specific lab monitoring criteria or refer to the DSHS Medication Audit Criteria. The DRRs included in the record sample had evidence that laboratory values were monitored and recommendations were made to the physicians, but the monitoring was not consistent. The drug regimen reviews did not produce any data for analysis related to benzodiazepine use or adverse drug reactions associated with the new generation antipsychotics. Results of the reviews were not documented in the Pharmacy and Therapeutics Committee minutes. The facility implemented a Psychoactive Medication Polypharmacy Review Committee. The first meeting was held on 9/1/10. The meeting was attended by the medical director, chief of psychiatry, clinical pharmacist, and an associate psychologist. The meeting minutes did not contain any discussion of polypharmacy. The minutes documented that the committee would meet every six months to discuss issues related to psychotropic medications within the facility and discuss polypharmacy.	Noncompliance
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	The format of the drug regimen reviews was revised in recent months, such that the prescribing physicians were required to indicate agreement or disagreement with the recommendations of the pharmacist. If the physician disagreed, an explanation was required on the form. The most recent four DRRs were reviewed for the individuals listed. The majority of these contained some comments and/or recommendations by the pharmacist. Most of the documents reviewed did not include any response on the part of the practitioner other than a signature. The following are examples of recommendations/comments and practitioner responses: • Individual #492 (12/9/09) o Recommendation: Decrease ativan due to long term high dose use o Practitioner: Accepted	Noncompliance

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		• Individual #352 (5/21/10) o Recommendation/Comments: Decrease Vitamin D due to elevated calcium levels o Practitioner: Accepted. o There was no response to the same recommendation on the two earlier reviews. • Individual #507 (10/20/09) o Recommendation/Comments: Annual labs ordered, but are not in chart o Practitioner: No response, signed • Individual #507 (10/20/09) o Recommendation/Comments: Recommend repeating FBG o Practitioner: No response, signed • Individual #283 (4/23/10) o Recommendation/Comments: Recommend checking lipids since last done 2008 o Practitioner: No response, signed o Lipids done 4/29/10 • Individual #283 (12/4/09) o Recommendations/Comments: Need CMP o Practitioner: No response, signed • Individual #288 (6/15/10) o Recommendation/Comments: Recommend checking vitamin D level o Practitioner: No response, signed o Vitamin D level checked 7/9/10 • Individual #135 (6/2/10) o Recommendation/Comments: Check lipids (on statin for treatment) o Practitioner: No response, signed o Lipids done 8/26/10 • Individual 485 (3/25/10) o Recommendation/Comments: Recommendation to change dose of Simvistatin due to elevated lab values o Practitioner: No response, signed	

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		• Individual #431 (7/29/10) o Recommendation/Comments: Recommend increasing glucophage o Practitioner: No response, signed • Individual #321 (6/16/10) o Recommendation/Comments: Recommend increasing time between levothyroxine and calcium/vitamin o Practitioner: No response, signed	
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.	The MOSES and DISCUS rating scales for the past year were reviewed for 10 individuals. Over the past 12 months, both tools were consistently completed in a timely manner. In a few instances, the forms were incomplete or lacked a nursing signature. The majority of the forms either stated that no action was necessary or contained no comments at all on the part of the provider. This occurred even when there was some evidence of side effects related to drug use.	Noncompliance
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	The adverse drug reaction log maintained by pharmacy documented two adverse drug reactions. The adverse drug reaction report contained information presented to the Pharmacy and Therapeutic committee. It was dated 6/14/10. The first ADR was reported on 6/11/09. Verapamil and metoclopramide were considered as possible causes of galactorrhea. The medications were continued and galactorrhea was reported to have resolved. The second ADR was reported on 4/12/10. Vancomycin and clindamycin were considered as possible causes of an allergic reaction – rash. The clindamycin was discontinued on 4/12/10 and both medications were added to the individuals' allergy list. No serious adverse drug reactions were reported. The ADR report did not provide important information needed to determine the probability of an adverse drug reaction, such as improvement with withdrawal, time of event related to administration of a drug, or objective findings, such as a prolactin level in the individual with galactorrhea. The intent of adverse drug reporting is to (1) inform healthcare providers about ADRs to	Noncompliance

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		improve patient care, (2) identify trends to prevent future ADRs, and (3) provide the FDA and manufacturers with ADR reports when appropriate. Key requirements of an ADR Monitoring and Reporting System include: • A program that is ongoing and concurrent with reporting of suspected ADRs by pharmacists, physicians, nurses, and patients • Identification and monitoring of drugs likely to cause ADRs • Use of probability scale to categorize each ADR • Investigation of suspected ADRs to determine the probability that the drug caused the symptoms • Severity established by a ranking system • Review of all ADRs by a designated committee, such as the P&T Committee • Dissemination of information to health care professionals for educational purposes • Data collection, analysis, and trending both aggregate and individual data with results being incorporated into the facility's quality improvement program Revision of the facility's policy is needed and should reflect the fact that the reporting of adverse drug reactions is a facility wide process that should result in several ADRs being detected and reported yearly. Criteria for which of those ADRs should be reported to the FDA should be included in the procedure. Implementing an effective ADR reporting and monitoring system that provides useful information for the facility will require training of all healthcare personnel. LSSLC staff were made aware of this need during the onsite review.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The facility completed drug utilization evaluations on the following drugs: • Risperidone • Lithium • Vitamin D • Benzodiazepines The following is a summary of the DUE findings: • Risperidone (date of evaluation November 2009 – April 2010) – risperidone was selected for evaluation due its frequent use and use of higher than recommended dosages. Fifty individuals were receiving risperidone with four individuals receiving dosages greater than 6 mg/day. o Conclusion: Only eight residents were on higher than recommended dosages and all had a DISCUS and MOSES completed to assess for side effects. Information to be shared with medical staff. Recommendations:	Noncompliance

#	Provision	Assessment of Status	Compliance
		Continue to monitor for side effects. • Lithium (date of evaluation April 2009 – April 2010) – The objective of the evaluation was to assess for appropriateness of indications for lithium therapy, presence of contraindications, and dosing guidelines. Sixteen individuals received lithium and all were evaluated. o Conclusion: Doses were individualized and determination made through clinical judgment with all doses being within the recommend dosage ranges for lithium therapy. Four percent of individuals were on lithium therapy for clinically acceptable diagnoses and treatment. Ten residents (62.5%) of individuals had a documented relative contraindication of unspecified hypothyroidism with lithium therapy. o Recommendations: Caution should be exercised with individuals who have a relative contraindication to lithium. Proper monitoring should be followed. • Vitamin D (date of evaluation December 2009 – June 2010) – the objective of the review was to analyze the dosages of vitamin D that were provided to individuals to determine if they fell within acceptable recommended guidelines or can lead to potential toxicity. One hundred fifty individuals received vitamin D. One hundred forty individuals received Vitamin D for supplementation purposes while 10 received it for treatment of a vitamin deficiency. o Conclusions: The majority of individuals received vitamin D within an acceptable dosing range. o Recommendations: When selecting vitamin D, consider use of vitamin D3 over D2. Recommend obtaining vitamin D level more often than annually. • Benzodiazepines (date of evaluation January 2010 – July 2010) – The objective of the DUE was to determine which benzodiazepines were frequently being used in the facility. One hundred fifty one individuals received benzodiazepines. o Conclusion: Lorazepam was the most prescribed benzodiazepine (44%) and, in more than 75% of cases, a benzodiazepine was prescribed for the treatment of an anxiety disorder as an adjunct to a psychiatric diagnosis. o The use of benzodiazepines for all diagnoses should be monitored closely for adverse side effects and dosage reductions should be performed when possible and limit to short term use when possible. The Pharmacy and Therapeutics Committee meeting minutes dated 6/14/10 documented discussion of the lithium DUE. The minutes from the 8/14/10 meeting	

#	Provision	Assessment of Status	Compliance
		documented some discussion of the DUE on Vitamin D. The DUE on risperidone did not appear to be discussed at either meeting, although it found that four individuals received dosages higher than recommended. The DUEs are a means of improving medication use with the facility. The process must be systematic and structured to assure a continuous and consistent approach to drug use. The use of the drugs must be measured against predetermined criteria established by experts. Once data has been analyzed, it is important to take corrective actions and to assess the effectiveness of those actions. Given the fact that there may be a lapse in time from completion of the DUE to the reporting in the P&T Committee, it is imperative that individual specific data be provided to the practitioner for immediate correction. Communication of relevant information to the appropriate persons is a fundamental step in the process. All DUEs should be presented at the Pharmacy and Therapeutics Committee meeting because this is the body that governs the process. The facility had not set a calendar for completion of future DUEs.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	The facility collected data on medication errors and reviewed those data as part of the Medication Error Review Committee. The system, however, had significant flaws in data collection, analysis, and corrective actions. The Medication Error Committee met biweekly to discuss medication errors. Participants included the chief nurse executive, medical director, nurse managers, pharmacy director, lead pharmacy technician, and the QA nurse. The following are examples of errors and concerns documented in the minutes: • 3/10/10 o LVN admitted that she gave 8 mg of diazepam rather than 2 mg ordered during the 0700 med pass. o Pharmacy errors- 10 errors where not enough medication was sent at cart exchange; one error where too much medication was sent at cart exchange and two errors where the wrong medication was sent. • 7/14/10 o Nurse gave extra dose of Lamotrigine 10 mg at 12:05pm. Error was self-reported. ▪ Beginning on 6/17/10, this individual's Depakote 500 mg x 3 was given incorrectly. On some days, it appeared that she did not receive enough and other days received too much. The	Noncompliance

#	Provision	Assessment of Status	Compliance
		count was wrong for six days in a row and several different nurses were giving the medication on different days. • 7/28/10 o Error occurred three times each day. The dosage was 500 mg but it should have been 1500 mg as ordered. o 40 mg of Prilosec was ordered, nurse gave one tab when two tabs were needed to complete the ordered dosage. Patient only received 20 mg. • 8/11/10 o LVN self reported that she gave an extra dose of .5 mg Ativan to the individual during the 2100 med pass. The minutes contained suggestions, such as changing how medications are delivered to the homes and changing the system so that nursing prints out the MARS. The majority of the corrective actions were employee-specific and included coaching, training, and establishing competency. The chief nurse executive reported that graphs had been recently added to the analysis of data. The graphs reviewed were primarily bar graphs. The graphs were labeled, but did not provide any indication of the time period represented by the graphs. Trending could not be established. Graphs included percentage errors by department, error type, med errors by unit, and med errors by shift. No control charts were included in the graphs submitted. Proper data analysis is essential to correction of the problems. The data must be presented in a format that allows for analysis. Longitudinal data is important to determine if corrective actions have made an impact. The MERC minutes documented that the same types of errors occurred. Attention should be given to this as a function of systems. A medication use system must include checks to offset the human error that will eventually occur. During discussions with the chief nurse executive, medical director, and pharmacy director, it was clear that much of the problems were attributed to employee error. Little discussion or corrections had been targeted at systems issues.	

Recommendations:

1. The pharmacy must determine how to document that the appropriate steps have occurred in filling medication orders. Additional training is needed on the capabilities of the WORx software and the use of the Patient Single Intervention Report.

2. An ADR reporting and monitoring system should be developed.
    a. This is a comprehensive program that requires reporting by all healthcare practitioners, not just pharmacy staff.

b. A data collection tool is needed to assist staff in detecting and reporting suspected ADRs. The tool should include a probability scale, a severity scale, and individual outcome thresholds.
c. All data should be reviewed by the P&T Committee and submitted to the facility's quality department.

3. Additional work is needed in the area of medication errors.
    a. All errors, potential and actual, must be reported.
    b. Accurate data are needed. Graphs and data should contain the appropriate information, including the time span of the data.
    c. Data should be analyzed for trends and corrective actions taken. While individual accountability is important, greater emphasis should be placed on examination of the current processes. Mapping out these process may prove to beneficial in determining gaps in the current processes that are worthy of correction.
    d. Data should be provided to the facility's quality department for analysis.

4. The Drug Use Evaluation system must be developed to fulfill the requirements of the Health Care Guidelines. The Pharmacy and Therapeutics Committee should provide oversight for the system. The committee should set the calendar for evaluation of drugs and all DUEs completed should be reported to the committee.

5. The agency's drug regimen review system must be evaluated. The reviews, if more substantial in content, could provide valuable resources to clinicians. The revision process should include input from the medical staff. The facility should revise its lab matrix to include all parameters for monitoring. Collaboration with other facilities may prove to be beneficial for the pharmacy director and clinical pharmacist.

6. The Polypharmacy Review Committee has the responsibility of oversight for ensuring appropriate justification for the use of polypharmacy. That will require a meeting frequency greater than twice a year.

7. The results of the side effect rating tools should be incorporated into the evaluation and treatment decisions for medical, psychiatry, and neurology practices. The medical director should track compliance with this requirement and take corrective action as necessary.

8. Staff responsible for quality improvement and performance improvement initiatives should be provided appropriate training on data integrity, data analysis, and performance improvement methodology.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **<u>Documents Reviewed</u>:** o DADS Physical Nutritional Management policy #012, 12/17/09 o DADS At-Risk Individuals Policy #006, 10/05/09 o Habilitation Therapy Registered Therapist list o Continuing education documentation for PNMT members o List of Individuals with PNMPs/Profiles o PNMPs submitted o Dining Plans submitted o Assistive Equipment List (9/8/10) o Inventory PT Equipment (7/6/10) o Inventory PT Equipment (9/9/10) o Adaptive Eating Equipment for LSS (7/15/10) o Long Distance Wheelchairs o Primary Mobility Wheelchairs o Individuals Evaluated for New Seating Systems o List of Individuals Who Have Received New Seating Systems o List of PNM Assessments completed in last two quarters o PNMP Monitoring Sheets submitted o Pneumonia report o HST assessment Rating Levels 9/3/10 o 2009/2010 Wound Clinic Spreadsheet o Falls list (9/7/10) o Past three Months Injuries (9/7/10) o OT/PT Evaluations and Mat Evaluations for the following: • Individual #599, Individual #202, Individual #539, Individual #225, Individual #36, Individual #361, Individual #447, Individual #28, Individual #202, Individual #265, Individual #397, Individual #546, Individual #502 o OT/PT Evaluations for the following: • Individual #47, Individual #549, Individual #458, Individual #375, Individual #511, Individual #441, Individual #437, Individual #247, Individual #43, Individual #344, Individual #425, Individual #195, Individual #336, Individual #502, Individual #104, Individual #334, Individual #191, Individual #339, Individual #161, Individual #24, Individual #467, Individual #232, Individual #96, Individual #36, Individual #52, Individual #172, Individual #361, Individual #560, Individual #265, Individual #298, Individual #447, Individual #43, Individual #195, Individual #417, Individual #188,

	Individual #262, Individual #353, Individual #476, Individual #379, Individual #574, Individual #13, Individual #16, Individual #351, Individual #137, Individual #488 o PSPs for the following: • Individual #43, Individual #13, Individual #344, Individual #425, Individual #195, Individual #336, Individual #262, Individual #188, Individual #417, Individual #353, Individual #336, Individual #137, Individual #195, Individual #425, Individual #351, Individual #476, Individual #379, Individual #574 o Functional Eating and Swallowing Skills assessment template o Individuals whose diets have been downgraded during the past 12 months o MBSS reports and associated documentation submitted o MBS database o NMT meeting sign in sheets/Nutritional Management Team Reports: **1/21/10, 2/11/10,** 4/21/10, 4/28/10, 5/11/10, 5/12/10, 5/19/10, 6/23/10, 6/30/10,7/28/10, 8/24/10and 8/31/10 o List of individuals with enteral nutrition o Choking Incidents in Past Year (9/7/10) o Choking Incident documentation o Health Status List o BMI Equal to or Greater than 30 o Fecal Impactions in the Last 12 Months (9/10/10) o Individual Oral Hygiene Assessments by Dental Staff (9/10/10) o Weight Loss of 10% or more in six months o Dining Plan inservice training sheets o List of individuals with falls in the last 12 months o Mealtime Observation Sheets o PNMP Monitoring Sheets o Tube Feeding Orders o New Employee Orientation training curriculum (mealtime new and old versions) o Habilitation Therapies Inservice Training Competencies for Mealtimes o Personal Record documents including: Personal Support Plans and Addendums, Integrated Progress Notes (previous three months), Physicians Annual Medical reviews, Active Problem list, Significant Past Medical History, HST Assessment Tools, Comprehensive Nursing Assessment, Quarter Nursing Quarterly Assessments for the last PSP year, Habilitation Therapies section, PNM Monitoring for the last six months year, Mealtime Monitoring for the last six months, Communication monitoring forms for last six months • Individual #35, Individual #256, Individual #488, Individual #196, Individual #322, Individual #41, Individual #216, Individual #438, Individual #148, Individual #435, Individual #411, Individual #347 Individual #523, Individual #405, Individual #268, Individual #164, Individual #431, Individual #589, Individual #59, Individual #486, Individual #331, and Individual #212 o Choking event follow-up documentation for Betty Howard, Ola Johnson, Donise Chappell o Modified Diet List

	o Thickened Liquids list o Dining Plan template **<u>Interviews and Meetings Held</u>:** o Christina Pedroni, MS, CCC-SLP, Habilitation Therapies Director o Kristi Hodges, MS, CCC-SLP o Catherine Ratcliff, RD o Leighann Johns, RD o Rhonda Hampton, MA, CCC-SLP o Sharon Setzer, OTR o Lisa Barnes, MS, CCC-SLP o Candace Crawford, MS, CCC-SLP o Jeremy McKnight, OTR/L o Cassidi Hairgrove, OTR/L o Brenda Webb, COTA/L o Jason Burson, COTA/L o Jennifer Burson, COTA/L o Gail Harris, PT o Maria Nash, PT o Various Supervisors and Direct Support Staff **<u>Observations Conducted</u>:** o Living areas o Mealtimes o Habilitation Therapies clinic areas o NMT meeting o PNMP Clinic o Wheelchair Clinic
	Facility Self-Assessment: LSSLC's self-assessment identified noncompliance for all items of this provision. Per the POI reviewed, the primary issues cited the development of new processes as the rationale for unsuccessful completion of the action steps outlined. This self-assessment was consistent with the monitoring team's assessment of noncompliance. A new PNMT process was in development. LSSLC had identified the team members and had held a planning meeting prior to this onsite visit by the monitoring team. Subsequent meetings will be held to begin implementation of the new directives from the state office in this regard. The existing NMT functions were to be integrated into the PSP process within the next month.
	Summary of Monitor's Assessment: The process used to establish health risks continued to be inconsistent across the HST and NMT. A new

	system for risk assessment had been developed, but was not yet in place statewide. There was also a new draft policy developed by the state to provide for a Physical Nutritional Management Team (PNMT) with an implementation date of 9/1/10. A PNMT assessment for one individual had been initiated by the PNMT at LSSLC and a follow-up was planned after the onsite review by the monitoring team was completed. Currently, individuals who received direct and indirect PNM and OT/PT supports received annual OT/PT assessments in addition to medical, nursing, and nutritional assessments provided annually to each individual. Assessment was not specifically driven by level of health risks. These were discipline-specific assessments with the exception of the OT/PT assessments, and little collaboration at the time of assessment was noted among professional staff for any individual, and especially for those at highest risk. PNMPs and Dining Plans were developed by the QMRPs in most of the homes at LSSLC based on findings documented in the OT/PT and communication assessments, although habilitation therapies staff was responsible for taking the pictures. Based on observations of individuals during meals across a variety of homes, there continued to be concerns for staff implementation of interventions and recommendations outlined in the mealtime plan portion of the PNMP. Primary concerns for positioning and alignment were also noted and related to staff not positioning the pelvis back in the seat, posterior tilt of pelvis, and inadequate foot support. By report, the mealtime aspect of new employee training had been undergoing revision to be more competency-based. Specific skills requiring demonstration were outlined, and a form had been developed to document this. Some of the inservice outlines were "read and sign" for staff and others highlighted those specific competencies were to be demonstrated. There was no mechanism to ensure that staff training occurred as outlined in the training plans when not conducted by Habilitation Therapies staff. The training for supervisors and home managers will be critical as it was observed that these staff did not consistently provide oversight and coaching for the direct support staff they were responsible for. Monitoring was conducted to address mealtimes, as well as communication, transfers, and positioning in the homes. No monitoring was completed related to bathing, medication administration, or oral hygiene. Mealtime monitoring conducted was noted on the mealtime observation forms. There was no existing policy that outlined the process of monitoring, identifying the roles and responsibilities of monitors, training and validation of monitors, frequency, distribution, documentation, or follow-up and communication of findings. The NMT did not specifically review aggregated findings across homes for trend analysis to drive system change and training. There was no system in place to conduct trend analysis to consistently review if interventions had a positive outcome on an individual's health status. They also did not review overall incidence of health concerns such as aspiration pneumonia, use of bowel management aides, weight loss/gain, falls, fractures, and so forth over time to address system outcomes as a result of interventions and supports.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner,	**Standard: PNM team consists of qualified SLP, OT, PT, RD, and, as needed, ancillary members (e.g., MD, PA, RNP).** Minutes from the Nutritional Management Team (NMT) meetings were dated 3/31/10 to 8/31/10. Though not clearly specified, the core members of the Nutritional Management Team (NMT) listed as attending these meetings included the following: • Kristi Hodges, MS, CCC-SLP • Catherine Ratcliff, RD • Leighann Johns, RD • Rhonda Hampton, MA, CCC-SLP • Sharon Setzer, OTR • Lisa Barnes, MS, CCC-SLP • Nancy Jo Flournoy, MS, CCC-SLP (no longer employed at LSSLC at time of this review) A variety of nurses, QMRPs, PNMPCs, psychologists, and others attended these meetings depending on who was being reviewed by the Committee. Meetings were held on 3/24/10, 3/31/10, 4/21/10, 4/28/10, 5/11/10, 5/12/10, 5/19/10, 6/23/10, 6/30/10, 7/28/10, 8/25/10, and 8/31/10. On average, there were 15-22 staff who participated in the meetings. There were no physical therapy or physician members. The team chairperson at the time of this review was Kristi Hodges, MS, CCC-SLP. A meeting was observed by the monitoring team during the week of this onsite review. The format of the meeting was consistent across each meeting and included a summary for each individual reviewed. This included NMT issues, the annual staffing month, date of an MBS, diet order, and EDWR. The current review date, reason for review, and discussion/recommendations was included for each individual and for each date he or she was reviewed by the NMT. A memo was sent out to notify members of the meeting in advance with a listing of the individuals scheduled for review. This process of review was going to be transitioned to the PST. Guidelines for this were not yet developed and further review by monitoring team will be necessary in subsequent onsite visits. **Standard: PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.** Per state policy, meetings were to be held at least monthly, with additional meetings held	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	related to the following: eating/health problems, changes in risk level by the HST, after esophagrams or other medical or diagnostic tests, before finalizing treatment decisions, to address follow-up activities, and at any phase in the Nutritional Management process. Based on a review of NMT meeting documentation, it was noted that this group had typically met at least one time monthly since 3/31/10. There was no evidence that the team convened for any additional meetings to address other specific issues that came up for an individual in the interim.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	**Standard: A process is in place that identifies individuals with PNM concerns.** The process used to establish health risks was inconsistent across the HST and NMT. A new system for risk assessment had been developed, but was not yet in place statewide. Review of this system will occur during subsequent onsite monitoring visits. There was a new draft policy developed by the state to provide for a Physical Nutritional Management Team (PNMT) with an implementation date of 9/1/10. A PNMT assessment for one individual had been initiated and a follow-up was planned after the onsite review by the monitoring team. The effectiveness of this new process will be further evaluated in subsequent reviews. Existing risk identification continued to be a concern. Per a list submitted, there were nine individuals who experienced 12 choking events since 9/14/09. Individual #191, Individual #507, and Individual #457 had each experienced two such events during that period. Documentation of follow-up for each choking case had been requested, though was only submitted for three individuals. In each of these cases, a chairside evaluation was conducted by the SLP no later than the next day, though not before the next meal. A review by the NMT at the next scheduled meeting was also noted, however, no one at LSSLC was considered to be at high risk for choking. Only 12 individuals were considered to be at medium risk and all others were considered to be low risk, including those who had experienced one or more actual choking events in the last year. There were 40 individuals who had experienced one or more incidents of pneumonia in the last 12 months per the list submitted, dated 9/7/10. Approximately 50% of these incidents were identified as aspiration pneumonia events. Individual #339 (2), Individual #96 (2), Individual #36 (2), Individual #232 (2), Individual #172 (4), Individual #173 (2), Individual #170 (2), and Individual #52 (2) were listed with two or more incidents of aspiration pneumonia. Only two individuals were listed at high risk for aspiration, including Individual #172 and Individual #170. There were approximately 38 individuals identified at medium risk for aspiration, including Individual #52 listed above with two incidents of aspiration	Noncompliance

#	Provision	Assessment of Status	Compliance
		pneumonia in the last year. All others were listed at low risk, including the other five individuals listed above with multiple incidents of aspiration pneumonia. No one was identified at high risk for weight concerns. There were 27 individuals listed at medium risk, yet there were over 60 individuals listed with a BMI of 30 or greater and another 43 who had experienced an unplanned weight loss of 10% or more over a six month period since 1/1/10. No one was listed with a BMI of 20 or less. Only 11 of these individuals were listed at risk relative to weight and the others were considered to be at low risk. There were at least 12 individuals with one or more pressure ulcers in the last year. There were 26 individuals identified at medium risk for skin integrity. All others were considered to be at low risk with no one at high risk relative to skin integrity. Only Individual #560, Individual #586, Individual #570, and Individual #265 were included at medium risk, while Individual #187, Individual #147, Individual #141, Individual #298, Individual #172, and Individual #36 had been listed with incidents of pressure ulcers. Some of these had been persistent over many months. Individuals who received direct and indirect PNM and OT/PT supports received annual OT/PT assessments in addition to medical, nursing, and nutritional assessments provided annually to each individual. Assessment was not specifically driven by level of health risks. These were discipline-specific assessments, with the exception of the OT/PT assessments, and little collaboration at the time of assessment was noted among professional staff for any individual, and certainly not for those at highest risk. As described above, there was a new draft policy developed by the state to provide for a Physical Nutritional Management Team (PNMT). This was to include a comprehensive assessment by the team that included the OT, PT, RD, SLP, and nurse. Further review of this area will occur as this system evolves.	
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	**Standard: All persons identified as being at risk and requiring PNM supports are provided with a comprehensive Physical and Nutritional Management Plan (PNMP).** There were approximately 322 individuals who were listed with PNM needs and PNMPs. The facility-wide system, HST, of risk did not appear to consider actual incidence of a concern, but rather the designation of risk appeared to be more driven by meeting frequency rather than actual risk or incidence. These risk designations also did not drive review by the NMT and there was little integration of that team with the HST. Per the HST risk levels, there were only 10 individuals with a high risk designation in any area, per the list submitted dated 9/3/10. These included Individual #172 (aspiration and medical concerns), Individual #36 (medical concerns), Individual #170 (aspiration and	Noncompliance

#	Provision	Assessment of Status	Compliance
	positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	medical concerns), Individual #129 (medical concerns), Individual #393 (cardiac), Individual #365 (challenging behavior), Individual #31 (challenging behavior), Individual #444 (Diabetes and medical concerns), Individual #463 (diabetes), and Individual #389 (seizures). The NMT used an entirely different method to designate risk and it did not correlate with those used by the HST. It was understood that the HST system and was under current revision to address these issues and further review of integration of these two systems will be indicated in the future. All assessments were discipline specific and comprehensive PNM assessments were not completed at this time. The new PNMT assessments were intended to be focused on those at high risk and will be reviewed during the next onsite visit by the monitoring team. The PNMP contained information related to the focus, hearing/vision, assistive equipment, communication, mobility, transfers, movement instructions, and positioning, as well as mealtime instructions. The plans were dated and, in some cases, these dates were highlighted, indicating a change in the plan, though this was difficult to interpret. The majority of the plans reviewed were current within the last 12 months, though the dates of the plans were not generally changed to correspond with the date of the annual PSP. This would be indicated whether or not the plan was modified. In the event that a plan was changed in the interim, a revised date should be used. Criteria considered to develop a comprehensive individual record sample of 18 individuals at risk included some or all of the following: • Emergency Room visits • Hospitalizations • NMT Committee meeting documentation • Individuals with active pressure ulcer within the last six months • Individuals with severe dysphagia • Individuals with chronic constipation or who experienced fecal impaction within the last six months • Individuals with unexplained weight loss or BMI ≤ 20 • Individuals ≥ BMI of 30 • Individuals who experienced a choking incident which required abdominal thrust within the last six months • Individuals with a diagnosis of aspiration pneumonia • Individuals who have experienced significant falls related to transfers and/or ambulation • Individuals with chronic respiratory infections • Individuals with chronic dehydration	

#	Provision	Assessment of Status	Compliance
		• Individuals with a diagnosis of osteoporosis and/or osteopenia • Individuals who experienced a fracture • Reviewer observations of mealtime, positioning, transfers, medication administration, tooth brushing, personal care and functional communication The individuals selected included Individual #298, Individual #172, Individual #170, Individual #36, Individual #339, Individual #96, Individual #232, Individual #52, Individual #191, Individual #560, Individual #104, Individual #447, Individual #502, Individual #161, Individual #334, Individual #265, Individual #467, and Individual #24. The PNMPs submitted for each of these individuals was reviewed with findings as follows: • PNMPs for 17 of 18 individuals in the sample (94%) were current within the last 12 months. There was no plan submitted for Individual #339 and was listed as having a profile rather than a PNMP, though he was listed with two occurrences of aspiration pneumonia, on 2/28/10 and again on 3/16/10. • In 17 of 17 of PNMPs reviewed (100%), mobility was addressed, though in more detail in some plans than others. In 17 of the 17 PNMPs reviewed (100%), of individuals who used a wheelchair, specific positioning instructions for wheelchair and/or alternate positions instructions were included. • In 16 of 17 PNMPs reviewed (95%) of individuals who required transfer assistance, the type of transfer was included. "N/A" was documented under transfer for Individual #298 though he required use of a walker and a gait belt for ambulation. • In 3 of 17 PNMPs reviewed (18%), the PNMP listed bathing instructions concerning use of a wedge during bathing. This was not, however, listed under equipment. In a number of cases, there was reference to "flexibility" at bath time. It was understood that this was intended to mean that joint movement was provided by staff during bathing. No other instructions for positioning or bathing equipment were noted. • In 14 of 17 PNMPs reviewed (82%), handling precautions or instructions were included. Three of the plans stated none or that this was not applicable to those individuals. • In 17 of 17 PNMPs reviewed (100%) instructions related to mealtime or assistive equipment were included. This was referred to as "feeding" instructions or equipment. Six of the 17 individuals (36%) received all of their nutrition via gastrostomy tube and nothing by mouth, so oral intake instructions were not indicated. • In 16 of 17 PNMPs reviewed (95%), diet orders and, in many cases, snack guidelines were included. The diet order for Individual #52 was not indicated on her plan. She received enteral nutrition.	

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		• In 1 of 17 PNMPs reviewed (6%) the liquid consistency was indicated. Individual #298's plan indicated that he received honey thickened liquids, but according to the list submitted regarding thickened liquids, no modifications were identified for him. Individual #24's plan indicated she should receive lemon ice before and after each bite consistent with the liquid modification list submitted. Individual #334 was to be served liquids thickened to a thin milkshake consistency and he was to be offered lemon ice before and throughout his meal. Individual #161 was to be served honey thickened liquids and Individual #265 was to receive nectar thickened liquids with lemon ice during his meal. None of these instructions were included in their PNMPs. These instructions were also not listed on Individual #265's Dining Plan. Dining plans for the others were not submitted. • In 17of 17 PNMPs reviewed (100%), assistive mealtime equipment was addressed. In the case that an individual was enterally nourished and received nothing by mouth, "none" was documented, indicating that the individual did not require assistive mealtime equipment. • In 0 of 21 PNMPs reviewed (0%), strategies for medication administration were included. • In 0 of 21 PNMPs reviewed (0%), strategies for oral hygiene were included. • In 7 of 21 PNMPs reviewed (42%), individual dining positioning was addressed in the plan. There were no instructions offered for those who received enteral nutrition. • 17 of 17 PNMPs reviewed included a heading related to communication, though information included was very limited and did not address strategies for staff to use to communicate with the individual. **Standard: PNM plans were incorporated into individual's Personal Support Plans.** Information from discipline specific assessments was included in the assessment portion of the PSP, including OT/PT, Nutrition, Speech, Medical, and Nursing, among others. Findings and recommendations were generally listed there. In 83% of the PSPs reviewed, there was also a section under the General Discussion Record that addressed review of the PNMP, however, in most cases, there was a statement that indicated that the PNMP was reviewed. In only two cases, was there documentation of what specific changes were required. In the case of four individuals, there was no documentation regarding the PNMP or that it had been reviewed by the PST. These included Individual #232, Individual #560, Individual #334, and Individual #24. In many cases, the PNMP date had not been changed to reflect the current PSP.	

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		Standard: PNMPs are developed with input from the IDT, home staff, medical and nursing staff. Individuals who had received PNM supports were reviewed prior to the annual PSP meeting to complete assessments/updates and to address changes needed in the PNMP. These findings were documented in the OT/PT and SLP assessment reports. Recommendations were listed in the assessment sections of the PSP. By report, further discussion and review were conducted during the PSP meeting with other team members though, as reported above, this was not always well documented in the PSP. Bathing, oral hygiene, and medication administration were not addressed in the PNMPs. **Standard: PNMPs are reviewed annually at the PSP meeting, and updated as needed.** In 14 of 17 PSPs reviewed (82%), there was a section in the General Discussion Record of the PSP that included a PNMP heading. As described above, however, the review documentation was very limited.	
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.	**Standard: Staff implements interventions and recommendations outlined in the PNMP and/or Dining Plan.** PNMPs and Dining Plans were developed by the QMRPs in most of the homes at LSSLC based on findings documented in the OT/PT and communication assessments, though the Habilitation Therapies department was responsible for taking the pictures. Habilitation Therapies was, however, responsible for the development of these plans in Woodland Crossing and Lone Pine, as well as Home 506. Based on observations of individuals during meals across a variety of homes, there continued to be concern for staff implementation of interventions and recommendations outlined in the mealtime plan portion of the PNMP. Some examples are presented below: • Individual #221 was observed drinking from a large full size glass rather than from the four ounce one prescribed on her dining card. These cards had been discontinued and all individuals were supposed to be provided a Dining Plan. • Individual #4 (Hidden Forest) was to be served food cut in pieces no larger than a quarter. The pieces prepared for him were larger than that. • Individual #371 did not have a dining plan, but rather a card. Staff did not look for the it until noticing that the monitoring team was observing. Only two were found for the four men seated at the table. • Individual #23 was prescribed chopped foods with ground meat. The fruit she was served was pureed. By report, the fruit was processed rather than hand chopped. She was seated with three other individuals who received regular food	Noncompliance

#	Provision	Assessment of Status	Compliance
		and there was no staff supervision provided. • A training objective for Individual #91 was to "hold a serving utensil with her right side with no prompts 25 days in a row." Staff prompted her to pour from a pitcher using her left hand. • Individual #417, Individual #504, and Individual #66 were to receive foods cut in pieces the size of a quarter. She was served whole peach slices that had not been cut by staff. • Individual #11 was presented bites of food that were larger than the teaspoon size outlined in her Dining Plan. Upon prompting, staff adjusted the bite size appropriately. Staff was also observed to scrape the food off on Individual #11's teeth. When prompted, she adjusted this technique and Individual #11 effectively closed her lips on the spoon. • Individual #467 was presented pudding thick liquid rather than thin milkshake as prescribed in her Dining Plan. Her head was back in significant hyperextension that staff indicated was safe for her per the therapist. Individual #467 was observed to cough while drinking the thinner liquids and staff was directed by the Habilitation Therapies Director to provide support to her head. She continued to cough, so this was reported to a nurse who responded that she was a floater and did not know who she was. She walked away assumedly to find another nurse, but never came back. An RN was contacted who proceeded to conduct a physical examination. • Individual #334 was to receive thin milkshake-like liquids, but was served liquids that were thicker than prescribed. His chopped fruits and vegetables appeared to be over processed. • Individual #128 was to use a junior built-up handled spoon, but was using a regular metal teaspoon. When asked, staff reported that her spoon was missing, there was no backup, and a replacement had been requested a couple of months ago. This was reported to have been done on the PNMP sheets and the documentation log sheet. • Individual #61, Individual #104 and Individual #179 were missing adaptive mealtime equipment for over two months according to the supervisor. She indicated that this also had been reported numerous times. • Individual #447 was served ground meat on two pieces of bread. His plan designated that bread should be cut in quarter size pieces. It was noted that the PNMPC observing at the table did not notice this error. The monitoring team asked the staff about his plan and prompted her to cut the bread according to his plan. • Individual #77 was not provided a straw for her beverage as prescribed in her Dining Plan until staff were prompted to do so. • Individual #265 was using a high sided dish. His plan directed that the high side	

#	Provision	Assessment of Status	Compliance
		should be positioned away from him, but it was on the side closest to him. He was to have his glass filled only one quarter full but it was over half full. The lemon ice prescribed was not provided until staff were prompted to do so. • Individual #161 supposed to be in a regular dining chair according to her plan. She was seated in a sling seat and back wheelchair. Staff reported that she refused to transfer after returning from the Senior Center. • A roller knife prescribed for use by Individual #335 was missing. The staff stated that this had been reported, but a replacement had not been received. • Individual #85's Dining Plan instructed that he should not receive any pudding or pudding-like textures. He was eating thick mashed potatoes. He was in a wheelchair with his legs and feet extended off the foot rests. His plan indicated that he should sit in a regular chair for meals. He was using a large tablespoon to eat. This was not prescribed in his plan. He was observed to cough throughout the meal. • Individual #211 was not to drink nectar thickened liquids. Ice cream was at her place. Staff was instructed to not serve her the ice cream by the Habilitation Therapies Director when this was pointed out by the monitoring team, • Staff were to fill Individual #459's glass only one quarter full. It was two thirds full. Staff had to be prompted to correct this. • Individual #433 was assisted to drink fluids at a fast rate from a cut-out cup. There were no instructions regarding this on her Dining Plan. • Individual #211 was to be presented food with pressure down on her tongue. This was not provided by staff assisting her. Rather than present fluids throughout the meal they were presented to her all at the end. • Individual #502 was being assisted hand-over-hand to eat. The staff ended the meal though there was most of the food still on the plate. When asked about this the staff stated that Individual #502 was through with her meal. She was prompted by the Habilitation Therapies Director to try some more. The staff offered Individual #502 bites of food which she readily accepted. The staff again ended the meal after only a few bites. The staff was again prompted to continue. Individual #502 continued to eat her meal and there were no refusals noted. It was of great concern that this staff would have ended this meal had she not been observed and prompted to continue. Wheelchair positioning instructions were not specific in the PNMPs. Limited instructions identified that individuals should remain upright, described the angle of recline, and the type of transfer to be used. General practice guidelines with regard to transfers, seatbelt use, position and alignment of the pelvis, and consistent use of foot rests and seat belts were taught in New Employee Orientation.	

#	Provision	Assessment of Status	Compliance
		Primary concerns for positioning and alignment were related to not positioning the pelvis back in the seat, posterior tilt of pelvis, and inadequate foot support. There was no precision with regard to position and alignment, and staff did not appear to be attentive to this, particularly during mealtimes. Alternate positioning was not observed other than seating in a recliner. Trial use of tear drop bean bags was planned and there was some evidence of assessment for this for some individuals, however, by report, this had not yet been implemented because staff were not yet trained. Some references in PSP and PNMPs were noted with regard to use of bean bags. Medication administration and tooth brushing instructions were not included in the PNMP. **Standard: Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP.** Dining plans were generally out on the tables during the meals. A few staff were able to verbalize the rationale for specific strategies they were using as directed in the PNMP and/or Dining Plan, however, many did not appear confident and, as described above, there were numerous errors in implementation suggesting that staff did not fully understand the importance of these plans and the risks presented by the individuals they served.	
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.	**Standard: Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff.** By report, the mealtime aspects of new employee training were undergoing revision to be more competency-based. Specific skills requiring demonstration were outlined and a form had been developed to document this. The lifting and transfer sections continued to have skills-based competencies and were a requirement for re-training every two years. A mealtime refresher was to be initiated in December 2010 for home managers and charges. It was to be a one and a half hour class. A standard had been established that direct support staff were not permitted to assist at mealtimes unless they had been trained to assist they individual via an individual-specific inservice. **Standard: 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.** Competency-based training was in development and further review of progress in this area will occur in subsequent onsite reviews by the monitoring team. **Standard: All foundational trainings are updated annually**.	Noncompliance

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		Only lifting training was updated after initial NEO training, but only on an every two year basis at this time. A new mealtime refresher was to begin in December, but only for home managers and charges at this time. **Standard: Staff are provided person-specific training of the PNMP by the appropriately trained personnel.** Initial staff training was conducted by Habilitation Therapies for available staff. Training sheets for dining plans were requested, but only the templates were provided. Some of these were "read and sign" for staff, and others highlighted those specific competencies that were to be demonstrated. There was no mechanism to ensure that staff training occurred as outlined in the training plans when not conducted by Habilitation Therapies staff. **Standard: 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.** Staff training was not currently competency-based, so while staff may have received some level of training for implementation of PNMPs for those at high risk, it was not performance-based, and did not require successful performance of clearly established competencies. Training was not consistently effective as evidenced by the numerous implementation errors noted by the monitoring team and described above. **Standard: Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.** There was a policy that staff had to be trained prior to working with an individual at mealtime but based on the numerous implementation errors observed and described above, this did not appear to be effective.	
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.	**Standard: A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.** There was no policy that related to the process of monitoring. **Standard: Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities).** Monitoring was conducted to address mealtimes, as well as communication, transfers, and	Noncompliance

#	Provision	Assessment of Status	Compliance
		positioning in the homes. No monitoring was completed related to bathing , medication administration, or oral hygiene. Mealtime monitoring conducted was noted on the mealtime observation forms. There was no existing policy that outlined the process of monitoring, identifying the roles and responsibilities of monitors, training and validation of monitors, frequency, distribution, documentation, or follow-up and communication of findings. There had been a tremendous number of monitoring sheets completed in the last three months, predominately by the PNMP coordinators and a very few by professional staff. There was no method to track the frequency of observation conducted for specific individuals who were considered to be at highest risk. **Standard: All members of the PNM team conduct monitoring.** Evidence of formal monitoring by the PNM team was limited. Only a few sheets were submitted by professional staff. By report, informal monitoring occurred on an ongoing basis but documentation was inconsistent and related most often to a specific problem identified by the PST or PNMPC. **Standard: 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.** There was no mechanism to track data for system analysis in order to focus training and coaching. The NMT did not utilize PNMP or mealtime monitoring information in their reviews. The NMT did not specifically review aggregated findings across homes for trend analysis to drive system change and training. There was no system in place to conduct trend analysis to consistently review if interventions had a positive outcome on an individual's health status. They also did not review overall incidence of health concerns, such as aspiration pneumonia, use of bowel management aides, weight loss/gain, falls, fractures, and so forth over time to address system outcomes as a result of interventions and supports. **Standard: Immediate intervention is provided if the person is determined to be at risk of harm.** There was an expectation of immediate intervention when a individual was determined to be at risk of harm. When present during observations by the monitoring team, the QA monitor and Habilitation Therapies Director were observed to intervene when the PNMP, particularly the dining plans, were not properly implemented by direct support staff. Home supervisors were generally not observed to intervene unless prompted to do so.	

#	Provision	Assessment of Status	Compliance
		There was no mechanism to track training related to, communication of, or follow-up to concerns noted during monitoring.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	**Standard: A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk.** The NMT assigned a nutritional risk level for each individual reviewed. The team did not appear to complete a specific screening tool for this, but it appeared to be driven by the identified need for follow-up intervals as described above. The HST screening was completed every six months. The PST was to meet monthly on those deemed to be at highest risk. The HST screening system also reviewed a variety of health risk concerns. These two systems were not integrated and were inconsistent. By report, both systems were being revised by the state and further review will be necessary during subsequent reviews by the monitoring team. **Standard: Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.** Unless an individual participated in direct therapy, there was no consistent interval of review of other supports for those individuals who presented with PNM health risk indicators by professional staff. In the case that an individual participated in direct therapy, a monthly progress note was written, but functional and measurable goals were not identified in most cases and very few individuals received this. There was no system of monitoring of PNMP effectiveness for those at highest risk.	Noncompliance
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.	**Standard: All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status.** There were at least 55 individuals listed as receiving nutrition and hydration enterally. There was no evidence that there was a specific PST or NMT review of those who received enteral nutrition on annual basis, however, there was generally a statement in the OT/PT assessment to this effect. **Standard: People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above.** All individuals who received non-oral intake had been provided a PNMP that included the same elements described above. Specifics related to their intake, however, were not	Noncompliance

#	Provision	Assessment of Status	Compliance
		included in each of the PNMPs submitted and some inconsistencies were noted as described above. **The need for continued enteral nutrition is integrated into the PSP.** Based on a review of 18 PSPs in the individual record sample, there were six who received enteral nutrition and nothing by mouth. These individual's PSPs did not document the rationale for the continued need for enteral nutrition, however, other than in the recommendations offered in the OT/PT assessments. **Standard: 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.** This was not indicated for the individuals in the sample for this review. Further analysis of this will be conducted during a subsequent review by the monitoring team. **Standard: A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT).** There were no facility policies that defined the frequency and depth of evaluations related to an individual receiving enteral nutrition. **Standard: Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake.** The intent of the PNMP and dining plans was to provide consistent and effective supports to minimize the incidence of aspiration, oral intake to promote weight maintenance, and positioning and assistance techniques to ensure safe eating and drinking.	

Recommendations:

1. Continue to refine the development of staff training competencies in the area of PNM. The recently developed checklists were a good start for the mealtime aspect but competencies in other aspects of the PNMP will also be needed.

2. Ensure that the monitoring system is based on individual-specific needs; those at higher risk should be monitored with greater frequency. Include a mechanism to document recommendations for follow-up and a means to document closure on issues identified. This often works well when this is included on the form used to monitor.

3. Ensure that re-validation of monitors occurs on a regular basis to ensure consistency and accuracy.

4. Conduct trend analysis of all monitoring data. Review findings and make system adjustments. Consider review of trends as a role for the PST and PNMT.

5. PNMT assessment and review should focus on PNM concerns with follow-up through to problem resolution. Set outcome measures with regard to specific risk indicators and timeframes for achievement. For example, Mary will be pneumonia free for six months. Interventions should support achievement of identified outcomes. The PNMT should continue to monitor until the individual attains and maintains at the goal level. This may become more easily integrated with the new process.

6. Ensure that annual review of those who receive enteral nutrition is outlined clearly for the PSTs as this will likely become a function that they will be responsible for this process.

7. Integrate instructions for staff related to bathing , medication administration and oral hygiene in the PNMP.

8. Consider modifying the current practice of initial staff training conducted by Habilitation Therapies with subsequent staff training by supervisors and home managers. Many of these were "read and sign" for staff and there was no mechanism to ensure that staff training occurred as outlined in the training plans when not conducted by Habilitation Therapies staff. This should improve as specific competencies are outlined but home management staff will require additional training regarding how to train others and the competency check-off process to ensure the integrity of the training passed off to them by the clinician.

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** **<u>Documents Reviewed</u>:** o Habilitation Therapy Registered Therapist list o Continuing education documentation for OTs and PTs o DADS Policy, Occupational/Physical Therapy Services #014P, 11/04/09 o Pneumonia report o HST assessment Rating Levels 9/3/10 o 2009/2010 Wound Clinic Spreadsheet o List of Individuals with PNMPs/Profiles o PNMPs submitted o Individuals Receiving Direct PT Services and Focus of Intervention o Individuals Receiving Direct OT Services o Assistive Equipment List (9/8/10) o Inventory PT Equipment (7/6/10) o Inventory PT Equipment (9/9/10) o Adaptive Eating Equipment for LSS (7/15/10) o Long Distance Wheelchairs o Primary Mobility Wheelchairs o PNM Monthly log template o Individuals Evaluated for New Seating Systems o List of Individuals Who Have Received New Seating Systems o List of PNM Assessments completed in last two quarters o PNMP Monitoring Sheets submitted o Occupational/Physical Therapy Evaluation/Evaluation Update template o Falls list (9/7/10) o Past three Months Injuries (9/7/10) o OT/PT Evaluations and Mat Evaluations for the following: • Individual #599, Individual #202, Individual #539, Individual #225, Individual #36, Individual #361, Individual #447, Individual #28, Individual #202, Individual #265, Individual #397, Individual #546, and Individual #502 o OT/PT Evaluations for the following: • Individual #47, Individual #549, Individual #458, Individual #375, Individual #511, Individual #441, Individual #437, Individual #247, Individual #43, Individual #344, Individual #425, Individual #195, Individual #336, Individual #502, Individual #104, Individual #334, Individual #191, Individual #339, Individual #161, Individual #24, Individual #467, Individual #232, Individual #96, Individual #36, Individual #52,

	Individual #172, Individual #361, Individual #560, Individual #265, Individual #298, Individual #447, Individual #43, Individual #195, Individual #417, Individual #188, Individual #262, Individual #353, Individual #476, Individual #379, Individual #574, Individual #13, Individual #16, Individual #351, Individual #137, Individual #488 o PSPs for the following: • Individual #43, Individual #13, Individual #344, Individual #425, Individual #195, Individual #336, Individual #262, Individual #188, Individual #417, Individual #353, Individual #336, Individual #137, Individual #195, Individual #425, Individual #344, Individual #351, Individual #476, Individual #379, Individual #574 o Direct Therapy documentation and assessments for the following : • Individual #366, Individual #530, Individual #22, Individual #459, Individual #112, Individual #551, Individual #546, Individual #77, Individual #75, Individual #394, Individual #521, Individual #190, Individual #67 **<u>Interviews and Meetings Held</u>:** o Christina Pedroni, MS, CCC-SLP, Habilitation Therapies Director o Sharon Setzer, OTR/L, o Jeremy McKnight, OTR/L o Cassidi Hairgrove, OTR/L o Brenda Webb, COTA/L o Jason Burson, COTA/L o Jennifer Burson, COTA/L o Gail Harris, PT o Maria Nash, PT o Various Supervisors and Direct Support Staff **<u>Observations Conducted</u>:** o Living areas o Dining rooms o Habilitation Therapies clinic areas o PNMP Clinic o Wheelchair Clinic
	Facility Self-Assessment: LSSLC's self-assessment identified noncompliance for all items in this provision. The department reported that they had developed a database for equipment and that they were revising the training for PNMPCs and direct support staff. In many other areas, the department was working towards implementation. They were planning to develop a comprehensive assessment format and improve the content of the OT/PT assessments to include analysis and risk assessment as a foundation for recommendations and interventions.

	This self-assessment of noncompliance was consistent with the monitoring team's assessment of noncompliance with this provision. It is understood that the self-assessment tools were being revised and should be in place at the time of the next review.
	Summary of Monitor's Assessment: Staffing levels had increased since the previous review with the addition of a PT and a new PTA. Other staff had remained consistent, including the OTs and technicians. There were 15 therapy technicians who were assigned to assist in the wheelchair shop, take pictures for plans, implement therapy programs, assist the audiologist, and provide staff training. There were nine PNMPCs who provided monitoring and staff training. The training programs for these staff were under revision to identify specific competencies for PNM-related areas such as mealtime, alignment and positioning. All of the assessments reviewed described individuals with movement disorders and limitations in self-care and/or functional skills. There were 322 individuals identified with PNM needs by the department, however, it was noted that only four individuals received direct physical therapy treatment and five who received OT services. Others participated in range of movement-based interventions provided by therapy technicians. Many others received only indirect supports via annual assessments, PNMPs, or dining plans. There was no data system used to track completion of assessments submitted. It appeared that while some individuals had previously received OT and/or PT assessments, many had not received a recent comprehensive baseline assessment. In many cases, there was insufficient baseline outlined in the assessment to use for assessing progress as a result of intervention. The updates contained a significant amount of clinical information but did not consistently update the individual's current status relative to the previous status at the time of the baseline assessment and, as such, served essentially as another baseline. These assessments were not generally comprehensive and did not address specific risk issues or provide adequate analysis or rationale for interventions and recommendations. It did not appear that any modifications to the assessment process had been made in the last six months. Though equipment generally was available, implementation of plans by staff was not consistent as intended per the PNMP. A number of individuals were observed sitting with a posterior tilt, loose seatbelt, or pelvis not well back into the seat of their wheelchair. In a number of cases, the plans did not provide staff with visual cues regarding the appropriate position and alignment for individuals. Measureable goals were uncommon in the design of most of the plans and, as a result, there was little in the documentation to quantify progress or regression. From discussion with the clinicians, they generally had an appropriate justification and rationale for interventions and supports. This did not get translated to their documentation. There was no policy or guidelines to address the monitoring process completed by therapists or PNMPCs. There had been a tremendous number of monitoring sheets completed in the last three months predominately by the PNMP coordinators and very few by the therapists. There was no method to track the frequency of observation conducted for specific individuals who were considered to be at highest risk.

	There was no tracking system to analyze and report findings to drive needed staff training and to ensure system change as indicated.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	**Standard: The facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.** The Habilitation Therapies Director was Christina Pedroni, MS, CCC-SLP. Professional license numbers were submitted for OT/PT staff and all were reported to be current. OT services were provided by three full-time occupational therapists, Sharon Setzer, OTR/L, Jeremy McKnight, OTR/L, and Cassidi Hairgrove, OTR/L and three COTAs (Brenda Webb, Jason Burson and Jennifer Burson). By report, there was one open position. PT services were provided by Gail Harris, PT, a full-time clinician and Maria Nash, PT ,who was working four days a week. There continued to be one open position, by report ,and the Director had been speaking to a clinician who had expressed interest in the position. A newly graduated PT assistant had recently taken a position and was still being oriented at the time of this onsite review. There were 15 therapy technicians, one of whom worked as the supervisor and another who worked as a supervisor assistant. Twelve others were assigned to direct supports with individuals and one other worked under to assist the audiologist. They were assigned to assist in the wheelchair shop, take pictures for plans, implement therapy programs, and provide staff training. As stated above there were nine additional PNMPCs, though they did not work under the supervision of the Habilitation Therapies. Staffing levels had increased since the previous review with the addition of a PT and a new PTA. Other staff had remained consistent including the OTs and technicians. Fabrication of seating systems occurred onsite. Fabricators were responsible for collaborating with therapy clinicians to design seating systems for individuals living at LSSLC, fabricating custom components, and completing repairs and modifications. At the time of this onsite review, there continued to be three wheelchair technicians in the shop in addition to the therapy technician assigned to that area. During the previous review, the facility had begun to collaborate with an Assistive Technology Professional through a durable medical equipment (DME) vendor and this continued at the time of this subsequent review. The clinicians indicated that this had been positive and that learning and capacity building opportunities had improved since that time. The PNMP Coordinators were supervised under the Active Treatment department and had been assigned to specific homes. Habilitation therapies had initiated person-specific	Noncompliance

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		training with competencies identified in the areas of mealtimes, AAC, and OT/PT related programming. The training was continuing at the time of this review. Evidence of participation in continuing education was submitted as follows: Integrating Neurotherapeutic and Sensory Techniques into Therapy for The Special Needs Client on 2/18/10 (six contact hours) • Jennifer Burson, COTA/L • Jason Burson, COTA/L • Cassidi Hairgrove, OTR/L • Gail Harris, PT • Jeremy McKnight, OTR/L • Brenda Webb, COTA/L Functional Classifications for Assessing and Treating Individuals with Balance and Mobility Problems on 5/18/10 (seven hours) • Jeremy McKnight, OTR/L • Brenda Webb, COTA/L • Jennifer Burson, COTA/L PNMP and Wheelchair Clinic Teleconference on 5/5/10 (one contact hour) • Cassidi Hairgrove, OTR/L • Gail Harris, PT • Jeremy McKnight, OTR/L Educare Wound and Skin Care System on 2/17/10 (seven contact hours) • Gail Harris, PT • Brenda Webb, COTA/L **Standard: All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.** OT/PT assessments were completed rather than screenings. In general, a baseline evaluation was completed for each individual upon admission with updates conducted every three years for those who had received some level of services. Previously, Staffing Updates had been completed by some clinicians that were less comprehensive, though, by report, these were being discontinued. The monitoring team requested five assessments completed by each therapist with the associated PSPs to be submitted. As the OTs and PTs completed an integrated assessment and report, the documents submitted included Occupational Therapy/Physical Therapy Evaluation Updates. All evaluations submitted were completed by Gail Harris, PT, in conjunction with one of the three OTRs as follows:	

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		Cassidi Hairgrove, OTR • Individual #353 (8/2/10 and PSP: 7/13/10)) • Individual #262 (6/1/10/10 and PSP: 7/6/10) • Individual #188 (8/3/10 and PSP: 7/19/10) • Individual #417 (7/20/10 and PSP: 7/1/10) • Individual #336 (6/15/10 and PSP: 7/14/10) Jeremy McKnight, OTR • Individual #137 (7/5/10 and PSP: 7/14/10) • Individual #351 (6/30/10 and PSP: 7/15/10) • Individual #476 (7/6/10 and PSP:7/29/10) • Individual #379 (6/30/10 and PSP: not available, though held on 8/17/10) • Individual #574 (6/9/10 and PSP:7/29/10) Sharon Setzer, OTR • Individual #425 (7/6/10 and PSP: 7/14/10) • Individual #344 (8/12/10 and PSP: 7/14/10) • Individual #195 (7/6/10 and PSP: 7/14/10) • Individual #43 (7/20/10 and PSP: 7/14/10) • Individual #13 (7/26/10 and PSP: 7/14/10) Additional OT/PT assessments and PSPs were submitted as requested for the active record samples for 18 individuals including: • Individual #298 (9/2/08, 9/2/09 and PSP: 9/8/10) • Individual #265 (5/5/97, 3/28/02, 3/30/09 and PSP: 4/20/10) • Individual #560 (1/9/03,1/7/04 and PSP: 1/6/10) • Individual #361 (7/14/09, 6/22/09 and PSP: 6/15/10) • Individual #172 (4/22/96, 4/1/08 and PSP: 4/6/10) • Individual #96 (3/15/07 and PSP: 3/16/10) • Individual #52 (8/30/94, 7/20/06 and PSP: 7/7/10) • Individual #36 (8/4/03, 7/28/09 and PSP: 8/11/10) • Individual #232 (8/9/95, 10/13/10 and PSP:11/4/09) • Individual #467 (3/18/09 and PSP: 3/30/10) • Individual #24 (12/13/04, 12/10/07 and PSP: 12/9/09) • Individual #339 (8/12/09 and PSP: 8/16/10) • Individual #339 (7/18/95, 5/21/10 and PSP: 5/21/10) • Individual #339 (1/17/97, 11/20/01, 12/30/08 and PSP: 1/5/10) • Individual #161 (2/2/09 and PSP: 2/9/10) • Individual #334 (11/28/95, 10/9/07 and PSP: 10/20/09) • Individual #502 (5/9/97, 4/27/09 and PSP: 4/28/10) • Individual #447 (7/22/87 PT, 8/19/86 OT, 7/15/09 and PSP: 7/2/10)	

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		All of the assessments reviewed described individuals with movement disorders, and limitations in self-care and/or functional skills. There were 322 individuals identified with PNM needs by the department, however, it was noted that only four individuals received direct physical therapy treatment and only five who received OT services. Two of these individuals were participating in both OT and PT (Individual #521 and Individual #147). Others participated in range of movement-based interventions provided by therapy technicians. Many others received only indirect supports via annual assessments, PNMPs, or dining plans. There was no data system used to track completion of assessments submitted. As stated above, it appeared that while some had previously received OT and/or PT assessments, many had not received a recent comprehensive baseline assessment. Other than the actual assessments submitted, it was not possible to verify reports that all individuals had received a comprehensive baseline assessment. **Standard: All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.** By report, new issues that required additional assessment by OT or PT were generally addressed well within the 30-day period, by report. There was no system to track specific referrals through to resolution generated by the PST or via PNMP monitoring. As a result, the department was not able to determine how often they had to respond to special concerns beyond those issues that were identified through annual assessment. **Standard: 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.** In general, a baseline evaluation was completed for each individual upon admission with updates conducted every three years for those who had received some level of services. There was little difference between these and, as reported above, there was very little comparative analysis to describe progress or regression as indicated. The assessments appeared to be more focused on impairments and traditional clinical data rather than function and potential for skill acquisition. In many cases, the data reported did not significantly relate to the supports and services outlined, but appeared to be a rote exercise with minimal actual assessment and problem-solving. An update should reference the comprehensive assessment and/or a previous update within the three year period and describe supports and services provided during that year as well as progress or changes noted with recommendations for supports and services indicated.	

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		As described above, the monitoring team had requested five assessments completed by each therapist with the associated PSPs to be submitted. Each of these had been completed in 2010. Others were submitted as a part of the request for records of the sample of 18 individuals, each of whom received at least indirect services. There were only two of these assessments that were current within the last 12 months (Individual #339 and Individual #339), with one that expired the week of this onsite review (Individual #232). Each of these was an update to a previous update. In the cases of Individual #104 and Individual #339, their previous updates had been one year prior in 2008. The baseline for Individual #339 was documented as 7/17/95, 1/16/97 for Individual #104, and 8/9/95 for Individual #232. Per his current assessment, Individual #232's last evaluation update had been three years earlier in 2007 despite having received direct therapy services for range of motion for the last nine years. Additional assessments were submitted for the following individuals as requested in association with documentation for those receiving direct OT and/or PT. This included the following: • Individual #530 (8/14/07) • Individual #137 (7/5/10) • Individual #366 (11/9/09) • Individual #365 (10/14/04) • Individual #190 (11/11/05) • Individual #67 (7/11/06) • Individual #336 (6/15/10) • Individual #521 (1/10/07) • Individual #167 (10/14/08) • Individual #22 (5/6/09) • Individual #16 (10/30/07) A combined OT/PT assessment was completed and based on the assessments submitted it appeared that the baseline was completed only at the time of admission with updates completed generally every three years for those who received some level of therapy services. Though in the cases of Individual #530, Individual #365, Individual #190, Individual #67, and Individual #521, the interval was anywhere from over three years up to nearly five years. Some were noted at a more frequent interval, but it could not be determined why one individual been re-evaluated in one or two years (Individual #339 and Individual #339) while most others were evaluated every three years or more. The recommendations did not identify the intended frequency for subsequent re-assessment. All evaluations submitted were completed by Gail Harris, PT, in conjunction with one of the three OTRs.	

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		For the most part, the updates referenced a baseline evaluation and subsequent updates. Many of the previous assessments had been completed years ago with no evidence of a more current evaluation despite the provision of services. It appeared that most individuals had received an update every three years, though clinical analysis of individual changes over time was generally very limited. For example, in the case of Individual #334, he presented with upper extremity range of motion within normal limits on the left in 1995 with evidence of loss of range per his update in 2007. There had also been changes on the right, but current range was merely reported with no analysis of these changes other than to state that it had changed minimally since 2004. He was recommended to continue to participate in "flexibility services" with no rationale provided. OT/PT assessment templates were submitted as requested having been revised in April 2010. The format headings appeared to be essentially unchanged from the baseline evaluations noted in a number of the records submitted. The template provided standard language that was used for each of the assessments, again essentially unchanged from the baseline assessments noted in the records from the mid-1990s. In many cases, the template language used did not provide for a description of unique abilities for individuals. Generally, statements were made without examples so as to identify and analyze specific skills and abilities to serve as a foundation for interventions and supports to promote functional skill acquisition and change. Rather, the assessments were limited to a reporting of general skills. For example, Individual #334 was described in his baseline assessment with "motor planning adequate to complete familiar three-step activities." There was no description of what the clinicians observed to conclude this. There was no functional information that could have been used for program development to build on for further development of this skill in therapy or other programming, such as the geriatric group in which he participated. In his most current update in 2007, the clinicians reported that his motor planning was adequate for familiar two-step activities and impaired with novel tasks. Again, there was no detail related to the specific tasks observed reported. This represented a regression, though there was no discussion about this anywhere in the update. In addition, it was stated that he "appeared unable to relate individual steps to task completion." The meaning of this was not clear, there was no example provided to support this statement, and the assessment data served no functional purpose as a result. The assessment summary indicated that had limitations in fine motor skills and was unable to participate in most sensory motor activities without an explanation of why this was the case. Assessment format, detail, and clinical reasoning also varied greatly from report to report. Most of these were not comprehensive in that they lacked information regarding health risk indicators and generally only a list of medical diagnoses was offered with no real discussion of the individual' s medical history. There was no reference to the individual's current PNMP or the effectiveness of that plan over the last year. There was	

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		no identification of whether changes in the PNMP were required and no clinical analysis with rationale provided as a foundation for the recommendations identified. Specific risk indicators were not listed. There was no correlation with the health risk indicators identified by the NMC, HST, and/or interventions recommended by the clinicians. Content with regard to review of supports and services provided over the previous year, and rationale for the provision of those supports, including assistive equipment, was sparse and not consistently provided. In many cases, there was insufficient baseline outlined in the assessment to use for assessing progress as a result of intervention. The updates contained a significant amount of information and did not appear to update the reader as to the individual's current status relative to the previous status at the time of the baseline assessment and, as such, served essentially as another baseline. Though, as stated above, these were not generally comprehensive. It did not appear that any modifications to the assessment process had been made in the last six months. **Per the Health Care Guidelines, the comprehensive assessment should address the following:** • **Movement;** • **Mobility;** • **Range of motion;** • **Independence; and** • **Functional Status across each of these areas (Health Care Guidelines, VIII.B.2)** Range of motion was generally addressed, though specific range of motion measurements were provided inconsistently without rationale for including or not including this information. Overall, posture in a variety of positions was not described adequately. Often the feet and lower extremities were addressed, but not the upper extremities. Posture in sitting or dynamic balance was rarely discussed. Movement skills were included, but general skills were merely identified, rather than providing a description of movement quality. Individuals were typically reported to "retrieve, place, combine, manipulate, and use objects functionally." This provided very little information useful to other team members because there was no context offered through specific examples. **Standard: 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.** This was not apparent in the documentation submitted. For example, in the case of	

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		Individual #521, she had received a baseline assessment upon admission to LSSLC in 2007. She was to use a modified wheelchair and receive alternate positioning to prevent skin breakdown and further deformity. There was no evidence of subsequent updates since that time despite the need for these supports. An Activity Plan was developed on 12/16/09 to provide direct PT services related to "movement and developmental facilitation to enhance her ability to participate in her environment." The plan outlined that services would be provided by two habilitation therapists Monday through Friday for one hour per day. Documentation was limited to attendance on a Service Objective Review sheet and the therapist was to monitor Individual #521's tolerance for the activities in a monthly progress note. Though requested, no progress notes were submitted, but rather only the attendance record. The list submitted of individuals receiving PT indicated that therapy intervention was intended to promote head control and midline orientation following severe seizures suggesting that this was a new problem identified. There was no evidence of any assessment by the PT related to this new need for direct intervention. Documentation reviewed consisted of the Service Objective Review sheets submitted because no other documentation had been submitted. There were no comments by the clinician on these sheets related to tolerance or progress, but only that the program was to continue. Per the documentation submitted from 5/1/10 to 9/30/10, Individual #521 was seen only 12 times of the 108 possible sessions during that period based on the Activity Plan developed. Explanations were generally related to schedule conflicts and therapist absences. Clearly, if this was a critical need, there was no way that the recommended PT would result in a positive outcome at that frequency. In the case of Individual #530, he was identified as receiving PT related to increasing knee extension for improved body alignment during ambulation. On the a positive note, this plan was developed as an SAP stating that "Individual #530 will present with a 10 degree increase of bilateral him and knee extension, as measured by the Therapist, in a six month period of time." The plan was to be initiated on 8/2/10. Treatment frequency was to be three times a week through the Tone Inhibition program conducted by therapy technicians three days a week and also two days a week for ROM by habilitation therapists. Data collection were to be via attendance only until 1/28/11 when the PT would measure hip and knee extension. Documentation of attendance for the TIR program showed that the service was provided as outlined in the plan in August 2010 and September 2010. He was seen by habilitation therapists on three days only in August 2010 and only on one day during September 2010. Explanations were generally related to schedule conflicts and therapist absences. Clearly, if this was a critical need, there was no way that the recommended PT would result in a positive outcome at that frequency. It was of concern that there had not been additional assessment to justify the addition of direct service in these cases but also that the frequency outlined in the plans was consistently not met. Further, generally accepted professional standards of care	

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		would require that there be ongoing documentation of actual progress for interventions of this nature by therapy clinicians. In the case of Individual #530, measurement of progress should occur on an ongoing basis throughout the six month period rather than merely at the end. Review of progress at a more frequent rate would permit modification of the plan in the event that the expected changes were not occurring. Similar documentation was submitted for two others who received direct PT. No documentation was submitted for Individual #147 as requested, though he was listed as receiving direct PT services. In another case, a PSPA was held on 9/14/10 to review the high risk status of Individual #96 related to aspiration and apnea. The PST meeting on that day consisted only of the QMRP, a nurse case manager and MRA IV. It was determined that a referral to habilitation therapy was indicated to address bed positioning to reduce aspiration risk. A referral to NMT was also recommended to determine if there were any feeding issues contributing to her aspiration. On that date, it was reported that she was experiencing vomiting and diarrhea. She was transported to the emergency room and admitted to the hospital. Her discharge diagnosis was aspiration pneumonia and she was admitted back to LSSLC via the infirmary. There was no evidence of habilitation therapy assessment. Individual #96 was reviewed by the NMT on 9/30/10. At that time, it was determined that the nurse would request use of a suction toothbrush rather than regular tooth brushing. There was no discussion of her positioning at that time. Individual #96 returned to her home on 10/7/10. On 10/8/10 it was reported that she was observed slumped over in her wheelchair and had vomited. She returned to the infirmary for hypothermia and vomiting. She again returned to her home on 10/11/10. There was no evidence of assessment related to change in status. On 10/18/10, another PSPA was held at the request of her mother to discuss Individual #96's health status. OT and PT both attended this meeting. A plan was agreed upon to assess for bed positioning, adjust daily schedule, and assess for use of a suction toothbrush to reduce aspiration risk. Documentation on that same date indicated that OT and PT provided assessment related to positioning. Assessment for the suction toothbrush was not conducted until 10/20/10. Further follow-up by PT was documented on 10/20/10 and 10/21/10, however, Individual #96 was again transported to the ER on 10/23/10. Assessment by OT and PT did not occur in a timely manner related to a change in status throughout this period and the immediate nature of her identified needs. Further follow-up regarding this case will be necessary during subsequent reviews by the monitoring team. Individual #365 began physical therapy for a total knee replacement on 8/31/10 per documentation by the PT on 9/1/10 (late entry for 8/31/10). The date of her surgery was not known though she was discharged from the hospital on 8/30/10. While therapy was initiated in a timely manner, there was no plan for continued therapy outlined and	

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		no measurable functional goals established per this progress note. Also, there was no evidence of a comprehensive PT assessment of her status prior to the surgery and her status post-surgery. It was of concern that there had not been appropriate assessment related to this significant change in status. Her last assessment was an OT/PT update nearly six years ago on 10/14/04. Per the integrated progress note on 9/10/10, she received no further PT until that date due to "PT has been out ill most of this week." There was no plan identified related to the frequency or duration of treatment and there still were no established measurable and functional goals for Individual #365. The only plan was to provide inservice to direct support staff related to ambulating with a walker that same afternoon. There was no further documentation until 10/14/10, following a physician's order over two weeks earlier for continued ambulation training." On that date, direct intervention was provided by the PT. There was no evidence that therapy had been provided in the interim other than on that date. It was reported that she was developing adhesions with pain and the plan was to obtain orders for soft tissue massage "next week." Nursing notes reported complaints of knee pain. On 10/15/10 there was documentation that the PT massaged the knee and provided gait training. It was reported that Individual #365 was progressing well, but there was still no plan or goals outlined for this intervention. Additional interventions were documented on 10/18/10, 10/19/10, 10/21/10, and 10/22/10. There was a reported fall as Individual #365 was coming out of the bathroom on 10/24/10 by the direct support staff with follow-up by nursing. No further progress notes were submitted after that date. It was of concern that the therapy provided to Individual #365 was of insufficient frequency to appropriately address her rehabilitation post-surgery. **Standard: Findings of comprehensive assessment drive the need for further assessment such a wheelchair/ seating assessment.** Most of the assessments described the seating system components, though with essentially no justification for the properties or products selected. In the case that a new wheelchair was indicated, there was limited rationale as to why, such as what the presenting problems were. The reports often stated that the wheelchair was necessary to maintain proper postural alignment, but was not specific to the individual. There was often a statement to justify that a seatbelt was necessary for postural support. No further justification was noted in the majority of assessments and mat evaluation documentation reviewed. In the case of Individual #47, he was identified as a high priority for new seating, but there was no description of the issues with his existing wheelchair or specific needs from a new system. In many cases, simple repairs or modifications were possible at the time of this onsite review and, in the case that more extensive work was required, this was scheduled for completion at a different time. Further assessment in areas other than wheelchair or seating was not noted in the recommendations for the assessments reviewed.	

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		Standard: Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions. There was essentially no review of overall medical issues and health risk indicators, but rather a listing of the medical diagnoses only. There was a section of the assessment titled Functional Eating Skills and Swallowing Assessment (FES). A review of events or medical status related to eating and swallowing was included here. In some cases, a statement related to consults provided by therapy were included in the assessment such as issuing orthotics or training of staff on transfers following a fracture (Individual #225). Other consults, surgeries, hospitalizations, or other significant health concerns were not discussed in the OT/PT evaluations. There was no link to the NMT or HST risk assessments. These were not considered in the summary paragraph in the assessment in order to analyze changes over the last year or to justify supports recommended. By report, the clinicians were working on producing improved clinical analyses of the data they gathered during the assessment process. This should become more of a standard as the PNMT assessments are implemented over the next year. **Standard: Evidence of communication and or collaboration is present in the OT/PT assessments.** Each of the current assessments was signed by both the OT and PT and, in many cases, also by speech clinicians as well. There was limited evidence of collaboration or integration other than the speech clinician's signature. It was confusing to the monitoring team why this evaluation continued to be referred to as the OT/PT evaluation if, in fact, it was more interdisciplinary and included more SLP domains. Generally, there was little discussion of communication other than a brief description, such as the individual was nonverbal or that English was the primary language. There was a statement that the individual was reviewed related to eating and swallowing and usually included a mealtime observation for those who had oral intake. There was generally limited information from those observations included in the report though this varied across reports.	
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	**Standard: Within 30 days of the annual PSP, or sooner as required for health or safety, a plan has been developed as part of the PSP.** This was not consistent. For example, a number of individuals had been evaluated for use of a tear drop beanbag. A number of these were proposed as changes to the PNMP for approval by the PST. These were generally approved and, by report, training for implementation had commenced but the programs were not implemented as yet at the	Noncompliance

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	shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	time of this onsite review by report. Some of these changes had been approved by the team months earlier without changes to the PNMP within 30 days. For example, this had been proposed and approved for Individual #232 on 7/1/10 with an effective date of 7/12/10. There was no evidence of this change on his PNMP as submitted. The therapeutic value of this type of positioning is questionable, but when identified, a plan should be developed to address a specific need. **Standard: Within 30 days of development of the plan, it was implemented.** As described above with regard to the beanbag positioning, a need for this type of positioning was identified yet PNMPs had not been modified to include this nor had the plans been implemented over three months after assessment and PST approval (Individual #232) for some. There was no system of tracking referrals, response times, or follow-up submitted with the OT/PT tracking documentation requested. It did not appear that this information was tracked to assess timeliness of meeting support and service needs identified throughout the PSP year. **Standard: Appropriate intervention plans are: integrated into the PSP, individualized, based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies, and contain objective, measurable and functional outcomes.** As described above, there was evidence of only one training objective for a therapy intervention in the documentation of direct therapy submitted (Individual #530). Some had only a service objective that the individual would receive therapy, but without any type of outcome statement related to expected change as a result. For example, Individual #366 had a service objective for therapeutic services to improve strength, movement, and trunk stabilization/posture three days a week. This program had a start date of 11/3/09. Service Objective Review documentation was submitted which essentially reflected only an attendance record. Of 22 possible sessions in July 2010 there was only one treatment on 7/28/10, three treatments in June 2010 and four treatments in May 2010. Explanations cited were typically schedule conflicts. Each month, the treatment was recommended to be continued. An appropriate objective is a clear description of expectations for the individual. When written in behavioral terms, an objective should include three components: the anticipated behavior, conditions of performance, and performance criteria. These goals had no performance parameters or conditions, including level of independence or assistance expected, such as "with stand-by guard of one person," or "per goniometer measurements in sidelying." There were also no performance criteria outlined, such as the frequency or duration of the expected behavior (e.g., "three of five times for three	

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		consecutive days"), or whether it was acceptable for the behavior to occur one time only. Emphasis on progress related to a specific measurable objective should be clearly and consistently stated. Clear rationale to discharge or to continue therapy should be tied to progress or lack thereof related to established measurable objectives. PNMPs were the primary intervention plan and, while a general focus was identified in the rationale for the plan, the assessment did not consistently provide a clear rationale for the specific selection of interventions for that individual. **Standard: Interventions are present to enhance: movement; mobility, range of motion; independence; and as needed to minimize regression.** Other than the direct intervention discussed above, the primary support provided was via the PNMPs provided. One of the COTAs translated information from the therapy assessments into the PNMPs for those living in Home 506, Woodland Crossing and Lone Pine. In other cases, these were developed by the QMRPs and not necessarily reviewed by the therapy clinicians. PNMPs addressed areas related to positioning, transfers, range of motion, and mobility, but interventions were limited related to promoting independence and skill acquisition. There were a very limited number of intervention plans beyond the PNMP and the focus, while appropriately movement-related, was too general to be functional and meaningful. As described above, goals were not functional or measureable. PNMPs included staff instructions or precautions in the areas of mobility, transfers, movement techniques, and positioning. Toileting was addressed consistently, but not bathing. There were mealtime instructions and mealtime equipment. There was very brief communication section stating "moderate" or "severe," though not identifying to what this specifically referred. A list of assistive equipment and a description of hearing and vision were consistently provided in the plan. The PNMPs at LSSLC also included the following: consumer supervision, restrictions such as spending allowance, target behaviors and interventions, behaviors to increase, approved restraints, aquatic activities and restraints for involuntary self-injury and for postural support. These additional items should not be in the PNMP. In the case that a piece of equipment or property is indicated for postural support it would not be categorized as a restraint, so this heading was unclear. For example, a seatbelt and lap tray, as listed for some, when provided for postural support, would not be considered a restraint. If used for some other reason, such as keeping someone in their chair, it would be considered a restraint, but not for postural support, but rather of independent movement. The use of the PNMP in this manner was incongruent with the purpose of this plan and the facility should also reconsider this practice.	

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		There was little information that identified how the individual was able to participate (unless the individual was independent) or ways in which skill acquisition and practice could be incorporated into the individual's daily routine. These strategies could promote teachable moments throughout the day and should be included in training, monitoring, coaching, and modeling conducted by the therapy staff. This greatly enhances opportunities for learning and independence. Many of these may be as subtle as allowing sufficient time for the individual to give a signal that he or she was ready for a transfer (e.g., 1-2-3-GO) in that the individual may be able to blink, vocalize, or nod his or her head on "GO." Or, the individual may be able to look in the direction of the transfer, for example, by looking over to the bed right before the transfer from the wheelchair. Other examples include the individual may be able to hold his or her foot up for placement of shoes and socks, during mealtimes when an individual who received hand over hand assistance had the ability to bring the spoon to his or her mouth and only required assistance to scoop, or that an individual could hold a second toothbrush or hairbrush in his or her hand or on his or her lap while being assisted to have teeth or hair brushed. These subtle abilities or potentials for skill acquisition often go unnoticed by direct support staff due to their need to hurry to get everything done across their day. These types of activities would require that a baseline be established with regard to the individual's ability at the time of the OT/PT assessment, and then supports would be established to provide opportunities for practice of existing skills or for learning new ones. The clinicians did not appear to recognize that this was a need and tended to focus on basic clinical information in the assessments. This provided little foundation in the absence of also identifying functional limitations and the individual's potential for skill acquisition. As a result, they did not recognize needs for intervention and the staffing and training was inadequate to address them. **Standard: 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.** Each of the PNMPs reviewed listed specific assistive/adaptive equipment to address individual needs. The rationale offered in the assessment, however, was generally insufficient. The assessment should provide a clear analysis and rationale for equipment, rather than a rote assignment of these systems without clear and well documented need in regards to functional abilities, potentials, and health risk indicators. As stated above there was also a listing of restrictive equipment that did not appear to be an appropriate use of this plan. **Standard: Therapists provide verbal justification and functional rationale for recommended interventions.**	

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		Measureable goals were uncommon in the design of most of the plans and, as a result, there was little in the documentation to quantify progress or regression. From discussion with the clinicians, they generally had an appropriate justification and rationale for interventions and supports. This did not, however, get translated to their documentation. **Standard: 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.** Only in the case that an individual received direct therapy, was progress reviewed routinely. A progress note was written for each intervention in some cases, though as stated above, there was no objective or goal with a clear measurement of progress toward achievement. In the case of the service objectives, the only documentation consisted of attendance and that the intervention should continue. In some cases, interventions of this type were discontinued, though also with insufficient justification. Individuals were not otherwise reviewed on a monthly basis, and PNMPs were reviewed and changed on an as needed basis only other than during the annual assessment.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	**Standard: Staff implements recommendations identified by OT/PT.** Though equipment generally was available, implementation by staff was not consistently performed as intended per the PNMP. A number of individuals were observed sitting with a posterior tilt, loose seatbelt, or pelvis not well back into the seat of their wheelchair. In a number of cases, the plans did not provide staff with visual cues regarding the appropriate position and alignment for individuals. Some examples included the following: • Individual #79 was observed in a plastic chair during a meal in a significant posterior pelvic tilt. • Individual #109 was observed seated in a wheelchair with significant space behind his hips. His trunk was leaning forward and to the right. The picture in his individual book was dated 9/10/08 and his seating was different than that pictured. The PSP in this book was dated 5/14/09 and not current. • Individual #339 was not positioned in the position as pictured in her PNMP. • A number of the pictures for staff use for positioning were outdated. • Individual #573 was seated in a wheelchair with the left lateral support pushing him out of alignment to the right. • Individual #546 was observed leaning to the left without staff assistance to correct his alignment. On another occasion he was noted to be leaning to the left	Noncompliance

#	Provision	Assessment of Status	Compliance
		with his left elbow down on his seat bottom. This was new seating for him, by report. The clinicians indicated that they still needed to "tweak" it. It was also noted that his feet were pulled back and his foot rest was positioned forward. • Individual #447's wheelchair brakes did not hold during transfers. Staff had not reported this as a problem. • Individual #184 was observed in poor alignment. Her pelvis was oblique, her legs were off to the right, and her trunk was twisted to the left. • Individual #321's seat did not appear to fit her appropriately and her alignment and equipment did not match the picture in her individual book. • Individual #549's wheelchair was dirty and appeared rusty. Her legs were adducted together and her feet were not well supported. • Individual #470 was observed leaning to the right. Staff encouraged her to sit up, but did not assist to correct her alignment. • Individual #129's feet were not supported on the foot rests and her hips were forward in the wheelchair with her legs off to the right. She was receiving enteral nutrition at that time. • Individual #599 was laying nearly in supine in a modified wheelchair with his head in hyperextension. He was chewing on a measuring cup. The condition of this device was poor and it was rusty and dirty. There were pictures in the book from 2008 with no current pictures available for staff use. • Individual #467's shoulders were not well aligned and supported. The right was elevated and the left was tilted down. She was observed in a significant posterior tilt during a mealtime. • Individual #335 was seated in a wheelchair with a very wide seat and back that did not provide sufficient support. His feet were not supported on the foot rests. He could not sit close to his plate because there was a center pedestal under the table that interfered with moving his wheelchair under the table. • Individual #85 was to sit in a regular chair for mealtime, but was observed in a wheelchair. His legs were extended and his feet were not supported on the foot rests. • Individual #539 did not have a picture of his new wheelchair in his individual book. His pelvis was not centered, but rather asymmetrically off to one side. • Individual #202 was not positioned appropriately by staff after his transfer and there were no pictures in his individual book. This was new seating for him, by report. • Individual #433 was observed without support under her feet during a meal. • Individual #515's gait belt remained on after the transfer from her wheelchair to a recliner. It was left tight around her trunk. She was using supplemental oxygen. Staff was prompted by the habilitation director to correct this despite having just being recently trained again on this practice.	

#	Provision	Assessment of Status	Compliance
		• Individual #265 was observed leaning to the left without assistance from staff. There was a picture of an old wheelchair in his individual book. • Individual #556 (or possibly Individual #285, the individual's full name was not obtained) was observed in a very broken down sling seat wheelchair. Staff indicated that he preferred this rather than the wooden chair as prescribed in his plan. • Individual #28's plan did not have a picture of his new wheelchair. **Standard: Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.** The only competency-based OT/PT training aspect of New Employee Orientation (NEO) was provided related to transfers and lifting. Lifting was the only PNM-related area for which re-training was provided at the time of this review. In several cases, transfers observed, stand pivot, and using a mechanical lift were not performed appropriately. As described above, person-specific training was not competency-based. Therapy staff provided inservice to available direct support staff and home managers or supervisors who were then responsible for training other direct support staff. There was no mechanism to ensure that the subsequent training provided hands on opportunities for practice to demonstrate competent skill performance. **Standard: Staff verbalizes rationale for interventions.** In the examples above, staff generally were not able to discuss the rationale behind recommended interventions. The rationale for interventions and supports was not consistently included in the PNMP. This would be an important aspect of staff training as well as monitoring and coaching.	
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	**Standard: System exists to routinely evaluate: fit; availability; function; and condition of all adaptive equipment/assistive technology.** The current system of PNMP monitoring was generally limited to availability and condition of equipment, rather than function and fit. Function and fit were consistently reviewed on an at least an annual basis via evaluation, at the request of the PST, and upon referral when a problem was identified. Proactive review of staff performance was reportedly conducted on an informal basis by therapy clinicians and PNMPCs. Tracking and documentation were not yet in place, however, the PNMPCs were more consistently providing staff training when issues and concerns were identified, both on the spot and with inservices. There were reports of resistance by direct support staff when	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	intervention or retraining was deemed necessary based on monitoring results. Despite consistent monitoring, many wheelchairs were noted to be dirty, rusty, and ill-fitting. It was of concern that none of the therapists or monitors had noted that many of the pictures for positioning were either absent, inaccurate, or not current. This was of particular concern as the PNMP Monitoring Sheet asked the monitor to refer to the PNMP pictures to determine if positioning, head position, and alignment were correct, **Standard: Person-specific monitoring was conducted that focused on plan effectiveness and how the plan addresses the identified needs.** The PNMPCs were supervised by Active Treatment staff. There was no clinical oversight for their work at this time. As stated above, monitoring typically was primarily limited to availability and condition of equipment by the PNMPCs, rather than efficacy of the interventions. The current supervisor or habilitation therapies had no system to ensure that those at greatest risk were monitored consistently and at an appropriate frequency as indicated by their level of risk. There was no mechanism to check if the monitors completed monitoring sheets for individuals routinely. By report, they were assigned a caseload and it was generally presumed that they conducted monitoring as assigned. Recent clinical training had been initiated by the therapists and was ongoing at the time of this review. The supervisor reviewed the monitoring sheets and emailed the home or therapists when an issue was identified by a monitor. There was no mechanism to track those referrals or to follow-up on problem resolution. It was reported that a plan to place the PNMPCs under the therapists for clinical oversight while personnel supervision remained with Active Treatment was under consideration. This would be a critical step in ensuring that this system provides appropriate and useful information. Follow-up would be critical and a system must be developed to track identified concerns through to resolution. **Standard: A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.** There were no policy or guidelines to address the monitoring process. There had been a tremendous number of monitoring sheets completed in the last three months predominately by the PNMP coordinators. There was no method to track the frequency of observation conducted for specific individuals who were considered to be at highest risk, though a schedule had recently been developed. **Standard: On a regular basis, all staff are monitored for their continued**	

#	Provision	Assessment of Status	Compliance
		competence in implementing the OT/PT programs. There was no tracking system to analyze and report findings to drive needed staff training and to ensure system change as indicated. Validation of the PNMP Coordinators had not been completed by the therapy clinicians. **Standard: Intervention plans are reviewed monthly by the program author to include observation of staff implementation.** See above. **Standard: 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 .** This was reported to be true by therapy clinicians, however, because training was not competency-based, there was no assurance that those who were most at risk were assisted by competent and well-trained direct support staff. **Standard: Responses to monitoring findings are clearly documented from identification to resolution of any issues identified.** There was no documentary evidence that issues identified during monitoring had been remedied or that home supervisors were notified of the findings. By report, there were emails though there were some incidences where the Therapies Director was not aware of an issue identified by the PNMPCs. There was no tracking system to enable systemic analysis of findings or to track follow-up. **Standard: Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available.** There were a number of cases where the appropriate adaptive equipment was not available. The home staff indicated that this had been reported, but replacements had not been provided by habilitation therapies for months. **Standard: Data collection method is validated by the program's author(s).** There were no plans implemented, other than the PNMPs, at this time, and no data collection was occurring, so validation was not indicated.	

Recommendations:

1. The frequency of PNMP monitoring needs to be driven by risk level; those at highest risk must be monitored with sufficient frequency to ensure adequacy and efficacy of the supports provided as well as the accuracy of staff implementation of these supports.

2. PNMP Coordinators continue to require structured, functional, competency-based training that includes didactic presentation of monitoring strategies and validation of competence through an ongoing "monitor the monitor" process, whereby they are observed during the monitoring process and compared to a licensed clinician. Tracking of this should occur to clearly document that each PNMPC has received the same training and frequency of oversight and review.

3. A strong comprehensive baseline assessment should be completed that provides clinical analysis and addresses specific identified risk issues via interventions and supports. These should e person specific rather than generic in nature.

4. The template assessment format provides insufficient detail to discreetly describe the individual's abilities and needs. If this is done with examples and in context of the individual's daily routine, this may serve as a better foundation upon which to build programming and training objectives for therapies as well as for other aspects of the PSP.

5. Include a comparative analysis of the individual's status in the assessment reports that describes actual change from year to year rather than merely reporting on their current status at the time of the re-evaluation.

6. Carefully assess those involved in the flexibility and TIR program activities completed by technicians and direct support staff to determine the specific changes that may or may not have occurred as a result of these interventions. These should result in positive change. These activities may not actually result in changes in measured range of motion but rather in management of skin integrity, for example, but this outcome should be outlined as a need and the intervention selected to address the issue.

7. Create a data system to track completion of OT/PT assessments to ensure that the cycle of re assessment occurs in timely manner.

8. Direct OT and/or PT therapy is not consistently implemented and documentation is limited to attendance. Specific measureable outcomes must be developed with routine documentation related to changes in status as a result of these interventions.

9. Carefully track health status changes to ensure that re-assessment occurs for those experiencing health concerns in a timely manner.

10. Provide clear rationale for properties selected for wheelchair seating and report routinely on the fit, function and condition of these systems.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o LSSLC Facility Operational Procedure Manual, Medical 14 Dental/Medical Sedation and Restraint, dated 7/16/10 o LSSLC Dental Data (3/10 – 8/10) o Admit/Seen o Refusal o Missed appointments o Extractions o Emergencies o Preventive services o Annual exams o Dental records for the individuals listed in Section L o Dental Pretreatment Sedation (3/10 – 8/10) Interviews and Meetings Held: o Louis Kavetski, D.D.S, Dental Director o Tina Murray, D.D.S. o Evelyn Barnes, Dental Assistant o JoAnne Lancaster, RDH o Brian Carlin, M.D., Medical Director Observations Conducted: o Dental department o Dental clinic
	Facility Self-Assessment: The facility's POI for section Q indicated noncompliance in all areas. While the monitoring team acknowledges that most individuals received dental services, concerns related to oral hygiene, the use of pretreatment sedation and TIVA, unresolved issues related to missed appointments, and a lack of data to substantiate compliance with the requirements for annual assessments have resulted in the monitoring team's agreement with the facility's self –assessment of noncompliance.
	Summary of Monitor's Assessment: Record reviews indicated the individuals received a variety of services in the dental clinic. Problems were

	identified in the areas of missed appointments and refusals, but there was no comprehensive strategy in place to address the issue of missed appointments. Oral hygiene care in the homes was problematic as individuals were frequently seen in clinic with heavy calculus accumulation. The facility had a substantial number of individuals with poor oral hygiene ratings, but no systemic interventions were implemented. Desensitization plans were being written by the dental hygienist without meaningful input from the psychology department. Individuals appeared to receive HRC approval to undergo general anesthesia for routine exams and cleanings.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	Dental services were provided in the onsite dental clinic. The dental clinic moved into a larger physical plant six months prior to the onsite review. The department was staffed with a full-time dental director, and one part-time dentist who worked four hours a day, Monday through Friday. There was one fulltime dental hygienist and one part-time hygienist who worked 10 hours on two days of the week. There was also one full-time dental assistant. There was a vacancy for a part-time hygienist. Emergency care was available for individuals. During regular work hours, the home nurse faxed referrals to the clinic. After work hours, the physician on call made the determination to call the dentist or send the individual to the emergency department. All of the records reviewed had evidence that individuals were receiving dental treatment on a regular basis. Annual assessments appeared to be completed in a timely manner for most of the individuals in the record reviews. Data on agency compliance with annual assessments was not provided. There was documentation of preventive and restorative services. Individuals received regular cleanings, extractions when necessary, and restorative procedures, such as amalgams. In the records reviewed, individual #492 experienced a dental emergency when a filling fell out of a tooth. The nurse noted this, but did not exam his oral cavity and did not notify the physician on call of the problem. The individual was seen in dental clinic several days later. This was not a life threatening emergency, but loss of a filling is a dental emergency and the on call MD should have been notified.	Noncompliance
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop	The monitoring team conducted a lengthy interview with the dental director, full-time hygienist, and dental assistant. The dental director reported that the facility was in the process of incorporating the state issued policies and procedures into the facility practices. There was a consensus among the staff that clerical assistance was needed in	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	dental clinic. The clinic saw an average of 15 individuals per day. Data were maintained on clinic appointments and the types of procedures being completed. There were also some data on oral hygiene status of the individuals. A list of persons with poor oral hygiene was provided for review. It was clear that data were being collected, but were not being utilized to assess performance of dental services or the provision of oral care in the facility. There was no analysis of the data on the individuals with poor hygiene to determine any trending or potential causes. The dental hygienist reported that individuals with poor ratings would be put on a more frequent recall schedule – two weeks, one month, and three months. It was also reported that the clinic encountered difficulty in getting participation from unit managers and home managers due to participation in other meetings. The part-time dental hygienist worked primarily in the homes addressing issues of oral hygiene and training staff. This training was in addition to training received in new employee orientation. All of the staff expressed concerns related to the oral hygiene provided in the homes. The opinion expressed was that staff were fearful of taking the measures necessary to complete hygiene in the homes, perhaps due to a hesitancy to use prompting procedures that might be considered to be a use of restraint. The dental director believed it was necessary to hire another part-time hygienist to increase the amount of hygiene provided in the homes. Data reviewed in the clinic showed that 105 (26%) individuals had poor hygiene ratings. In the record sample reviewed, the most recent dental hygiene ratings of 14 individuals showed that 64% rated good, 21% rated fair, and 14% rated poor. The dental director reported that no mechanical restraints were used in dental clinic. Oral sedation and TIVA were utilized for completion of procedures. The handwritten list provided by the dental clinic documented that some individuals received TIVA for exam and cleaning only. Other individuals received foot care, phlebotomy, EKGs, and x-rays, along with cleaning and x-rays during the period when anesthesia was administered. Some of the hand written notes were difficult to read. The dental work done under TIVA was largely prophylactic and not restorative. This raises some concern regarding the use of TIVA in the facility.	

#	Provision	Assessment of Status	Compliance

Dental Pre-Treatment Sedation 2010						
	March	April	May	June	July	August
Oral Sedation	5	1	4	0	0	0
TIVA	6	10	10	8	9	7
Total	11	11	14	8	9	7

Desensitization plans were being developed by the dental hygienist through the PALS. All individuals who had general anesthesia were required to have alternative strategies in place. The desensitization plans documented were usually in the very initial stages of development or implementation. The psychology department did not appear to have an active role in this process.

There were 133 episodes where care was not provided either due to missed appointments or refusals. There were approximately 71 missed appointments and 62 refusals reported during the months of March 2010 through August 2010. Explanations for missed appointments included school, illness, hospitalizations, no show, community trip, and lack of staff. There was no evidence that the dental department or the facility had taken any significant steps in determining the root causes of the problems. Strategies to overcome these barriers were not evident and the facility did not appear to have a comprehensive plan to address these issues

The following are examples of serious issues related to the provision of dental care noted in the sample of records reviewed:

- Individual #454
  - 4/29/10: "Individual came for recall dental prophy. Plaque covered all teeth except the four front teeth again and let DCS who came with individual see where dental plaque was being retained. Individual resist being restrained. Individual resist brushing, so we will refer her to Marill Gerthe the hygienist who works with DCS and individuals on the home. Individual would benefit from total and paste and we have requested it from warehouse. Marill will introduce the total when it arrives. Please keep daily, OH better, plaque that was retained throughout mouth was disclosed with two tone. It was determined to be at lest three weeks old."
  - 5/11/10: OH much improved
- Individual #431
  - 3/18/10: Removed more calculus from individual's mouth. Stopped when he became restless.

#	Provision	Assessment of Status	Compliance
		o 5/20/10: OH check – no bleeding from gingiva. OH is good. o 6/24/10: Individual came in for OH. Recommend using a spin brush at least 1x daily. o 10/21/10: Individual in dental clinic for E&P. "Today he is not very cooperative- turning his head away. Individual had very deep calculus and needs root planning in most areas of his mouth. I do not think he will be able to tolerate this extensive dental treatment with sedation alone as he might move too much and the necessary instruments are very sharp. Will contact re: TIVA.	

Recommendations:

1. The facility must determine the reasons for the large number of missed appointments and take corrective actions to decrease that number. This will require further explanation of missed appointments. Appointments missed due to community trips, lack of staff, and no show must be addressed. The dental clinic should collaborate with home managers and PSTs, when appropriate, to correct these problems.

2. The dental clinic must establish a data tracking mechanism. Handwritten lists make data analysis an arduous task. Consideration should be given to creation of a simple database that tracks the key data elements such as annual assessment dates, number of preventive procedures, restorative procedures, and emergency appointments.

3. The oral hygiene status of every individual should be tracked on a quarterly basis. The quarterly rating could be extracted from clinic visits. For persons not seen in clinic during the quarter, assessments can be completed by the hygienist in the homes. The data should be entered into a database that is capable of stratifying by homes. This will allow for easier identification of systemic problems related to oral hygiene. Tracking oral hygiene in this manner allows the facility to monitor its performance in providing oral hygiene and recognize when issues arise. Individuals who have any deterioration in oral hygiene, such as a drop from good to fair, should have a specific plan to address the deterioration in hygiene status. Facility data should be monitored by the facility's quality department.

4. The dental clinic should work with home managers and team leaders to identify strategies to improve oral hygiene. Accountability for this process should be enforced.

5. The use of TIVA and pretreatment sedation should be carefully monitored to ensure that it is being used appropriately. Teams should give serious consideration to alternative strategies and ensure that the strategies are individualized. This is particularly important when TIVA is being utilized for completion of routine procedures, such as exams and cleanings.

6. The facility should consider additional training for all staff including the dental clinic on the use of restraints in carrying out oral hygiene.

7. Given the significance of the problems with missed appointments, oral hygiene, and pretreatment sedation, the facility should consider having the QA department assess the magnitude of the problem and determine if a performance improvement project is warranted.

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** **<u>Documents Reviewed</u>:** o List of PNMT members o Continuing education documentation for PNMT members submitted o Settlement Agreement Monitoring Instrument Section R o Communications Dictionary template o Communication Skills Evaluation template o Communication Skills Therapeutic Equipment spreadsheet 9/17/10 o Communication Skills Therapy List o Communication Skills Assessments and PSPs for the following: • Individual #425, Individual #195, Individual #267, Individual #335, Individual #417, Individual #545, Individual #574, Individual #407, Individual #43, Individual #13, Individual #554, Individual #500, Individual #223, Individual #525, Individual #597, Individual #298, Individual #172, Individual #361, Individual #36, Individual #339, Individual #96, Individual #232, Individual #52, Individual #191, Individual #560, Individual #105, Individual #447, Individual #502, Individual #161, Individual #334, Individual #265, Individual #24, Individual #467 o PNMPs submitted o PNMP Monitoring sheets submitted o Section R POI and Supplemental POI **<u>Interviews and Meetings Held</u>:** o Christina Pedroni, MS, CCC-SLP o Lisa Barnes, MS, CCC/SLP o Candace Crawford, MS, CCC/SLP, CFY o Rhonda Hampton, MS, CCC-SLP o Kristi Hodges, MS, CCC-SLP o Discussions with various individuals, supervisors, and direct support staff **<u>Observations Conducted</u>:** o Mealtimes in many residences o Most residences
	Facility Self-Assessment: Per the facility's POI, LSSLC reported that all elements and actions steps were in noncompliance in section R, communication. A number of elements indicated that the speech department was initiating programs and systems. In addition, assessments and monitoring tools were being developed and refined. There

	were no data offered for any of the elements listed in this section. Implementation of the data analysis aspect of the monitoring system and collaboration with QA to evaluate actual performance will provide a better picture of status and progress with each of the elements in this section. The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the POI self-assessment findings of noncompliance in all areas.
	Summary of Monitor's Assessment: Christina Pedroni, MS, CCC-SLP, reported that the major focus of the department in the last six months had been to prioritize and organize clinician caseloads. The level of professional staffing had essentially remained unchanged since the baseline review. The recent reorganization of the caseloads took into consideration the existing skill sets and experience of the clinicians. Though as reported in the baseline review, clinician caseloads were still high and it would likely be difficult to meet all the provisions of this section of the Settlement Agreement with the current numbers of staff. Beginning the month of this review, the clinicians had begun work on their Master Plan to appropriately prioritize individuals for assessment. This plan had not, however, considered those with behavioral concerns as required by the Settlement Agreement. The baseline assessment format had been designed to identify each individual's need and potential to benefit from AAC systems to enhance his or her communication skills and was being reviewed and revised to enhance the quality of content to better meet the requirements of the Settlement Agreement. By report, the clinicians were attempting to observe individuals and conduct assessments in a greater variety of settings. Based on review of communication assessments submitted for 32 individuals, at least 82% of these assessments identified individuals with significant expressive and/or receptive language deficits. At the time of this onsite review, the clinicians reported that not all individuals with a need for AAC had been identified. Per the AAC database submitted, there were approximately 63 individuals listed with some type of AAC system, though over 50% were limited to a community poster only. Another 67 individuals were recommended for some type of equipment per the database, but these had not been issued. Approximately 40 of these were recommended for an environmental switch rather than a communication based system. The speech clinicians had initiated some pilot groups with a focus on the development of communication skills and social interaction, including a coffee group and a music group. They were pleased with the progress of these groups and planned to develop additional groups within the homes and training environments in order to model for and engage direct support staff. Based on review of the PNMP monitoring sheets submitted, it appeared that at times, the monitors were marking the sheets without regard to the actual communication supports and programs provided to the individual and as such was ineffective to assess the consistency of implementation of those AAC systems currently issued to individuals.

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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.	**Standard: The facility provided an adequate number of speech language pathologists or other professionals (i.e., AT specialists) with specialized training or experience. Training included augmentative and assistive communication.** At the time of the onsite monitoring review, there were four full-time SLPs employed at LSSLC, (Lisa Barnes, MS, CCC/SLP, Candace Crawford, MS, CCC/SLP, Rhonda Hampton, MS, CCC-SLP, and Kristi Hodges, MS, CCC-SLP). License numbers were included on the list, but copies of credentials were not submitted, so the current status of their licensure was not verified at this time. CVs were submitted for each. A CV was also submitted for Nancy Jo Flournoy, MS, CCC-SLP, though she was no longer employed at LSSLC. Nathan Stevens was listed as a Speech Language Pathology Assistant who worked in the department from June 2010 through 10/15/10. Christina Pedroni, the Habilitation Therapies Director, was also a licensed speech language pathologist. Lisa Barnes completed her Master's degree in 1999 and had worked in the school system since that time. She began her employment at LSSLC on 8/1/10. Candace Crawford started her fellowship at LSSLC in June 2010 and became a fulltime SLP on 9/7/10. Rhonda Hampton completed her Master's degree in 2006 and worked fulltime in Lufkin at the Woodland Heights Medical Center for one year. She had worked at LSSLC since July 2007. Kristi Hodges completed her clinical fellowship year in 2002 and began working in the school system at that time. She began her employment at LSSLC in July 2009. There was one unfilled position at the time of this review per Ms. Pedroni. One contract therapist with significant background in AAC and assistive technology provided services one day a week at the time of this review. She was assisting to develop pilot programs for AAC and groups. There was one speech technician working with the clinicians for approximately three hours per day, five days a week. Documentation of continuing education completed in 2010 included: Lisa Barnes • Measuring Effectiveness of AT Devices and Services • Administer, Score and Interpret the CAAP® • Using Software to Remediate Auditory Processing Disorders • Speech Language Pathology Jurisprudence Exam Candace Crawford, Kristi Hodges, and Rhonda Hampton listed participation in various workshops and presentations, but specific titles of the courses were not listed and there was no evidence of their attendance or CEUs submitted. Some of these listed research of a product, attendance at meetings, and phone calls to vendors that, although learning opportunities, did not qualify as continuing education. Ms. Pedroni reported that the major focus of the department in the last six months had	Noncompliance

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		been to prioritize and organize clinician caseloads. She indicated that Ms. Crawford and Ms. Barnes had limited experience with dysphagia issues and, therefore, their caseloads were focused primarily on communication. Caseloads for the clinicians had been reorganized earlier in the month. The staffing had essentially remained unchanged since the baseline review. The primary difference was that now, the CFY student (Candace Crawford) was fully licensed, however, she was a recent graduate with limited experience and, as such, required ongoing oversight and supervision. The recent reorganization of the caseloads took into consideration the existing skill sets and experience of the clinicians. Though as reported in the baseline review, clinician caseloads were still high and there would be difficulty accomplishing all the requirements of the Settlement Agreement. The addition of an experienced contract SLP to assist with AAC one day a week was a positive step to addressing needs in this area, to develop expertise, and to build capacity among existing clinicians. In addition, a consultant SLP had been contracted to review the existing AAC services and provide recommendations. By report, the staff had found this to be an excellent opportunity and had hoped to continue this relationship via further consultations. The clinicians reported, however, that at this time the SLP was not likely to agree to further consultations at LSSLC because he had not yet been paid for the work he completed in May. **Standard: Communicative Aids and Speech Generated Devices (simple and complex) were provided to individuals based on need and not staff availability. All individuals in need of AAC, received AAC. SLPs actively participated in all facets of care in which communication is relevant.** Based on review of communication assessments submitted for 32 individuals indicated that there were at least 82% individuals identified to have significant expressive and/or receptive language deficits. Though requested, there was no communication assessment submitted for Individual #447. There were 32 individuals listed as receiving direct communication therapy, though the therapists reported that there were approximately 50 individuals receiving therapy two times a week. Four other individuals were listed as receiving oral motor therapy, though only one of those was listed as related to improving speech (Individual #300). The other three appeared to be related to minimizing drooling and/or increasing oral facial muscle tone. Though requested, no progress notes or evaluations were submitted for individuals identified as receiving direct communication therapy, with the exception of three evaluations for individuals that had been submitted as a recent evaluation by each speech clinician. The evaluations submitted for that request included Individual #425, Individual #545, and Individual #195.	

#	Provision	Assessment of Status	Compliance
		In the case of Individual #267, he had been previously recommended for direct speech therapy to address his speech intelligibility and volume, and this was initiated on 9/21/09. It was reported in his Communication Skills Evaluation Update that his participation had been poor and that no significant progress had been noted. It was recommended that therapy be discontinued as of the evaluation dated 4/30/10. There was no evidence that measureable objectives were developed to identify specific outcomes of therapy or to measure his progress during the seven months of services provided. He continued to present with concerns regarding breath support for speech resulting in reduced intelligibility, according to this update. The current evaluations for the other eight individuals presenting with significant communication deficits did not recommend direct services, but rather the following, indicating an absence of service provision. • Individual #417: She was recommended for use of an environmental switch in her home and training areas in addition to her Communication Dictionary. There was no indication that supports would be provided by the SLP. • Individual #407: She was recommended for use of a voice output device in her home and training areas in addition to her Communication Dictionary. There was no indication that supports would be provided by the SLP. • Individual #597: He was recommended for use of an electronic capability switch in his home and training areas in addition to his Communication Dictionary. There was no indication that supports would be provided by the SLP. • Individual #223: He was recommended for use of a voice output/capability switch in his home and training areas in addition to his Communication Dictionary. There was no indication that supports would be provided by the SLP. • Individual #500: He was recommended for a switch to activate preferred electronic items in his home and training areas in addition to his Communication Dictionary. There was no indication that supports would be provided by the SLP. • Individual #43: She was recommended for use of a communication poster to comment, make requests, and to interact with staff in her home, in addition to her Communication Dictionary. A service objective for this activity was discontinued as of her assessment dated 8/13/10 and use of the poster was to be monitored in the communication database. • Individual #13: Staff were referred to his Communication Dictionary and were instructed to respond to his attempts to vocalize or verbalize. There were no further recommendations. • Individual #525: Per his Communication Skills Evaluation Update, dated 6/8/10, it was reported that he had previously been recommended for diagnostic therapy for use of a picture schedule board to improve his	

#	Provision	Assessment of Status	Compliance
		understanding and compliance with his daily routine. Per his Staffing Summary in 2009, this had not been completed, but it was recommended that this be pursued through the school system. A service objective for use of a community communication poster was recommended for use in his home and in other program areas. There was no reference to a Communication Dictionary. There was insufficient rationale as to why the community communication poster was recommended rather than a picture schedule board. Per the AAC database submitted, there were approximately 63 individuals listed with some type of AAC system, though over 50% were limited to a community poster only. Another 67 individuals were recommended for some type of equipment, per the database, but none had been issued. Approximately 40 of these were recommended for an environmental switch rather than a communication based system. By report, the clinicians were attempting to observe individuals and conduct assessments in a greater variety of settings. They had initiated individual specific training for PNMPCs in the area of AAC since June 2010. There was, however, no evidence of new employee training related to communication.	
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.	**Standard: All individuals in need of AAC were identified as being in need of AAC.** At the time of this onsite review, the clinicians reported that not all individuals with a need for an AAC device had been identified. The baseline assessment format had been designed to identify each individual's need and potential to benefit from AAC systems to enhance his or her communication skills and was being reviewed and revised to enhance the quality of content to better meet the requirements of the Settlement Agreement. Beginning the month of this review, the clinicians had begun work on the Master Plan to appropriately prioritize individuals for assessment. They identified individuals receiving direct therapy and those with previous AAC recommendations as priorities for assessments (1A per their database). An additional priority was established for those who were nonverbal and did not have an assessment for AAC (1B per their database). Priority 2 individuals were those who had verbal skills, but they were not sufficiently functional. Priority 3 were those individuals whose speech was limited. Priority 4 were those individuals who verbalized their wants and needs without difficulty. This plan had not considered those with behavioral concerns as required by the Settlement Agreement. By report, the plan was insufficiently developed at the time of this onsite review for submission to the monitoring team. The clinicians were reminded that they should consider those who were nonverbal with behavioral concerns in their prioritization of need as outlined in the Settlement Agreement. During interview with the SLP clinicians,	Noncompliance

#	Provision	Assessment of Status	Compliance
		they discussed their progress with this plan. At this time, they were essentially completing assessments for individuals receiving services as their PSP came up because the prioritization system was not yet fully developed for others who might also be in need of a communication assessment. Documents requested by the monitoring team included the five most current assessments by each clinician along with the current PSP for those individuals. Speech-Language Update Evaluations (15) were submitted by three speech clinicians. Five assessments were submitted as completed by Nancy Jo Flournoy, MS, CCC-SLP, though she no longer was providing services at LSSLC. A number of the assessments submitted by these clinicians could not be considered most current, however, because they had been completed six to eight months prior to the onsite review because it was assumed that new assessments were completed on an ongoing basis with PSPs occurring each month; assessments would have been completed for some individuals more recently. Moreover, no assessments were provided as completed by Candace Crawford, MS, CCC-SLP or Lisa Barnes, MS, CCC-SLP. The corresponding PSPs were submitted for each of the assessments submitted as requested. All of these were current within the last 12 months. The assessments submitted included the following with dates reflected in parentheses below: Nancy Jo Flournoy, MS, CCC/SLP • Individual #425 (6/22/10) • Individual #195 (6/25//10) • Individual #267 (4/30/10) • Individual #335 (6/19/10) • Individual #417 (8/12/10) Kristi Hodges, MS, CCC/SLP • Individual #545 (4/12/10) • Individual #574 (6/10/10) • Individual #407 (5/14/10) • Individual #43 (8/13/10) • Individual #13 (7/26/10) Rhonda Hampton, MS, CCC/SLP • Individual #554 (2/9/10) • Individual #500 (4/14/10) • Individual #223 (6/8/10) • Individual #525 (6/8/10) • Individual #597 (8/5/10)	

#	Provision	Assessment of Status	Compliance
		A variety of documents from the personal records, including the communication assessments of a sample of 18 individuals selected by the monitoring team were also requested including Individual #298, Individual #172, Individual #361, Individual #36, Individual #339, Individual #96, Individual #232, Individual #52, Individual #191, Individual #560, Individual #105, Individual #447, Individual #502, Individual #161, Individual #334, Individual #265, Individual #24, and Individual #467. All 18 of the records requested were received. Communication assessments from the active records were submitted as follows with the date of the assessment(s)and PSP in parentheses: • Individual #298 (8/22/05, 9/10/08 and PSP: 9/8/10) • Individual #265 (4/24/09 and PSP: 4/20/10) • Individual #560 (12/29/04 and PSP: 1/6/10) • Individual #361 (8/2/00, 6/22/06, 6/30/09 and PSP: 6/15/10) • Individual #172 (4/8/02, 3/10/05 and PSP: 4/6/10) • Individual #96 (3/19/07 and PSP: 3/16/10) • Individual #52 (8/25/00, 7/24/06 and PSP: 7/7/10) • Individual #36 (8/19/03, 11/23/09 and PSP: 8/11/10) • Individual #232 (7/27/95, 11/15/01, 11/5/07 and PSP:11/4/09) • Individual #467 (4/4/03, 3/18/09 and PSP: 3/30/10) • Individual #24 (12/15/04, 12/11/07 and PSP: 12/9/09) • Individual #339 (8/16/06, 7/28/09 and PSP: 8/16/10) • Individual #191 (5/27/10 and PSP: 5/21/10) • Individual #105 (12/22/08 and PSP: 1/5/10) • Individual #161 (1/23/09 and PSP: 2/9/10) • Individual #334 (10/26/07 and PSP: 10/20/09) • Individual #502 (4/3/09 and PSP: 4/28/10) • Individual #447 (no communication assessment submitted and PSP: 7/2/10) Of the 18 individual records received and reviewed, only two (12%) included communication assessments current within the last 12 months, for Individual #36 and Individual #191. While it was possible that a more current assessment had been completed for the others, the reports were not contained in the individual's active record. Assessments submitted for six individuals were baseline assessments. Updates to baseline assessments completed three years earlier were submitted for eight individuals and for 12 individuals, assessments submitted were updates to previous updates that were completed three years earlier. In some cases, individuals had not received a more recent baseline assessment in as many as six to 10 years (Individual #172, Individual #24, Individual #52 and Individual #232). Four individuals had also	

#	Provision	Assessment of Status	Compliance
		not received an update assessment in more than three years, including Individual #560, Individual #96, Individual #172, and Individual #52. None of these assessments indicated that further communication assessments were not indicated for any of these individuals due to adequate and functional communication skills. Most of the assessments contained a section related to Augmentative/ Alternative Communication. This area was not assessed, however, for Individual #24 in the baseline assessment on 12/15/04 or her most recent assessment update on 12/11/07. For those who had been evaluated for AAC, these sections were generally very brief and a number did not reflect a sound rationale to rule out whether the individual would benefit from some type of AAC system. The American Speech-Language-Hearing Association (ASHA) states that "it is imperative that the goal of augmentative and alternative communication (ACC) use be the most effective interactive communication possible. Anything less represents a compromise of the individual's human potential." An AAC system is an integrated group of four components used by an individual to enhance communication. These four components are symbols, aids, techniques, and/or strategies. ASHA also states that there are no prerequisites to use AAC and that the currently accepted evidence in the literature suggests that no specific skills are prerequisite for successful use of AAC in the broadest sense. It is a widely accepted practice at this time that prerequisites are not necessary for an individual to benefit from AAC systems, yet this had been used a rationale by speech clinicians for not providing this technology to a number of individuals at LSSLC. Some examples are described below. • Individual #172 received a baseline assessment on 4/8/02 that indicated that he became quiet when talked to or touched, responded differently to angry versus pleasant voices, and showed an interest in commercials, jingles, and simple songs. It was stated, however, that because he lacked "prerequisites," such as not following simple instructions, displaying object recognition, or attending to a structured task, he was not a candidate for AAC. An update on 3/10/05 restated that he was not a candidate, though he was considered nonverbal. It was of concern that Individual #172 had not received an appropriate communication assessment at least since 2002 and, as a result, was not likely receiving adequate supports and services. • Individual #96 received a baseline assessment on 3/19/07 that indicated that she initiated affection to staff, understood simple phrases, showed an interest in photographs, recognized familiar family members, and enjoyed music. It was stated, however, that because she lacked "prerequisites," such as not following simple instructions, recognizing objects or attending to a structured task, she was not a candidate for AAC. It was of concern that Individual #96 had not received an appropriate communication assessment at least since 2007 and as	

#	Provision	Assessment of Status	Compliance
		such was not likely receiving adequate supports and services. • Individual #339 received an update on 8/16/06 that stated that he lacked prerequisite skills of following simple instructions. It was of concern that Individual #339 had not received an appropriate communication assessment at least since 2006 and, as a result, was not likely receiving adequate supports and services. • Individual #52 received a baseline evaluation on 8/25/00 and an update on 7/24/06. In each, it was stated that she also lacked the necessary prerequisites for AAC. It was of concern that she had not received an appropriate communication assessment at least since 2000 and, as a result, was not likely receiving adequate supports and services. • Individual #361 had received an assessment on 8/2/00 and an update on 6/22/06. The more recent update referenced another update completed on 6/19/03, but that was not included in the documents submitted or available in her active record. In each of these, she was identified as not presenting with the necessary prerequisites and as such was not a candidate for any type of AAC system. The most current update also stated that she did not have communicative intent, however, she was observed to vocalize pleasure and displeasure, smile when spoken to, resisted objects or people by turning away, cried to gain attention, and quieted when her needs were met. It was of concern that she had not received an appropriate communication assessment at least since 2000 and as such was not likely receiving adequate supports and services. • Individual #467 received a baseline evaluation on 4/4/03 and an update on 7/24/06. In each, it was stated that she also lacked the necessary prerequisites for AAC. It was of concern that she had not received an appropriate communication assessment at least since 2003 and as such was not likely receiving adequate supports and services. • Individual #334 had received updates on 10/22/04 and 10/26/07. In each, it was stated that AAC had been addressed in the past and was not successful due to noncompliance with limited progress. He reportedly used two to four word utterances that were described as emotionally charged and not always intelligible. He anticipated his daily routine, manipulated some objects functionally, and followed some simple verbal requests without gestures. There were no recommendations related to communication. It was of concern that he had not received an appropriate communication assessment at least since 2004 and as such was not likely receiving adequate supports and services. • Individual #574, Individual #554, Individual #161, Individual #36, and Individual #560 were not assessed for AAC because they were described as verbal. There was no assessment to determine if their verbal skills could have been enhanced with AAC. There were no other communication-related	

#	Provision	Assessment of Status	Compliance
		recommendations for these individuals. **Standard: All people received a communication screening or assessment within 30 days of admission, readmission, or change in status.** There were no assessments submitted for individuals who had been recently admitted to LSSLC. There had been only two, but, by report, all newly admitted individuals were evaluated within the 30-day timeframe. There was no database available at this time to confirm this. Further assessment of this provision item will be necessary during a subsequent review. There was no indication that individuals were re-evaluated upon change in status. The LSSLC POI indicated that a plan was being developed to ensure that this occurred as indicated. **Standard: Communication Assessment addresses:** • **Both verbal and nonverbal skills** • **Expansion of current abilities** • **Development of new skills** • **Whether the individual requires direct or indirect Speech Language services and** • **The need for further assessment in Augmentative Communication.** The majority of the assessments reviewed (only current assessments were reviewed for the above elements) generally addressed both verbal and nonverbal skills. In some cases, there was insufficient information and specificity upon which to base potential for expansion of existing skills and to establish goals and objectives for communication supports and interventions. It was also often not clear as to how effective the current methods used by each individual were within their daily routine. The clinicians usually reported what system the individual had, how it was used, and whether or not it was effective. Recommendations for further assessment related to AAC were noted in a few cases, including Individual #425 and Individual #36, for example. During interview with the speech clinicians, they stated that the current approach to assessment did not sufficiently address strategies to expand current abilities or the development of new skills. There was no consistent mechanism to follow-up on implementation of recommendations. In some cases, the assessment addressed expansion of current abilities via very limited recommendations for communication strategies, such as reinforcing the individual's communicative efforts or advising staff to refer to the individual's communication dictionary. There was no evidence that there was a specific effort to expand current skills or develop new ones via specific goals for supports and interventions. In the case	

#	Provision	Assessment of Status	Compliance
		of Individual #425, the clinician reported that recommendations had been made in the evaluation in 2009, but that they had not been implemented. It was unclear how this clinician would expect that these recommendations would be integrated without her assistance, and it was of concern that this problem was only identified in the assessment one year later rather than earlier in the year so that action to address the issue could be taken in a timely manner. There were occasional references to diagnostic therapy for some individuals and recommendations to trial specific AAC systems for effectiveness. Most of the assessments completed in the last year were identified as updates to previous updates, many of which were completed at least three years ago. In some cases, the assessment identified as baseline had occurred more than three years earlier. As such, the assessment was not comprehensive and clinician conclusions typically stated that an individual was not considered to be a candidate for AAC at that time due to the lack of prerequisite skills. Current practice standards suggest that prerequisites are not required for an individual to benefit from AAC and, as such, individuals should receive a current comprehensive baseline assessment with a thorough assessment of the individual's potential for AAC use. **Standard: If receiving services, direct or indirect, the individual was provided a comprehensive Speech-language assessment at a frequency that ensured relevance and appropriateness of goals.** By report, the clinicians previously completed a staffing summary for the annual PSP rather than an assessment. There was a plan to shift toward completion of assessment updates rather than these summaries with comprehensive assessments completed every three years for those receiving communication supports and services. Of the individuals for whom assessments were submitted, the following were listed as receiving direct services from an SLP: Individual #545, Individual #195, Individual #105, and Individual #232. • Individual #545 had not received a communication assessment since 2007 until his most recent evaluation dated 4/12/10. While there was no evidence that he had previously received direct services, there was a reference to a Communication Dictionary. It would have been expected that he would have been assessed annually to review this indirect support. He was recommended for direct services at the time of his current assessment. • Individual #195 had not received a communication assessment since 2007 until his most recent evaluation dated 6/25/10. It was reported that there had been a service objective in the last year to use a community poster in his home and other program areas. It would have been expected that he would have been assessed annually to review this indirect support.	

#	Provision	Assessment of Status	Compliance
		• Individual #105 had not received a communication assessment since 2005 until her most recent evaluation dated 12/28/08. It was reported at that time that she had a communication board and an electronic device. She was using the device with the therapist and also had a service objective for use of a communication board. Recommendations included continuation of these systems and she was listed as currently receiving direct speech therapy yet she had not received an assessment in nearly two years. • Individual #232's most current assessment was dated 11/5/07. It recommended that he participate in a trial for training with a communication poster and/or board to enhance and improve his communication skills. Currently, he was listed as receiving direct therapy for visual training using eye gaze and to explore use of an AAC system. It was of concern that he had not been assessed by an SLP in nearly three years despite receiving these services. In 2009, Individual #425 was provided opportunities to use a switch to activate a radio or fan, and was recommended to use a talking photo album, but was reported to not have demonstrated "communicative intent." No assessment had been completed since 2007. The clinician documented concern that recommendations had not been implemented at that time. During his most current assessment, dated 6/22/10, he was recommended for exploration of AAC in direct therapy and had been introduced to a Dynavox device. It was of concern that he had not received a communication assessment in three years and his potentials had not been identified sooner. The speech clinicians had initiated some pilot groups with a focus on the development of communication skills and social interaction, including a coffee group and a music group. They were pleased with the progress of these groups and planned to develop additional groups within the homes and training environments in order to model for and engage direct support staff. In the case that there were service objectives for interventions, documentation was limited to attendance only and this constituted the majority of services provided by the SLPs at the time of this onsite review. As skill acquisition plans were developed, documentation was to occur with each session and data collected related to the specific goal at least two times monthly with a progress note written monthly. Current service objectives were being converted to skill acquisition programs as the individual's PSP occurred. **Standard: For persons receiving behavioral supports or interventions, the Facility had a screening and assessment designed to identify who would benefit from AAC. Note: this may be included in the PBSP.**	

#	Provision	Assessment of Status	Compliance
		The development of the Master Plan had just begun during the month of this review and, by report, had not included those with behavioral support needs in the prioritization system. As such, there was no system to address this issue at this time. **Standard: Communication programs were integrated into the BSP as indicated.** By report, the directors of psychology and habilitation therapies had met regarding this element, but had not yet outlined specific strategies to accomplish this element. Communication Dictionaries were requested, but only the template was submitted, so it was not possible to determine if aspects related to behavior were included in these. There was no evidence of collaboration with psychology in the development of communication plans or of integration of these plans into the PBSPs. It was noted that elements of the PBSPs had been included in detail in the PNMP documents for many individuals. As stated above, it was of concern that the PNMPs contained significant information related to restraints and target behaviors/interventions; this was different than the PNMPs seen at other DADS facilities across the state or as described in state guidelines. While integration is an important goal, it cannot be accomplished simply by putting a lot of information into one plan but rather by collaborating in the development of the plans to ensure that they are consistent. **Standard: Policy existed that outlined assessment schedule and staff responsibilities.** The current state policy referenced a "Communication Master Plan" that was intended to prioritize assessments and services based on need. As stated above, the development of this Master Plan had just begun during the month of this review and by report was incomplete at the time of this onsite review.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	**Standard: Standard: The PSP contained information regarding how the person communicated and strategies staff may utilize to enhance communication.** As stated above, the PSP offered very limited descriptions of how an individual communicated with others and offered even more limited instructions as to how staff would best communicate with him or her. The PSPs generally included the communication assessment in part or in full when there was one available. The communication section of the General Discussion Record was limited to a couple of sentences regarding how the individual communicated, but it was not typical to read anything about how staff should communicate with the individual as a partner. The Communication Dictionary template suggested that this was included in that document but other than mentioning that there was one in some cases, the actual	Noncompliance

#	Provision	Assessment of Status	Compliance
		strategies were not addressed in the PSP itself. Rationales and descriptions of interventions regarding use and benefit from AAC were reflected only in the text included from the SLP assessments. **Standard: AAC devices were portable and functional in a variety of settings.** In general, it appeared that the existing AAC systems were functional. It was not clear, however, that they were used consistently across a variety of settings and, in many cases, appeared to be left to the direct support staff and program training staff to implement without sufficient integrated support from the SLPs. In some cases, equipment was listed in the communication equipment database, but was not included in the PNMP. For example: • The database submitted indicated that Individual #288 had been issued a Dynavox device on 8/20/09, yet this was not identified anywhere on her PNMP. She also was listed with a communication book that was referenced in the PNMP. • In the case of Individual #535, he was listed with a Dynavox device issued on 11/3/09. This was not identified in his PNMP with reference only to a communication dictionary. • Individual #190 was identified with a Dynavox device issued on 6/16/09, but it was not included in her PNMP. The communication board was referenced under the Communication heading of the plan. These devices did not appear to be available for use by these individuals. **Standard: AAC devices were individualized and meaningful to the individual.** In most cases, the selection of a device was not typically well justified in the assessment. In other cases there was insufficient rationale for not recommending AAC for an individual. For example, the clinician described that she assessed Individual #417 over three sessions related to AAC use and concluded that development of AAC was not indicated. She reported trying one- and two-button voice output switches with her to request "more" and "all done." The therapist stated that Individual #417 turned away and refused hand-over-hand assistance as well as not showing awareness of the voice output component. Recommendations for training in this area were limited to switch activation of an electronic device rather than related to communication during activities that would incorporate the need to request "more" as during meals or at the conclusion of other activities ("all done"). There appeared to be more of a focus on the device and the individual's response to it rather than an assessment of the individual's participation in his or her routine activities to determine where he or she may have a need for getting	

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		attention, making a request, or making a choice, for example. These may provide cues for opportunities for communication enhancement that may be overlooked when the assessment occurred only during a clinical sample of behavior. With appropriate staffing, the clinicians would be more readily available for integrated supports and ongoing assessment across settings and environments throughout the PSP year rather than in a defined time period just before the annual meeting. **Standard: Staff were trained in the use of the AAC.** Staff received 30 minutes of new employee training related to deaf awareness, but no other training related to communication or AAC. Further staff training in the area of communication strategies by speech staff was limited due to the many other responsibilities of the staff**.** By report, the speech therapists had initiated person-specific training for staff in the area of AAC in June 2010 and were continuing to provide this for existing systems. Person-specific training was limited to any available direct support staff present at the original inservice that generally included supervisors and home managers who were then responsible for providing training to the remaining staff. There were no established competencies and the clinicians were not able to verify whether the subsequent training conducted by home staff included demonstration or were inservices consisting of only "read and sign" strategies. Individual #176 had a significant hearing impairment and had moved to LSSLC last year from a state hospital where she had a full-time interpreter. Per the therapists, Individual #176's mother had requested that she live at LSSLC and had stated that her daughter did not require an interpreter. At the time of her move, Nancy Jo Flournoy, MS, CCC-SLP, was still employed at the facility and had a background in sign language. She provided some initial staff training and a poster was placed on the wall in Individual #176's room. At the time of this review, however, there were inadequate supports for her to use her primary mode of communication, sign language. There was no interpreter provided for her at meetings and there was reportedly no one on campus that had sufficient proficiency in sign language to fully support her. Apparently, there had been efforts to obtain these supports at the local college, but these were not successful. Subsequent staff training had not occurred by report. The clinician's questioned whether that this was their responsibility because they considered sign language as a "language" (as Spanish or German are considered to be languages) and, in the case of an individual who spoke those languages, they would not be primarily responsible for those supports. They also expressed concerns over the provision of assistive technology for her in lieu of providing improved supports for sign language. According to ASHA, AAC consists of unaided methods that require no equipment and	

#	Provision	Assessment of Status	Compliance
		include gestures, sign language, and finger spelling. Aided methods include non-electronic and electronic communication devices, books or boards that may contain pictures, photographs, words, and/or voice output communication devices. Many AAC users use a combination of methods, including both unaided and aided methods. For example, an AAC user may use an electronic voice output device through most of the day, but use a low-tech communication wallet containing pictures during meals so as not to risk damage to an electronic device during this activity (aided). The same individual may use head nods to answer yes/no questions throughout the day (unaided). Similarly, it would not be inappropriate for Individual #176 to use a variety of aided methods, such as posters or books, in addition to her primary unaided method of sign language and finger spelling. It was of great concern, however, that more supports had not been provided to both professional and direct support staff to promote their learning of sign language as well as to Individual #176 to ensure that she had interpreter services available to her for activities, such as meetings, psychiatrist appointments, and seeing her PCP and dentist. Very limited suggestions for communication strategies were listed in the assessments and listed under the recommendations section under Assessments/Services the Person Uses/Needs portion of the PSP. These strategies were usually not included on the PNMP, but rather a brief description of how the individual communicated was documented. For example, Individual #574 was described as communicating "verbally, usually with one word" under the communication heading of his PNMP. Individual #201 was described as "severe –can talk, but doesn't talk much." Individual #159 was described as "severe, needs typically anticipated" under the communication heading of his PNMP. In the case of Individual #160, "no problem" was all that was listed under the communication heading of his PNMP. These descriptions were not functionally useful for staff to assist individuals with their communication needs. In many cases, the only information on the PNMP was that an individual was verbal or that the reader should refer to the Communication Dictionary. Based on review of the PNMPs submitted, they did not consistently list the communication equipment under the assistive equipment section of the plan, but rather only referenced these in the communication section. **Standard: Communication strategies/devices were implemented and used.** Much of the interaction observed by the monitoring team was specific to a task with little other interactions that were meaningful. The therapists did not have a reliable way via the existing monitoring system to accurately determine if their recommendations and other programs were appropriately implemented. In some cases, as described above (e.g., Individual #425), the clinician was not aware that the recommendations had not	

#	Provision	Assessment of Status	Compliance
		been implemented as prescribed until the subsequent assessment. **Standard: General AAC devices were available in common areas.** A number of community devices were available (posters), but were not observed to be used during the onsite review by the monitoring team. There were no community electronic devices listed in the communication equipment database. The community posters were often referred to in PSP meetings and in PSP documents. It appeared that the purpose of these posters was so that individuals could point to items on the poster to make a request (or could receive assistance from staff to do so). Regarding these posters: • There was no training for staff on how and when use these posters. • Two posters were seen by the monitoring team, but no examples of their use were observed. • Posters could be used as a backup or extra system for individuals, but should not used as anyone's primary augmentative or alternative means of communication.	
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.	**Standard: A monitoring system was in place that: tracked the presence of ACC; working condition of AAC; the implementation of the system; and effectiveness of the system.** A system of monitoring, using the PNMP Monitoring Sheet, was completed by the PNMPCs as well as nurses and home staff. The indicators on the sheet included availability of the communication device, use of the device, working order of equipment, and whether the community poster was in use. Based on review of the PNMP monitoring sheets submitted, it appeared that, at times, the monitors were marking the sheets without regard to the actual communication supports and programs provided to the individual. For example, per the PNMP monitoring sheets, Individual #183, Individual #177, Individual #344, Individual #29, Individual #333, Individual #453, Individual #133, Individual #263, Individual #66, Individual #323, Individual #248, and Individual #455 were identified with communication devices and/or posters by the monitors. These findings, however, were not consistent with the information on the Communication Skills Therapeutic Equipment database submitted. Some examples included: • Individual #455 was not listed in the database at all, though the monitor documented observing him using both a communication device and a community poster on 7/29/10. • The monitor documented that she had observed Individual #177 using both a communication device and poster on 6/10/10, yet she was not listed as having	Noncompliance

#	Provision	Assessment of Status	Compliance
		either of these per the database. • It was documented that the monitor had observed Individual #344 using both a communication device and poster on 6/10/10. According to the database she had neither. • The monitor documented that she had observed Individual #29 on 6/8/10 with both a communication device and community poster, but reported that "she made no effort to use a board." She was not listed with any of these devices per the database. • The monitor documented that the communication device for Individual #453 was readily available, but not used on 6/9/10 and 6/17/10. The monitor also reported that the community poster was not used on those dates. Neither of these was listed as provided to Individual #453 per the database submitted. • It was documented that a communication device and community poster were readily available and used by Individual #133 on 7/6/10, however, she was identified as only having the community poster per the database. • It was documented that a communication device and community poster were readily available and used by Individual #263 on 6/24/10, however, the poster was not issued for use until 7/27/10. The monitor documented that the communication device was on the wall or in a folder. Per the database, her Dynavox device was reported as missing on 7/10/10. • It was documented that a communication device and community poster were readily available and used by Individual #66 on 7/6/10. The monitor marked that "equipment in good repair" was not applicable. The database did not list either of these systems as provided to Individual #66. • It was documented that a communication device and community poster were readily available, but not used by Individual #323 on 7/28/10. The monitor marked that the equipment was in good repair. The database did not list either of these systems as provided to Individual #323. • It was documented that a communication device and community poster were readily available and used by Individual #333 on 7/23/10, however, she was identified as only having the community poster per the database. There was no evidence that effectiveness of each individual's AAC system was monitored by the PNMPCs or by the SLPs beyond the assessment updates. **Standard: Monitoring covered the use of the AAC during all aspects of the person's daily life in and outside of the home.** Monitoring of AAC was conducted most often in the homes rather than across settings, per the monitoring sheets submitted.	

#	Provision	Assessment of Status	Compliance
		Standard: Validation checks were built into the monitoring process and conducted by the plan's author. There was no routine system to validate the continued competency of monitors at LSSLC at the time of this onsite review by the monitoring team.	

Recommendations:

1. Immediately complete the Master Plan to include individuals who are nonverbal with behavior concerns as a high priority for a comprehensive communication assessment. This should be a public list, so that PSTs are aware of the prioritization of individuals they support.

2. Many of the current assessments lacked adequate justification for the recommendations for specific AAC systems as well as for recommendations that communication supports (other than the Communication Dictionary) were not indicated. This must be addressed for the assessments not yet completed, but must be also addressed for those assessments already done. This is a key element to a comprehensive assessment that meets generally accepted professional standards of care.

3. A strong comprehensive baseline assessment should be completed for each individual per the Master Plan schedule based on the established priorities. Most of the assessments completed in the last year were identified as updates to previous updates, many of which were completed at least three years ago. In some cases, the assessment identified as baseline had occurred more than three years earlier. As such, the assessment was not comprehensive and conclusions were typically noted that an individual was not considered to be a candidate for AAC at that time due to the lack of prerequisite skills.

4. Ensure that the most current assessments (baseline and updates) are contained in the active record for each individual.

5. For those receiving direct services, well defined, measurable, meaningful, and functional goals or outcomes must be clearly stated with indices of progress reviewed no less than monthly. Modifications to intervention plans must be made when lack of progress is noted.

6. Consider implementation of more individualized AAC systems and greater variation in community systems because over 50% of the existing systems for individuals were limited to community posters only.

7. Staff training in the area of communication and AAC must be a priority. Foundational skills in these areas should be provided in new employee orientation with clearly outlined competencies as well as person-specific training to ensure appropriate implementation of communication plans. A focus on sign language is indicated for those who support Individual #176.

8. Many recommendations appeared to be left to the PST for the development and implementation of plans, even in the absence of sufficient staff training. It is critical that SLPs be involved at least in a consultative model to ensure that the plans, materials, and implementation are within the scope of the individual's abilities and/or promote enhancement and skill development, as well as training, modeling, and coaching for staff. SLPs should be utilized in the development of instructional plans in a variety of settings to ensure that they are individualized with regard to

the communication strategies incorporated into these plans. Communication goals can and should be addressed across the full gamut of training objective programming.

9. The focus of monitoring for AAC systems should address effectiveness and implementation versus only availability and condition. This will require professional staff to conduct more frequent and thorough monitoring in addition to that conducted by the PNMPCs.

10. Clarification of expectations for monitors related to the indicators on the PNMP Monitoring Sheet must be provided. Each element must be well defined. For example, there appeared to be confusion over the difference between a communication device and the community posters in the home.

11. Ensure improved consistency of how communication abilities and effective strategies for staff use are outlined in the PSPs and in the PNMPs.

12. Ensure improved integration of assessment and methodology for communication-related plans, both formal and informal, including sign language, picture exchange, assistive technology, and other AAC systems to include speech clinicians, psychology, and other staff responsible for program development. Selection should be bimodal, meaning that AAC should utilize the individual's full communication capabilities, including residual speech or vocalizations, gestures, signs, and communication aides. These should be based on what best matches each individual's skills and functional needs across environments and settings. The integration of effective communication strategies ensures that active treatment is engaging and more meaningful to the individual.

13. Provide appropriate and adequate communication supports for Individual #176 related to her use of sign language for meetings, medical appointments on and offsite.

The following are offered as additional suggestions to the facility:

14. When an update is completed subsequent to a strong baseline assessment, reference to the comprehensive assessment should be made in the update and the comprehensive assessment should not be purged until such time as a new comprehensive assessment is completed. This is critical to ensure continuity and to permit tracking of decision-making and clinical reasoning by SLPs. This will be particularly important as new staff are added to the department or when the assessment is completed by a different therapist during a previous year.

15. Consider continued use of the outside consultant for interim reviews of AAC systems at LSSLC. This would be important for capacity building with the existing clinicians many of which have limited experience.

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Personal Support Plans (PSPs) for: • Individual #166, Individual #79, Individual #201, Individual #450, Individual #205, Individual #487, Individual #316, Individual #492, Individual #297, Individual #482, Individual #333, Individual #219, Individual #305, Individual #476, Individual #422, Individual #41, Individual #491, Individual #22, Individual #131, Individual #562, Individual #170, Individual #249, Individual #294, Individual #57 o Skill Acquisition Plans (SAPs) for: • Individual #260, Individual #132, Individual #235, Individual #297, Individual #316, Individual #349, Individual #309, Individual #93, individual #482, Individual #333, Individual #492, Individual #160, Individual #557, Individual #57, Individual #131, Individual #562, Individual #170, Individual #249, Individual #294, Individual #22 o Dental desensitization plans for: • Individual #567, Individual #568, Individual #525, Individual #375, Individual #469 o SAP data for past 6 months for: • Individual #170, Individual #57, Individual #249, Individual #131, Individual #562, Individual #294, Individual #22 o Quarterly reviews of SAP data for: • Individual #431, Individual #51, Individual #219, Individual #476, Individual #422, Individual #131, Individual #170, Individual #249, Individual #562, Individual #22, Individual #57, Individual #294 o 5-Minute Engagement Monitoring Form, undated o Active Treatment Engagement Data for September, 2010 o IEPs and progress report information for Individual #41, Individual #305, and Individual #491 o Texas Education Agency, Residential Facility Monitoring System 2009-2010 Corrective Action Plan, submitted by LISD, and approved by TEA on 8/31/10 o List of 30 individuals who were under age 22 and received educational services, dated 8/27/10 (one individual had been discharged by the time of the onsite review) o LISD classroom schedule for classroom at LSSLC <u>Interviews and Meetings Held</u>: o Luz Carver, QMRP Coordinator o Lisa Curington, Director of Employment and Day Services o Shelia Gibson, QMRP; Robert Cheshire, QMRP; Shirley Hunt, QMRP Assistant; Shelia Lester, QMRP Assistant

	o Barbara Draper, Active Treatment Director o Tawnya Baker, Assistant to the QMRP director o Gladys Swanson, LISD assistant principal at Lufkin High School o Debra Antley, LISD teacher at the LSSLC classroom <u>Observations Conducted</u>: o Observations occurred in every day program and residence at LSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals including, for example: • Assisting with daily care routines (e.g., ambulation, eating, dressing), • Participating in educational, recreational and leisure activities, • Providing training (e.g., skill acquisition programs, vocational training, etc.), and • Implementation of behavior support plans o LISD High School o LISD classroom at LSSLC
	Facility Self-Assessment: LSSLC's Plan of Improvement (POI) indicated that all items in this provision of the Settlement Agreement were in noncompliance. The monitoring team's review of this provision was congruent with the facilities findings of noncompliance in all areas.
	Summary of Monitor's Assessment: This provision of the Settlement Agreement incorporates a wide variety of aspects of programming including skill acquisition, engagement in activities, and staff training. To assess compliance with this provision, the monitoring team looked at the entire process of habilitation and engagement. The facility was awaiting the development and distribution of a new policy in this area. It is expected that the policy will provide direction and guidance to the facility. Although no items of this provision of the Settlement Agreement were found to be in substantial compliance, the facility was making progress in several areas, including the addition of graphing of skill acquisition plans (SAPs), increasing the number of SAPs for dental desensitization and replacement behaviors, and the development of an engagement tool. Many of these improvements were too new to be fully evaluated by the monitoring team and will be reviewed in future reviews.

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two	This provision required an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at LSSLC. Although much work had been done to address this item, more work needs to be done to bring these	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	services, supports, and activities to a level where they can be considered to be in substantial compliance with this provision item. As a result, this item is rated as being in noncompliance. <u>Skill Acquisition Programming</u> Skill acquisition plans at LSSLC consisted of: • Skill Acquisition Plans (SAPs) that were written by QMRPs (qualified mental retardation professionals), and monitored by active treatment coordinators. QMRP assistants trained direct care professionals (DCPs) in the implementation of SAPs, and monitored progress • Vocational objectives that were written and monitored by employment services personnel • Medical desensitization programs that were written and monitored by the Dentistry Department • Activity Plans, written, monitored, and implemented by specific rehabilitation professionals (e.g., physical therapists, speech language pathologists) and, generally, implemented by DCPs. Medical desensitization programs were recently begun at LSSLC. These skill acquisition plans teach individuals to tolerate medical interventions (e.g., dental exams), and can result in a decrease in the use of sedating pre-exam medication. Since the baseline review, 61 new medical desensitization plans were developed and incorporated into the general training objective methodology for all SAPs. As such they are subject to the same strengths and weaknesses discussed below for all SAPs at the facility. The facility's obvious focus on the development of these plans, however, represented an improvement from the baseline visit. Outcome data (including the use of sedating medications) from the desensitization plans will be reviewed in more detail in future site visits. Another improvement from the baseline review involved the use of replacement behaviors (see K5 for a detailed description of replacement behaviors). Consistent with the baseline recommendation, replacement behaviors had been included into the SAPs at LSSLC. Review of those plans, however, indicated that none of the replacement behaviors reviewed included specific training strategies. It is recommended that replacement behavior training procedures, like those for the desensitization plans, be incorporated into the general training methodology, and conform to the standards of all skill acquisition programs listed below. An important component of an effective skill acquisition plan is that it should be based on each individual's needs identified in the Personal Support Plan (PSP), adaptive skill or habilitative assessments, or psychological assessment, and individual preference. In	

#	Provision	Assessment of Status	Compliance
		other words, for skill acquisition plans to be most useful in promoting individuals' growth, development, and independence, they should be individualized, meaningful to the individual, and represent a documented need. Conversations with the QMRP Coordinator and several QMRPs indicated that the facility did attempt to incorporate preferences and needs into the development of individual SAPs. The QMRP Coordinator indicated that she believed the new PSP format would better lend itself to documentation that SAPs were based on individual need and preference. In fact, the monitoring team did note some examples of the new PSP format including a rationale for why a particular SAP was chosen. For example: • Individual #166's PSP documented that she desired to live in the community. The PST determined that one skill necessary to be successful in the community would be being able to work in the community. Her treatment team determined that she needed to improve her vocational skills in order to maintain a job in the community. Therefore, a SAP to address Individual #166's speaking politely to others (a skill needed to for community employment) was developed. In reviewing 24 PSPs (nine of which were in the new format), however, it was not consistently obvious that SAPs were developed to address individual preferences and needs. It is recommended that the facility more clearly document how SAPs were based on individual needs and preference. Once developed, skill acquisition plans need to contain some minimal components to be most effective. The field of applied behavior analysis has identified several components of skill acquisition plans that are generally acknowledged to be necessary for meaningful learning and skill development. These include: • A plan based on a task analysis • Behavioral objectives • Operational definitions of target behaviors • Description of teaching behaviors • Sufficient trials for learning to occur • Relevant discriminative stimuli • Specific instructions • Opportunity for the target behavior to occur • Specific consequences for correct response • Specific consequences for incorrect response • Plan for maintenance and generalization, and • Documentation methodology The SAPs at LSSLC consistently included many of these components, such as task	

#	Provision	Assessment of Status	Compliance
		analysis, behavioral objectives, operational definitions, specific training instructions, the documentation methodology, and the use of consequences for incorrect responses. The SAPs reviewed did not, however, consistently contain the use of relevant discriminative stimuli, specific consequences for correct responses, or a plan for maintenance and generalization of skills. All skill acquisition plans should include the above components demonstrated to be necessary for learning and skill development. Conversations with the QMRP Coordinator indicated that LSSLC was planning to expand its training methodology by having an inservice by a behavioral consultant and attempting to better individualize training methods. Additionally, the QMRPs (rather than the QMRP assistants as during the baseline review) had recently begun to write SAPs. At the time of the onsite review, however, the training methodology for every SAP reviewed was identical. It included the training of one step of a task analysis, for example, turning on the water, for a goal of washing hands. When turning on the water was accomplished, then putting hands under the water was the next SAP. Additionally, all the SAPs reviewed used least-to-most prompting procedures. These training methods can be very effective, however they are not generally effective with every individual across all skills trained. LSSLC needs to expand its training methodology to other procedures shown to be effective in developing new behavioral repertoires. Examples of additional training methods include total-task chaining (i.e., the learner receives training on each step in the task analysis during every session), backward training (i.e., all the steps in the task analysis are initially completed by the trainer, except for the final behavior in the chain), and shaping. It is recommended that the facility expand its training methodology to other procedures shown to be effective in developing new behavioral repertoires. LSSLC had made several improvements in the review of SAP progress and the use of data based decisions to continue, modify, or discontinue an objective. QMRP assistants trained DCPs to implement SAPs, summarized ongoing data monthly, and presented those data at quarterly meetings. Since the baseline review, the facility had improved the review of SAP progress by including the graphing of outcome data to enhance decision-making. The monitoring team reviewed the graphed data from two quarterly reviews (Individual #431 and Individual #51) and were encouraged by the facility's efforts in this area, including the resulting enhanced ease of evaluating SAP outcomes. Future onsite reviews will objectively evaluate LSSLC SAP outcomes by reviewing these graphs. It is recommended that the facility continue to expand the graphing of monthly SAP data. Another variable that would likely improve the overall effectiveness of SAPs at LSSLC is the inclusion of regularly assessed integrity data. That is, a direct measure that DCPs are implementing SAPs as intended. The QMRP assistants reported that they no longer were	

#	Provision	Assessment of Status	Compliance
		responsible for ensuring that DCPs implemented SAPs as written. At time of the onsite review, active treatment coordinators were responsible to ensure that SAPs were implemented by DCPs with integrity. It is recommended that a plan be developed to collect and graph integrity data to ensure that SAPs are conducted as written. Finally, the monitoring team recognizes that the above discussion identified several critical steps for SAPs to promote growth, development, and independence. Those steps include 1. the writing of SAPs (ensuring they are based on individual need and preference, and are based on effective training methods), 2. training of staff who implement the plans, 3. ensuring that SAPs are implemented with integrity, 4. review of SAP progress, and 5. data-based decisions to continue, modify, or discontinue a SAP. At the time of the onsite review several individuals (i.e., QMRPs, QMRP assistants, DCPs, and active treatment coordinators), across three separate lines of supervision were required to coordinate their efforts in order for these steps to be successfully completed. It is suggested that the facility consider an organizational change that would streamline the SAP process and allow more time and focus for writing skill acquisition goals and SAPS as well as monitoring their implementation and progress. <u>Engagement in Activities</u> As a measure of the quality of individuals' lives at LSSLC, special efforts were made by the monitoring team to note the nature of individual and staff interactions, and individual engagement. Engagement of individuals in the day programs and homes at the facility was measured by the monitoring team in multiple locations, and across multiple days and times of the day. Engagement was measured simply by scanning the setting and observing all individuals and staff, and then noting the number of individuals who were engaged at that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. Specific engagement information for each residence and day program are listed in the table below. The monitoring team was encouraged by the generally positive and caring interactions between staff and individuals at LSSLC, and by the consistently high level of productive engagement in the workshop. The majority of activities observed in the residences, however, consisted of individuals sitting at a table, and staff attempting to engage them	

#	Provision	Assessment of Status	Compliance
		in table top activities one at a time. Consequently, although most of the individuals were sitting at tables with staff, typically only one or two individuals at a time were actively participating in the activity. The monitoring team observed very few group activities designed to include multiple individuals at the same time. One notable exception was in 549 D where a DCP was watching television with several individuals and had successfully engaged most of them in an ongoing conversation about what they were watching. In another example, in the home for the younger individuals (563B), staff successfully engaged the individuals in an arts and crafts activity involving a pumpkin story, coloring, and dancing with a white cloth. Staff and individuals were very engaged and involved. None of the DCPs questioned in any home, however, indicated that they had been specifically taught to conduct group activities. It is recommended that DCPs be specifically trained and encouraged to conduct meaningful group activities. The average engagement level across the facility was 46%, not substantially different from baseline measures of engagement (i.e., 42%). As can be seen in the table below, there was considerable variability across settings. An engagement level of 75% is a typical target in a facility like LSSLC, indicating that the engagement of the individuals at LSSLC had considerable room to improve. The facility has recently developed a methodology to collect engagement data in each setting. In fact, at the time of the onsite review, the facility was utilizing two tools to measure engagement. The results from one tool provided to the monitoring team indicated an average engagement in the month of September to be 46%, consistent with the engagement level found by the monitoring team. The monitoring team is encouraged by the facility's introduction of a methodology to measure engagement, and recommends that one engagement tool be adopted. It is also recommended that LSSLC now establish and track specific engagement goals in each home and day program site. <u>Engagement Observations</u>: Location / Engaged / Staff-to-individual ratio 561 B: 1/5: 1:5 561 B: 0/3: 3:3 561 A: 1/3: 2:1 561 A: 1/4: 1:4 565 Workshop: 16/19: 5:19 565 Workshop: 5/6: 1:6 565 Workshop: 18/20: 4:20	

#	Provision	Assessment of Status	Compliance

569 A	1/4	2:4
569 A	2/7	3:7
569 A	2/7	1:7
559 B	3/8	3:8
557 A	4/7	3:7
557 B	4/13	3:13
549 D	4/8	1:8
549 D	5/5	6:5
549 C	4/5	1:5
549 C	3/5	2:5
549 B	4/4	3:4
549 B	2/6	1:6
549 A	4/5	4:5
549 A	1/3	1:3
506	4/4	1:4
506	2/7	1:7
506	0/1	1:1
520 A	1/3	2:3
520 B	1/2	1:2
524	0/5	1:5
524	4/8	3:8
523	0/2	1:2
561 A	1/4	1:4
561 B	0/1	1:1
563 B	6/15	3:15
563 A	0/7	1:7
542	3/4	2:4
529	5/5	3:5

<u>Educational Services</u>
In the baseline report, the monitoring team noted a number of concerns regarding the educational services received by individuals at LSSLC who were entitled to educational services. LSSLC was responsive to these comments and worked with the local school district, Lufkin Independent School District (LISD), to correct some of these problems. It was good to see progress, however, more work needs to be done to ensure that the students at LSSLC are receiving the educational services to which they are entitled.

It appeared that the facility and public school maintained a productive working

#	Provision	Assessment of Status	Compliance
		relationship and, as stated in the baseline report, it is the intention of the monitoring team to support this relationship. Luz Carver remained as the facility's primary liaison with LISD. She continued to be assisted by Tawnya Baker. Ms. Baker had frequent, usually daily, contact with the school program by phone and/or by visits to the schools. The Texas Education Agency (TEA) did a review of LISD's services for students who resided in residential facilities in August 2010. The findings were in a report entitled, TEA's Residential Facility Monitoring System 2009-2010 Corrective Action Plan, submitted by LISD, and approved by TEA on 8/31/10. It had 18 deficient areas, one of which was regarding what was called a commensurate school day, that is, requiring that students have a commensurate school day unless the IEP includes an individual justification for a shortened day. Approximately 22 of the 29 individuals at LSSLC who were entitled to educational services attended LISD classrooms in the public school buildings for all or most of the full school day. Two other individuals received a relatively full day of educational services by attending part of the school day at LISD in the public school and part of the school day in the LISD classroom on the LSSLC campus. Overall, this demonstrated an improvement from the number of hours students were in school each day. The number of hours of education, however, remained a concern for the following three students: • Individual #99: two hours per day at LISD classroom on LSSLC campus • Individual #410: three hours per day at LISD classroom on LSSLC campus • Individual #233: three hours per day at LISD public school building. It appeared that some of the other students did not attend the public school program due to challenging behaviors, such as stealing food (Individual #253, for part of the school day), and running away from staff with no awareness of safety (Individual #99). It appeared that LSSLC was providing some assistance to LISD regarding behavioral programming. It is hoped that this will continue and will result in an improvement in behavior problems, so that students will not be denied attendance at the public school. None of the students received any type of extended year program (i.e., summer program). The assistant principal said that extended year programming was to prevent the loss of skills and that the ARD/IEP team made the decision regarding whether the student was likely to lose skills (and thereby qualify for extended year programming). The monitoring team noted that the summer break was approximately 12 weeks long, almost 25% of the calendar year. Moreover, given that the needs of these students was great enough for them to require residential placement, it seemed very likely to the monitoring team that these students would lose skills if they were not receiving educational instruction for 12 consecutive weeks.	

#	Provision	Assessment of Status	Compliance
		The monitoring team reviewed the IEP documents submitted by the facility for three individuals (Individual #41, Individual #305, and Individual #491). There was no indication on any of these documents regarding commensurate school day or extended year programming. These three IEPs were for the IEP year that ended in May 2010, so it was possible that revisions and updates have been made since the TEA review. The monitoring team will look at newer IEPs during the next monitoring review. The monitoring team visited Lufkin High School where one wing of the building was devoted to special education classrooms for students from LSSLC (as well as other non-LSSLC special education students). In this wing, there were five classrooms of approximately 70 special education students. The census of the entire high school was approximately 2300 students. For the most part, the special education students spent their entire school day within this program, that is, there were very little integration or inclusion oriented activities occurring. Moreover, it did not appear that the older students from LSSLC were involved in any vocational and employment training activities. The monitoring team observed in three classrooms as well as in the gym and spoke with the assistant principal in charge of these classrooms. The monitoring team also observed in the LISD classroom on the LSSLC campus and spoke with the special education teacher. The initiation of an on campus classroom had occurred since the baseline review and represented an improvement in service provision by LISD. The classroom was relatively new and only a few students attended for a few hours each day. The classroom provided the opportunity for a fuller educational experience, but should be considered a supplement for the public school building-based programming rather than a replacement. The classroom teacher was an energetic, experienced educator who requested this assignment. She appeared to have a good relationship with the one student observed (Individual #253), that is, he was smiling and responsive to her engaging interactions. The teacher worked collaboratively with the facility's coordinator of day programming at LSSLC (the school classroom was located in the facility's day program building). The brief observation by the monitoring team, however, indicated that the classroom would benefit from consultation regarding appropriate education for students with autism and other developmental disabilities. For example, there was an absence of training in communication and social skills, vocational skills, or independence. Instead, Individual #253 was engaged in doing something called shoebox activities that did not appear to be functional. The facility might consider helping the school district's classroom at LSSLC improve the educational programming. One way might be to explore the use of the Assessment of Basic Language and Learning Skills-Revised (ABLLS-R, www.behavioranalysts.com) as a way to help guide some of the programming for these students.	

#	Provision	Assessment of Status	Compliance
		Similarly, the IEP documents submitted from the school district indicated a limited range of instructional activity (i.e., number of breadth of educational objectives). Moreover, the progress noted for every IEP objective was rated as either "continuing" or as a "work in progress." This provided very little information regarding their actual performance and progress. Finally, during the onsite review, the monitoring team learned that Individual #350 was graduated from high school at around the time he turned 19 years of age. Although graduation is an ARD/IEP decision, the monitoring team, after meeting Individual #350, believes that he would have continued to qualify for educational services for another three years. The surrendering of this entitlement was extremely unfortunate for this young man who had few communication and social skills, little independence, and no vocational skills. LSSLC, in its role on the ARD, needs to ensure that students are only graduated from the public school system when it is appropriate.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	LSSLC conducted annual assessments of preference, strengths, skills, and needs. As discussed in S1, however, how this information impacted the type of instructional programming offered to each individual at the facility was not consistently documented in the PSP. Therefore, this item is rated as being in noncompliance. It is suggested that the facility incorporate the results from multiple assessments and evaluations (i.e., in addition to the PALS) to choose individual skills to be trained, and that this process be more clearly documented in the PSP. Additionally, while the PSP attempted to identify preferences, no evidence of systematic preference and reinforcement assessments were found. Subsequent monitoring visits will continue to evaluate the tools used to assess individual preference, strengths, skills, needs, and barriers to community integration.	Noncompliance
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions,	The facility was progressing on this provision item. Some of the components of this item,	Noncompliance

#	Provision	Assessment of Status	Compliance
	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	however, had only recently been developed while others continued to require more work. Therefore, this item was rated as being in noncompliance. The monitoring team did not observe the implementation of SAPs in any of the day or residential homes during the onsite review. SAP data sheets were reviewed in several residences to evaluate if data were completed as scheduled. The monitoring team was encouraged that all SAPs sampled (i.e., Individual #328 in 561A, Individual #440 in 557A, Individual #356 in 506, Individual #600 in 520, Individual #479 in 561A, Individual #330 in 563B) were completed as scheduled. Generally, the skill acquisition plans appeared practical and functional, such as Individual #79's SAP for safely crossing the street. As discussed in S1, the facility recently began to graph SAP monthly data. At the time of the onsite review, graphing of SAP outcomes had only been occurring for approximately 30 days, so the monitoring team could not evaluate the process or progress. Future visits will more closely review the graphs to evaluate if SAPs are producing meaningful change. Finally, reinforcement for correct responding was not specified in any of SAPs reviewed. The facility should ensure that specific consequences for correct responses are specified in each SAP.	
	(b) Include to the degree practicable training opportunities in community settings.	Many individuals at LSSLC enjoyed various recreational activities in the community. It was not clear, however, if each individual was provided with training in the community that addressed specific needs for services or preference. Therefore, this item was rated as being in noncompliance. The facility was, however, making progress on this provision item. At the time of the onsite review, three individuals at LSSLC worked in the community. This was an increase from one individual working in the community during the baseline review. Since the baseline review, the facility had begun a community volunteer program that supported two additional individuals in a community training program. Additionally, in reviewing PSPs and SAPs, the monitoring team learned of several examples of training in the community. For example: • Individual #79's PSP indicated that he will demonstrate safe street crossing in the community. • Individual #166's PSP indicated she will practice money skills in the community. • Individual #160's purchasing SAP specified that he will, on occasion, go to a dinner in the community to demonstrate purchasing skills. The monitoring team was encouraged by these improvements in skill acquisition in the	Noncompliance

#	Provision	Assessment of Status	Compliance
		community. Subsequent monitoring reviews to LSSLC will further evaluate the training individuals receive in the community in order to assess compliance with this provision item.	

Recommendations:

1. It is recommended that replacement behavior training procedures, like those for the desensitization plans, be incorporated into the general training methodology, and conform to the standards of all skill acquisition plans at the facility.
2. It is recommended that the facility more clearly document how SAPs are based on individual needs and preference.
3. SPOs should include the use of relevant discriminative stimuli, plans for the maintenance and generalization of acquired skills, and specified consequences of correct responses.
4. LSSLC needs to expand its SAP training methodology to other procedures shown to be effective in developing new behavioral repertoires.
5. The facility should continue to expand the graphing of monthly SAP data.
6. A plan needs to be developed to collect and graph SAP integrity data.
7. It is recommended that DCPs be trained to conduct meaningful group activities.
8. The facility should choose one engagement measure tool, and establish and track specific engagement goals in each home and day program site.
9. The facility should continue to expand the number of individuals receiving training in the community.
10. Explore whether the three students identified in S1 (Individual #99, Individual #410, and Individual #233) are receiving an appropriate number of hours of schooling each day.
11. Explore whether LSSLC students qualify and/or should be receiving an extended school year.
12. Ensure there is a plan to address challenging behaviors that prevent the student from attending a full day in public school.
13. Offer programming assistance to LISD regarding objectives and teaching methodology for students with autism and other developmental disabilities, including communication, social, and vocational skills, as well as opportunities for inclusion with nondisabled students.
14. Obtain more detailed information regarding student progress (i.e., more detail than continuing or work in progress).
15. Develop and implement policy and/or procedures regarding student graduation prior to the student's aging out of the educational system.

The following is offered as an additional suggestion to the facility:

16. It is suggested that the facility consider an organizational change that would streamline the SAP process and allow more time and focus for writing skill acquisition goals and monitoring implementation and progress.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.1, updated 3/31/10, and five attachments (exhibits) o DADS Promoting Independence Advisory Committee reports, January 2010, April 2010, July 2010 o Organizational chart, dated 9/21/10 o DADS Obstacles Report for SSLCs, October 2010 o LSSLC policy list, 9/23/10 o Updated policies since April 2010 o LSSLC Policy, Initiation and Discontinuation of Services, Client Management-11, dated 7/17/08 o LSSLC Policy, Placement Appeals, Client Management-29, dated 4/1/08. o LSSLC POI, updated September 2010 o LSSLC POI Supplement, September 2010 o LSSLC Admissions and Placement Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 10/18/10 o List of typical meetings that occurred at LSSLC o Position description: Admissions/Placement Coordinator and Post-move monitor o List of individuals who were referred for placement since 5/4/09 (22 individuals) and had not yet been placed, dated 10/14/10 o List of individuals who themselves requested placement, but were not referred (nine individuals) and an indication of the reason why each individual was not referred o List of individuals who were not referred solely due to LAR preference (17 individuals) o List of individuals placed since 1/1/10 (eight individuals) o Name of one individual alternately discharged by mistake, but corrected (same as from baseline report) o List of alleged offenders as of 9/1/10 (three individuals) o Description of how the facility assesses an individual for placement o List of all individuals at LSSLC and whether or not each was referred for placement as of 9/7/10 (the list did not indicate the reason for the individual not being referred) o Various lists showing individual participation on tours of community providers, through 9/9/10 and updated 10/14/10

	o Various emails and memos regarding the status and improvement of community tours o List of individuals who have had a CLDP developed since 1/1/10 (eight individuals) o CLOIP and Permanency Planning lists, April 2010 through October 2010 o The obstacles to placement for five individuals • Individual #339, Individual #67, Individual #431, Individual #43, Individual #573 o Note indicating that no individuals had been returned to LSSLC from community placement o Post move monitoring schedule for 22 individuals (some from other SSLCs), dated 10/8/10; as well as a listing of post move monitoring for Richmond SSLC showing that post move monitoring was being done for two individuals placed by LSSLC o Description and sign in sheets for various training provided to staff since 4/5/10 regarding referral and placement o Description of LSSLC QA activities related to section T of the Settlement Agreement, prepared by Stephen Webb, QA program compliance monitor, 10/20/10 o Documentation from PSPA regarding the rescinding of referral for Individual #449. o Documentation of PSPA regarding the placement of Individual #63 o Completed monitoring forms of living options discussion section of annual PSP meetings for three individuals, October 2010 o Example of proposed revised CLDP format (blank) o Monitoring team monitoring tools completed by APC, PMM, and QA staff for various individuals for section T of the Settlement Agreement o Note from PMM to MRA staff and facility staff regarding interviews assessing knowledge of referral and placement processes at LSSLC o Proposed new post move monitoring form o New Style PSPs for: • Individual #312, Individual #349, Individual #307, Individual #232, Individual #167 o PSPs for: • Individual #269, Individual #57, Individual #124, Individual #600, Individual #183, Individual #238, Individual #323, Individual #131, Individual #249, Individual #170, Individual #176, Individual #524, Individual #41, Individual #491, Individual #22, Individual #525, Individual #562, Individual #215, Individual #484, Individual #294, Individual #134, Individual #573, Individual #387, Individual #305, Individual #67, Individual #431, Individual #102, Individual #339, Individual #43, Individual #379 o CLDPs for: • Individual #269, Individual #278, Individual #346, Individual #340, Individual #113, Individual #350 o Post move monitoring checklists for: • Individual #54, Individual #508, Individual #89, Individual #180, Individual #269, Individual #206, Individual #443, Individual #63, Individual #186, Individual #346, Individual #340 <u>Interviews and Meetings Held</u>: o Lisa Pounds Heath, Admissions and Placement Coordinator

	o Glenda Pierce, Post-Move Monitor o Gale Wasson, Facility Director o Group of QMRPs and Luz Carver, QMRP director o Holly Spencer, QMRP, and Suzanne McWhorter, QMRP o Stephen Webb, QA program monitor o Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs. <u>Observations Conducted</u>: o PSP Meeting for: • Individual #312, Individual #349 o Community Living Discharge Plan Meeting for: • Individual #350 o Community group home visit, post-move monitoring for • Individual #63 o LSSLC Self-advocacy meeting o Many residences and day programs at LSSLC
	Facility Self-Assessment: The facility's self-assessment, its POI, for section T indicated that all items were in noncompliance, except for a small number of items that were rated as being in substantial compliance. Within the T1 provision items, all were self-assessed by the facility as being in noncompliance, except for item T1c2. The monitoring team was in agreement with all of these self-assessment ratings and also rated T1c2 as being in substantial compliance. The facility rated itself as being in substantial compliance for a number of the items in section T2. The monitoring team, however, rated both T2a and T2b as being in noncompliance as noted below, based primarily on the need for more work to be done in the post move monitoring regarding the determination of the presence of supports and the identification of serious issues when post move monitoring is conducted. The facility provided a lot of information in the comments section throughout this portion of the POI. This was helpful to the monitoring team in learning more about their status on a number of items. Overall, these comments indicated that new policies and procedures were in development and would be implemented soon. The POI did not indicate that the facility looked at any of the PSPs, LODs, optimistic vision statements, CLDPs, or post-move monitoring forms to make a determination of their own substantial compliance or noncompliance. Given the many upcoming changes to most integrated setting and community placement processes that are anticipated to occur at LSSLC over the next few months, it is hoped that the facility will engage in specific activities to self-assess the status of its performance for this provision and all of its components. This will probably involve monitoring, sampling, and providing feedback to PSTs, post-move monitors, and facility management.

	The monitoring team's review was based upon observation, interview, and review of a sample of documents. The facility will need to do much of the same in order to conduct an adequate self-assessment.
	Summary of Monitor's Assessment: LSSLC was engaged in a number of activities related to the movement of individuals to most integrated settings, that is, to placements in the community. This provision, however, is rated as being in noncompliance due to the additional tasks and activities that are required by the provision, and improvements to a number of activities, as are detailed below in this section of the report. Further, the monitoring team learned that updates to the DADS policy and procedures for most integrated setting practices were forthcoming. Overall, LSSLC had made progress in some areas since the baseline report. For instance, at the time of this onsite monitoring review, more individuals (eight) had been placed in the community and more individuals (25) were on the referral list compared to six months prior, during the onsite baseline review. LSSLC maintained an active admissions and placement department. The Admissions and Placement Coordinator was remarkably knowledgeable about the details of every individual who had been place or who had been referred. The post-move monitor was energetic and committed to making the placement process an effective one. Nevertheless, the number of individuals placed in the community represented a relatively small percentage of the LSSLC population, that is, 2.5% of the individuals over the past 12 months. The 25 individuals on the current list, however, represented more than 6% of the population. The facility created listings of individuals for whom LAR preference was the only reason for he or she not being referred for placement. The lists did not include all of the individuals to whom this applied and it is recommended that the lists be corrected so that this important information can be regularly shared with LSSLC management. In other areas, little progress had been made, such as in the determination of needed supports, the identification of obstacles, and the identification and definition of essential and nonessential supports. Some progress was noted in the describing of evidence required to indicate the presence of a support. The new PSP was recently initiated at LSSLC. Four annual PSP meetings were observed by the monitoring team. The new process appeared to have the potential to improve the depth and breadth of discussion regarding optimistic optimal living characteristics for each individual. At the time of this onsite review, however, the new style PSP meetings were not accomplishing this goal. This was not surprising given that it was only the first or second time that each QMRP had implemented the new process. It seemed apparent, however, that the QMRPs needed to become more fluent with this new process. In addition, the QMRPs would benefit from, and should be given, training in how to facilitate and lead these types of meetings. LSSLC continued to engage in a number of activities to educate individuals and their families or guardians to make informed choices. The facility had engaged in each of the five activities listed in the DADS policy.

	In addition, LSSLC should consider ways of making the provider fair more effective. One way to do so is to determine specific goals and objectives (i.e., outcomes), a way to measure them, and a way to evaluate the overall effectiveness and success of the fair. Similarly, the CLOIP process had been in place for a number of years. Outcomes of the CLOIP should be determined and the effectiveness of the CLOIP assessed. Further, as noted below, more work should be done on the system of community tours (though there had been progress made since the baseline tour), and self-advocacy groups should be used as an opportunity to educate individuals about community placement. The CLDP process was also being revised. Comments are provided regarding the proposed new CLDP and post-move monitoring forms and procedures. A continuing problem was the inclusion of individualized and meaningful essential and nonessential supports within the CLDP. The ability of PSTs to play a more active role was needed; examples are provided. Post move monitoring was occurring as per the required schedule. There continued to be a need for more detailed descriptions of essential and nonessential supports, so that they could be observed and so that the post-move monitor would know what was required to indicate evidence of the presence of the support. A visit by the monitoring team to a home where post-move monitoring had occurred resulted in the identification of serious concerns about the placement. This led to state and facility involvement and a change in provider and placement. Specific quality assurance procedures were not in place (see section E above), however, admissions and placement staff, as well as one QA staff member, had recently begun to complete monitoring tools regarding some of their work. Modifications are recommended for improvements to the CLDP, the CLDP process, determination of essential and nonessential supports, and contents of the community placement report.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with	LSSLC and the state continued to engage in activities to encourage and assist individuals to move to the most integrated setting. These activities were, as required, not opposed by the individual or the individual's LAR, and appeared to be made by taking into account the statutory authority of the state, and the needs of others with developmental disabilities. This provision item, however, cannot be considered to be in substantial compliance due to the need for further actions and activities to occur, including the implementation of the state's newly revised policies for PSP development, and upcoming changes to the way the CLDP is to be developed and implemented. These changes are expected to make the	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	referral and placement process more consistent with each individual's PSP. In addition, little change or progress had occurred since the baseline monitoring review regarding: • determination of needed supports • identification of obstacles • identification of essential and nonessential supports • objective determination of the presence or absence of essential and nonessential supports following community placement. The monitoring team, as noted above, learned about many changes that were in the works at both the facility and state levels regarding PSP processes, CLDP contents, determination of evaluation of essential and nonessential supports, and training of all facility staff and departments regarding the community referral and placement process. The new PSP process was observed in action during the onsite review, and a draft of a revised CLDP format was presented to the monitoring team for review. These two new processes are discussed in this section (T) of the report. It was clear that LSSLC continued to take the Settlement Agreement provision requirements for most integrated setting practices very seriously. This was most evident by the facility's numbers as of the week of the onsite monitoring review: • 8 community placements occurred since the baseline review; compared with 5 community placements made during the six months prior to the baseline review; • 25 individuals were on the active referral list, an increase of eight since the baseline report; and • 16 of these 25 were new referrals, that is, made in the past six months. The facility's work on placement was further demonstrated by the daily activities of the staff of the admissions and placement department, the inclusion of referral and placement information in senior management meetings, and the special efforts taken by the admissions and placement coordinator (APC) and post-move monitor (PMM) to support individuals and their placements. Examples of these special efforts are presented below. • After LSSLC had worked for months planning a successful admission to LSSLC for Individual #256, his parent removed him after only three days at the facility and returned him to live at the family home. The individual soon ended up hospitalized for psychiatric and behavioral reasons. LSSLC staff continued to make efforts (e.g., meetings, phone calls, suggestions) to help the family and to help locate a community provider. As a result, a community provider was identified and he was placed. Unfortunately, at the time of the onsite monitoring	

#	Provision	Assessment of Status	Compliance
		review, the individual was again hospitalized. • Individual #340 was recently placed in a community group home. Overall, he had done well, but in the week before the onsite monitoring review, he had exhibited some problem behaviors, such as threatening to hurt staff. LSSLC staff scheduled a phone conference to support the community provider by providing suggestions for interventions that had been effective while he lived at LSSLC. • The admissions and placement coordinator noted that it had been difficult to find providers who could successfully support individuals with more challenging medical needs. As a result, it had taken a long time to find a possible provider for Individual #142. A provider had finally been identified and a very thoughtful series of visitations were scheduled for the individual, including visiting for one hour, then for four hours, and then for eight hours. Special inservices for the community provider's staff were scheduled, too. In addition, the facility was planning to create a small transition home on campus for individuals whose PSTs recommended an interim step before moving to the community. Nevertheless, the number of individuals placed in the community represented a relatively small percentage of the LSSLC population, that is, 2.5% of the individuals over the past 12 months. The 25 individuals on the current list, however, represented more than 6% of the population. The monitoring team encourages the facility to engage in extra efforts to place some of the younger children at the facility (e.g., Individual #557). Lisa Pounds Heath was the Admissions and Placement Coordinator (APC). She was assisted by Glenda Pierce, the facility's Post-Move Monitor (PMM). The monitoring team had the opportunity to meet with both of these professionals. They were knowledgeable about the placement process and experienced with local providers and families. They described many of the upcoming changes to the state and facility policies and practices regarding most integrated setting practices that were listed above (e.g., PST involvement, CLDP contents, determination of essential and nonessential supports). As noted in the baseline report, the APC was remarkably knowledgeable about every individual who was on the referral list or who had been placed from the facility. This continued to be the case at the time of this onsite monitoring review. The APC continued to maintain a document that was updated each week called the "Admission and Placement Weekly Report." The report was presented by the APC to the senior management team at their Tuesday meeting every week. At the meeting, she presented the contents of the document. The following was included. Data are also included below showing changes from the time of the baseline review to the time of this onsite monitoring review.	

#	Provision	Assessment of Status	Compliance
		• requests for admissions from other SSLCs to LSSLC o current: two individuals listed o baseline: five individuals listed • requests for admission from the community o current: nine individuals listed o baseline: nine individuals listed • status of each active referral from LSSLC to the community o current: 25 individuals listed, but no details provided ▪ note: 16 of the 25 were referred since the baseline review o baseline: 17 individuals were listed, with details regarding the status of each of these 17. • transfer requests from LSSLC to other SSLCs o current: two individuals listed o baseline: one individual listed • on campus moves planned o current: one individual listed o baseline: no individuals listed • on campus moves requested o current: 23 individuals listed o baseline: 22 individuals listed • individuals who were referred by the PST for a community provider tour o current: 17 individuals listed as scheduled to go on a tour o baseline: listed 29 individuals who were referred to go on a tour The format of this report appeared to be useful to senior management at LSSLC (and very informative to the monitoring team). It could provide a consistent metric for the facility (see section E above) as well as be a model for admissions and placement departments at the other SSLCs. The facility also maintained a list of individuals who themselves requested to move, but were not referred (nine individuals). Of these nine, four were listed as being due to LAR preference. Only one was due to medical reasons and only one was due to behavioral or psychiatric reasons. One other was due to a preference to live only with his family, but this was not an available option for him. The other two were noted as "exploring community options," however, this was not really a reason for not referring. Instead, it was done as a way to allow the individual to explore more possibilities for community placements before an official referral was made. In addition, the facility maintained a list of individuals for whom LAR preference was the only reason for a referral not occurring (17 individuals) whether or not the individual	

#	Provision	Assessment of Status	Compliance
		could independently express a preference. In addition, the monitoring team believes there were a number of individuals at LSSLC for whom LAR preference was the only reason for the lack of referral, but who had not made it to this list. For example, in the PSPs for Individual #525, Individual #484, and Individual #349, LAR preference was identified as the only obstacle, however, none of these individuals were included in the facility's listing. LSSLC should also incorporate this information into its regular data system for admissions and placements. Further, it should be used as the facility develops a comprehensive reports and plan regarding obstacles to placement. The baseline report commented on the rescinding of a referral of Individual #449. The monitoring team reviewed the PSPA notes from a 5/5/10 meeting. It appeared that his referral was rescinded because of the lack of support available in the community, not because of the appropriateness of community placement for the individual. The 5/5/10 PSPA note included the following statement: "Discontinue his referral to the community at this time because the needs and supervision he has cannot be met in the community with his current level of need." LSSLC should review this case and, if a community home is the most integrated setting for this individual, he should remain on the referral list, even if an appropriate provider cannot be identified at this time. Overall, funding did not appear to be an obstacle to any individual's transition. The APC reported that there were no instances of a placement being delayed or prevented due to lack of funding and that there were plenty of slots available to individuals at LSSLC.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	The monitoring team looked to see if policies and procedures had been developed to encourage individuals to move to the most integrated settings. This provision item was found to be in noncompliance due to upcoming changes in the state and facility policies regarding most integrated setting practices, and the comments made below regarding all subsections of this provision T1b. The state developed a policy regarding most integrated setting practices and it addressed this provision item. It was numbered 018.1 and was dated 3/31/10. This policy was updated from a previous version. The updates were relatively minor, primarily regarding methods of reporting facility information to the state central office. The purpose of the policy was stated in the first paragraph and noted that it was to encourage and assist individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the United States Supreme Court's decision in Olmstead v. L.C. The policy stated that it applied to all DADS SSLCs and numerous definitions were included.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The policy also detailed procedures for assisting individuals with movement to the most integrated setting, identifying needed supports and services to ensure successful transition, procedures for identifying obstacles for movement, and post-move monitoring procedures. The policy also described procedures to meet other items in this provision of the Settlement Agreement. The policy called for encouraging individuals to move to the most integrated setting consistent with the determination of professionals on the individual's PST 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. The policy provided detail on the types of meetings, documents, and processes that were to occur. The policy did not specifically note that placement must take into consideration the statutory authority of the state, the resources available to the state, and the needs of others with developmental disabilities. The policy did, however, note that part of its purpose was to bring the state into accordance with the Olmstead decision. That decision specifically referred to these considerations and, therefore, these aspects did not need to be identified specifically in the policy. The APC reported that LSSLC had adopted the state policy and was working under the policy, however, a number of revisions to policy and practice were in process and being updated. The revised policies were likely to include more involvement of the PST in the referral process and the post-referral process, PST involvement in visits to community providers, a review of post-move monitoring with the PST, and extra assurances and procedures regarding the determination of essential and nonessential supports in the CLDP. LSSLC had two policies in its manual related to admissions and placement that will need to be removed or updated. These were Initiation and Discontinuation of Services, Client Management-11, dated 7/17/08, and Placement Appeals, Client Management-29, dated 4/1/08. If LSSLC keeps these policies (or develops new policies), the facility should obtain some type of documentation of approval of this policy from the DADS central office discipline head. Also, future revisions of facility policy might focus on only including additions to, and differences from, the state policy, rather than including repetitions of state policy. In this way, future updates to state policy might not require a revision to also be made to facility policy. The monitoring team also looked to see if the policies and procedures were being implemented consistently. LSSLC staff were working towards implementing the DADS policy #018.1 and expected to modify facility practice based upon upcoming policy updates.	

#	Provision	Assessment of Status	Compliance
	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.	This provision item was found to be in noncompliance based upon the need for implementation of a process to adequately identify the protections, services, and supports that need to be provided to the individual, as well as the identification of obstacles to movement to the most integrated setting and a plan to overcome those obstacles. New statewide policies and procedures were being implemented at LSSLC regarding the PSP process. These policies and procedures were recently taught to QMRPs sometime over the few weeks prior to the onsite monitoring review and implementation had recently occurred. Four of the five annual PSP meetings held during the week of the onsite review were observed by the monitoring team. These were implemented under the new PSP format. It was only the first or second time that each of the observed QMRPs had used the new PSP format. All five of the resulting new style PSP documents were reviewed. In addition, 30 of the "old style" PSP documents listed in the Documents Reviewed list at the beginning of this section of the report were reviewed. The total sample included individuals representing different levels of referral for placement, need for extensive supports, language abilities, medical needs, and family involvement. The PSPs occurred across the previous 12 months. Given that the PSP process had recently been changed, and given that it will take some time for the QMRPs to become accustomed and comfortable with this new process, the following comments are based upon the review of the five new style PSPs. Before doing so, some comments regarding the 30 PSPs reviewed are warranted. First, across the 30 PSPs, there was a lot of consistency in the format and content across many of the living options discussions. This indicated that the facility QMRPs likely conducted their meetings and completed their documentation in a similar manner. Some individualization was seen (e.g., a pool at the home, live near a zoo, be able to play Bingo) and relevant important information was included in a paragraph called Quality of Life later in the LODR. In some cases, the reason for referral or lack of referral was provided, and other cases, no reason was provided. Overall, this set of PSPs indicated that the facility had a solid foundation upon which to build the new PSP format. <u>Protections, Services, and Supports</u> The new-style PSP for each individual noted a variety of needs, required supports, and objectives (though only a few) for the individual while he or she lived at LSSLC. Information regarding the PST's review, consideration, and discussion of movement to the most integrated setting was found in the section titled "Integrated Discussion -	Noncompliance

#	Provision	Assessment of Status	Compliance
		Optimistic Living Vision." This terminology, however, did not reflect the contents nor the observed content of this section of the PSP. That is, although many important topics were discussed regarding the individual's preferences and needed supports it was not what one would call a discussion of the ideal optimistic or optimal living vision. The discussion about the ideal optimistic vision should focus on the components of an environment that would best suit the needs and preferences of the individual, ensure safety, and provide adequate habilitation (including habilitative services, skill development and maintenance), and quality of life activities, such as leisure and recreation activities. The optimistic vision should not merely be a listing of the individual's preferred items. If so, it will not meet the goals of what is now called the "Integrated Discussion, Optimistic Living Vision." The PSP then listed the individual's needed supports, following the structure of the PSP form. The actual discussion observed by the monitoring team (as noted below), however, was more open and free flowing, setting the occasion for the new-style PSP to meet the goal of having greater participation and individualization of discussion. Five annual PSP meetings occurred during the week of the onsite monitoring review. Four were observed by members of the monitoring team. Details are provided below for two of these meetings. The content of each of the LODs (now called Integrated Discussion) was inadequate to meet the requirements of this provision item as noted in the descriptions below and in the comments that immediately follow. • The annual PSP meeting for Individual #312 included a living options discussion that lasted for 15 minutes. It began with the individual's parent and LAR talking about her previous history living in a group home that had closed. The MRA CLOIP worker (who was a substitute for the regular MRA staff member who knew the individual) then described the CLOIP process that had been conducted, types of local homes, and the possibility of tours. The individual's parent/LAR said that she would like to go on some tours, but to not bring along the individual at this point. She stated that she knew what the individual needed. A single obstacle was discussed: proper use of hearing aids. The services and supports the individual would need were also discussed and included having her own space and belongings, living in an uncluttered space, having a daily routine and schedule, and having opportunities to be independent in her routine. There was active discussion from many PST members. The Integrated Discussion, however, failed to focus on the full range of characteristics of an optimistic ideal setting for the individual. Further, there was no explicit discussion of whether or not to make a referral, however, it appeared that an important step was taken, that is, for the LAR to agree to begin to tour community homes. • Individual #349's PSP began with the QMRP stating that the team wanted to	

#	Provision	Assessment of Status	Compliance
		teach him some things to help him in the community. Comments from team members noted that he knew his name, walked around on campus independently, and was working on making his bed. Next was discussion of dental care and his sister/LAR stated that she didn't want a desensitization program because he was so fearful and preferred for sedation to be used. Then, his sister stated that she was opposed to him being referred to a group home because he once was placed in a home that was filthy and in which his clothes were stolen in the first week. She stated that things were going very well for Individual #349 at LSSLC and she did not want to make a change. She added that he'd been at LSSLC since 1989 and wanted him to stay there. The MRA CLOIP worker stated that she had sent information and that she felt the sister was aware of all of the community options available. The PST continued discussing the types of things that the individual preferred, including getting regular phone calls from family members. Despite that, this Integrated Discussion also failed to focus on the full range of characteristics of an optimistic ideal setting for the individual. Based on these observations, review of documents, and discussions with the QMRPs and QMRP director, the following comments are provided regarding the new PSP process at LSSLC. Positive comments: • The process was very new and will take some time for QMRPs to be comfortable and competent with it. • It was implemented fairly consistently across QMRPs. • Participation from PST members appeared to be greater than in the old style format. • Time was not wasted on topics that were not relevant to the individual or for the bland reading of reports and assessments. Comments requiring attention: • PSTs may fail to cover all of the important areas due to the more open and free flowing nature of the new format. Some of the QMRPs talked about the need for some sort of checklist. • The LOD/Integrated Discussion was weak in the PSP meetings observed. It will require attention from the QMRP facilitating the meeting if the required components are to be addressed. • The characteristics of an ideal successful most integrated setting (i.e., optimistic vision) were not discussed, but should be. • QMRPs will need support and specific training on how to lead a meeting and to	

#	Provision	Assessment of Status	Compliance
		be an effective facilitator. The advantage of the new format also sets the occasion for PST discussions to become in depth, to stray from the important topics at hand, and to include disagreements. Therefore, QMRPs as facilitators (and leaders of these meetings) must be confident and skilled. The monitoring team believes the QMRPs would welcome this type of training. Obstacles to Movement There continued to be no coordinated plan or approach to address obstacles to movement to the most integrated setting across the facility (also see T1g below). LSSLC submitted to the monitoring team information regarding the obstacles to movement to the community for five individuals (five whose records were submitted to the monitoring team prior to the onsite monitoring review). The obstacles presented on this one page listing are listed below. Note, however, the fourth and fifth bullets do not appear to be describing an obstacle. Moreover, the two individuals below, for whom LAR choice was listed as the sole obstacle, were not included in the lists of individuals submitted and as described in section T1a above, further indicating the need for the facility to begin to do more work in identifying, assessing, and analyzing obstacles. • Behavioral/psychiatric needs, and LAR choice • LAR choice • LAR choice • Quality of life issues • No preference stated In the five new style PSPs reviewed, action plans were not provided that were directly related to any identified obstacles and/or to community placement. Moreover, as indicated in other sections of this report (e.g., section S), there were few meaningful training objective actions plans in any of the PSPs. Strategies to overcome obstacles were not in place at LSSLC. Any plan to identify and overcome obstacles should include strategies that: • are measurable, • identify a person(s) responsible for their implementation, • identify expected time frames for completion, and • are reviewed regularly and modified as necessary.	
	2. The Facility shall ensure the provision of adequate education about available community placements to	LSSLC continued to engage in a number of activities to educate individuals and their families or guardians to make informed choices. The facility had engaged in each of the five activities listed in the DADS policy.	Noncompliance

#	Provision	Assessment of Status	Compliance
	individuals and their families or guardians to enable them to make informed choices.	This provision item is rated as being in noncompliance due to the need for further activities to occur as indicated in some of the paragraphs below. First, LSSLC had conducted a fair for all providers to present information to interested individuals, family members, LARs, staff, and families from the community. It occurred in October 2009 and was discussed in the baseline monitoring report. The next provider fair was scheduled for November 2010. Due to past low attendance, and in order to ensure that good outcomes are obtained from the provider fair, LSSLC should consider ways of making the provider fair more effective. One way to do so is to determine specific goals and objectives (i.e., outcomes), a way to measure them, and a way to evaluate the overall effectiveness and success of the fair. In addition, the facility might focus on increasing attendance, providing family members with sufficient guidance before the fair and then escorting them during the fair to ensure that they have an opportunity to interact with providers who might best meet their family member's needs, and helping providers prepare to answer the types of questions most often raised by family members. Second, the APC reported that there was a very good working relationship between the facility and the local MRA. The APC had attended a recent MRA service coordinator's meeting (on 10/8/10) and an annual training inservice given by the MRA and other local providers was held the week prior to the onsite review. The agenda indicated a variety of topics relevant to community referral, transition, and services were presented to LSSLC staff. Signed attendance sheets indicated attendance by more than 100 staff. This included five family members of individuals who lived at LSSLC. Donnie Wilson, DADS central office continuity of care coordinator, conducted training for QMRPs and other staff at LSSLC for a total of two hours on 4/5/10 regarding the community referral process. He also conducted an additional two hours of training for the admissions and placement department staff (Ms. Pounds Heath, Ms. Pierce, and Mr. Garrett) regarding post-move monitoring. Third, a Community Living Options Information Process (CLOIP) or Permanency Planning Process (for individuals under age 22) was in place for all individuals. It was implemented by the CLOIP worker from the contracted MRA. The purpose of the CLOIP was to educate individuals and family members about community living options. The results of these processes were recorded on a worksheet. State tracking forms submitted to the monitoring team indicated that these CLOIP and PP processes were being completed for all individuals. The CLOIP process had been in place for a number of years. The monitoring team, therefore, recommends that the facility assess the effectiveness of the CLOIP process, that is, whether or not it achieved the outcomes the facility intended it to achieve.	

#	Provision	Assessment of Status	Compliance
		Fourth, the facility took individuals on visits to community providers. This was discussed with the admissions and placement staff during the onsite baseline monitoring review, and addressed in the baseline monitoring report. The facility was responsive to the recommendations of the monitoring team and improvements had occurred at LSSLC. As a result, 30 individuals had gone on community tours since 6/30/10. Most of the tours were with only one or two individuals and, therefore, the experience could be made more individualized and more time could be taken for the tour compared to when larger groups toured. This was an increase from the previous quarter during which community tours only occurred during a single week in March 2010, and in which only about a dozen individuals participated. Further work may help to make the system of tours more effective at LSSLC. First, ensure that all individuals have the opportunity to go on a tour, not only those who are referred for a tour by their PST, as also noted in the baseline report (except those individuals and/or their LARs who state that they do not want to participate in tours). Second, ensure that PSTs know what information is needed by the APC to make the tour meaningful (e.g., type of home, location, mobility needs). Third, obtain comments from staff and individuals, if possible, about the individual's response to the tour. This was reported to have been occurring at LSSLC recently, but there was no indication in the record of any review by PSTs. Fourth, incorporate data on tours into the admission and placement department's data, and include these data in the facility's overall QA data system (see section E above). The monitoring team appreciated the discussion with the APC and PMM during the onsite visit regarding terminology, especially regarding the difference between community tours (these occurred when there was not a referral for placement) and pre-selection visits (these occurred after a referral had been made by the PST). Fifth, a living options discussion was required to occur and this, as noted above, was occurring at every annual PSP, however, more work (including training and support of the QMRP facilitators) was needed to have these discussions be more comprehensive and meaningful, especially given the new PSP format. Finally, although not solely related to education about community placements and providers, very limited self-advocacy activities occurred at LSSLC. A new facilitator was recently assigned and meetings were recently re-initiated. This presents possible opportunities for education regarding community placement (also see section E above).	
	3. Within eighteen months of the Effective Date, each	This provision item required the facility to assess individuals for placement. The facility provided the monitoring team with a description of what it considered its assessment for	Noncompliance

#	Provision	Assessment of Status	Compliance
	Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	placement. The description listed out the components of the LOD as well as a number of steps taken directly from the DADS policy on most integrated setting practices. This was the same information submitted for the baseline monitoring review. The APC told the monitoring team that everyone at LSSLC met the criteria for placement and that it was up to the PST, during the LOD component of the annual PSP (or at any time during the year), to review the individual's needed supports as well as consider possible options for placement. In addition, a listing of all individuals at the facility and their referral status was submitted to the monitoring team. The monitoring team understands the difficulty in determining a process for assessing an individual for placement, that is, what tools, questions, or criteria, if any, should be included. Therefore, as noted in the baseline report, the facility will need guidance from DADS regarding this provision item. Consequently, it is rated as being in noncompliance. Note that the CLOIP should not be considered an assessment for placement. Its primary purpose was to document that attempts were made to inform the individual and LAR about community placement options and to document the individual and LAR's preferences 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:	As noted in section T1b above, the DADS policy on most integrated setting practices was being revised. This included development of a new CLDP document format, and the process for managing the CLDP. Recent training had been conducted by the DADS central office continuity of care coordinator on the new CLDP. The monitoring team had the opportunity to review this new CLDP form. Many of the changes to the CLDP format were in response to discussions that monitoring team members had with facility and state staff during onsite monitoring reviews, as well as in response to findings noted in baseline monitoring reports. The monitoring team appreciates and acknowledges the facility and state's responsiveness. Some comments regarding the new CLDP form are presented below. Note that this new format CLDP had not been implemented at the time of the onsite monitoring review. Therefore, these comments are based solely upon a review of a blank form. • Overall, the form was more comprehensive, included more information, and provided more direction to PSTs than did the previous form. • The new process directed the PST to begin the CLDP process at the point of referral. This was an improvement from the previous process. It sets the occasion for PST members to be involved in all aspects of transition, including visiting potential community providers, ensuring that all relevant assessments	Noncompliance

#	Provision	Assessment of Status	Compliance
		are completed and reviewed, and following up after the individual has moved by reviewing the results of each post-move monitoring visit. • A list of standard items to be completed and in place prior to every individual's move now appeared on page 6 (e.g., 30-day supply of medications, signed physician orders, required adaptive equipment). In the previous format, these items filled (i.e., unnecessarily cluttered) the list of essential supports and, thereby, detracted from the PST's ability to focus upon identifying those essential and nonessential supports that were truly based upon individual needs and preferences. • The list of summaries and recommendations on page 9 was also an improvement. It was designed to help the PST remain focused on its primary task related to reviewing assessment, that is, ensuring that all recommendations are reviewed and, moreover, that recommendations are then included in the list of essential or nonessential supports. • Psychiatry should be added to the list of summaries and assessments. • The review of every action plan (i.e., training objective and service objective) was another good addition to the process. The final statement on page 12, however, indicated that the PST could only make recommendations about action plans. It is the opinion of the monitoring team that the PST can, and should, make certain action plans (training objectives and/or service objectives) essential or nonessential supports if the PST believes that implementation of any of these plans is important. The CLDP is the PST's chance to specify the supports and services that the provider must agree to provide. PSTs should be assertive in this area and not squander this opportunity. DADS should remove the statement on page 12 because it appeared to be at odds with the state's desire for transition to grow out of the PSP process. An example occurred during the CLDP observed by the monitoring team and described in more detail below in T2a and T2b. The PST, with encouragement from the monitoring team, included instruction in communication and language (i.e., a training objective) for an individual with autism as a nonessential support in his CLDP. The community provider readily agreed to it. • It was also good to see that the CLDP required a description of the evidence to indicate whether or not an essential or nonessential support was in place. This was a new component to the CLDP. PSTs will need to be thoughtful and ensure that the requirements look for observable, objective evidence with specific criteria. • The pre-move site review should also be sure to include the list of standard items on page 6. This could be added to the list on page 23. The monitoring team looks forward to reviewing the implementation of these new	

#	Provision	Assessment of Status	Compliance
		procedures.	
	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 DADS policy on most integrated setting practices #018.1 provided detail on the development of the CLDP. The policy directed the PST to work in coordination with the MRA to develop and implement the CDLP in a timely manner. It also directed that a representative of the individual's PST submit a current assessment and/or discharge summary for inclusion in the CLDP. As noted above, this policy, including the CLDP process, was being revised. The CLDPs reviewed in this section of the report were implemented as per the current policy and procedures. Six CLDPs and their associated documents (e.g., discharge assessment summaries, PSPs, post move monitoring checklists) were submitted to the monitoring team and were reviewed. One of these six was the CLDP most recently completed; it was written subsequent to the onsite monitoring review and was for the CLDP meeting attended by the monitoring team during the onsite review. All but one of the CLDPs were for younger individuals who were either under 22 years old or had recently turned 22 and were no longer in the public school system. The other individual was 57 years old and had lived at LSSLC for many years. There were, however, no discernible differences in format across these CLDPs. The monitoring team appreciated the facility's provision of CLDPs for individuals who were placed during the time between submission of documents to the monitoring team and the first day of the onsite review. Overall, processes were in place at LSSLC for this provision item. The impending changes to the process are likely to lead the facility towards substantial compliance with this provision item. At LSSLC, the CLDP was developed after a provider was chosen and a specific home was identified. This was typically only two to three weeks prior to the individual's move. Although activities had occurred prior to the CLDP meeting (e.g., referral, home visits, exchange of information), some of the CLDP topics might be better addressed, or at least initiated, much earlier to allow team members more time to participate and plan, especially, in regards to the development of lists of essential and nonessential supports. The facility planned to address this with the upcoming CLDP changes. The CLDP activities were coordinated and managed by the APC and the post move monitor. They gathered documents, put together a draft CLDP, and organized and ran	Noncompliance

#	Provision	Assessment of Status	Compliance
		the meeting. This provision item addresses the assignment of responsibilities for implementation of the CLDP. This was primarily indicated in the CLDP in sections V. and VI. and was standard in all CLDPs. The CLDP also included a list of essential and nonessential supports, each of which was assigned to a staff member at the provider agency or at the facility. Essential and nonessential supports and their implementation responsibilities are addressed in section T1e below. A CLDP meeting was held during the week of the monitoring review and was observed by the monitoring team. The meeting and its generation of essential and nonessential supports is addressed in section T1e below. The CLDP included updates of assessments, completed by discipline department heads or therapists. Full assessments, records, and reports were still included in the overall referral packet, but the CLDP document itself only included updates. This was an improvement over the previous system that often included lengthy and somewhat outdated information that was not helpful to the CLDP process. The provision item on assessments is addressed below in section T1d. At LSSLC, the CLDP document was an appropriate length and contained information about the individual, including for example: • method of communication • behavioral issues • adaptive equipment • diagnoses • medications • history of placement and the activities taken during the referral and search for an appropriate provider • a summary of assessments (e.g., social, medical, psychological, daily living skills, vocational, leisure and recreation) • essential and nonessential supports • signatures from the SSLC, MRA, and Provider • a description of monitoring activities • agreements It did not appear that DADS central office had conducted any reviews of CLDPs at LSSLC as it had done at other SSLCs. The content of these reviews can be very helpful to an APC and PMM. The monitoring team recommends that CLDP reviews be conducted by DADS central office and that feedback be provided to the staff at LSSLC.	

#	Provision	Assessment of Status	Compliance
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDPs included indication that the APC and/or her staff had responsibility and had agreed to the contents of the CLDP. (Actions specific to essential and nonessential supports are considered in section T1e below.) Each CLDP also referred to a specific date for moving to the new placement.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Narrative sections of the CLDPs indicated a high level of involvement by individuals (when appropriate) and by their LARs and family members. There was, however, no evidence of individual and LAR review in any of the CLDP documentation submitted other than a signature of one LAR for one of the six individuals (Individual #113) and one signature from one individual (Individual #340).	Noncompliance
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.	As per the DADS policy #018.1, current comprehensive assessments were provided to the receiving agency or provider as per report of the Admissions and Placement Coordinator. Full assessments were provided as part of the referral packet of information to the provider. In preparation for the CLDP meeting, assessments were updated and summarized. Therefore, the CLDP document contained these updated/summarized assessments, rather than full assessments. This appeared to be an adequate process. The APC reported that she reviewed all assessments and all assessments updates/summaries in order to ensure that all recommendations were reviewed and considered by the PST during the CLDP meeting. A review of the six CLDPs indicated a standard set of assessment updates/summaries in the following areas: • Medical • Nursing • Dental • Nutritional • Social • Psychological • PSP • QMRP • Employment • Communication • OT/PT	Noncompliance

#	Provision	Assessment of Status	Compliance
		The monitoring team recommends that some sort of checklist or tracking tool be used by the APC to ensure that all relevant assessment updates/summaries are submitted. This was also recommended in the baseline report.	
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.	A key part of the community placement process was the identification of essential and nonessential supports. Essential supports were those program components that were required to be in place, that is, those that were essential to the success of the individual's transition. Nonessential supports were those that were very important, but would not serve to prevent a move from occurring. Even so, the expectation was that all nonessential supports needed to be in place and addressed. Nonessential did not mean not needed. The APC and the PMM described the facility's process for creating a list of essential and nonessential supports to be a work in progress. They described the process as occurring during the CLDP meeting. The APC reported that she also reviewed the individual's assessments in an attempt to ensure that the CLDP content was consistent with the assessments. Each of the LSSLC CLDPs had a table that listed out essential and nonessential supports. Across the six CLDPs, there was a remarkable uniformity in content. Although this indicated implementation of a consistent process, it resulted in lists of supports that were not individualized. The standardized supports were: • Pre-move site review • Life safety code approved • Transportation provided • Home in a safe location • Residential 24 hour staffing provided • Staff inserviced on needs • Participate in social activities • Participate in leisure activities • Participate in religious activities • Receive training in money management Examples of individualization were seen as follows: • Obtain DARS involvement and pursue employment • Training objectives were included for each person and these were individualized • Obtain a communication/speech and language assessment	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Ensure communication dictionary and poster were available The wording of the three most recent of these CLDPs showed some improvement, based in part on the facility's responsiveness to comments made in the baseline monitoring report, in the wording of the essential and nonessential supports in that they included the type of evidence of confirmation that was expected to be made available by the provider. Each CLDP had one nonessential support related to medical needs. These entries were too long, and contained too much information, some of it not relevant to the support. These entries should be split into a number of entries that simply describe each of the needed medical supports. The CLDP meeting for Individual #350, attended by the monitoring team, provided a good example of some of the improvements and some of the problems with LSSLC's CLDP process. The APC ran the meeting. There was a large attendance that included the PMM for Richmond SSLC (she'll be doing the post-move monitoring), the MRA worker from the new MRA, and someone from continuity of services, all on the telephone. Present in the meeting room were the individual's QMRP, nurse case manager, psychologist, dietician, home manger, direct care staff, social worker, physical therapist, the post-move monitor, and two directors from the new community provider, MGS Community Living Center. The APC began by reviewing his history since his referral. He had just turned 19 and graduated from LISD. (It was a great concern to the monitoring team that this individual had been graduated at age 19 while he had three years of eligibility remaining. His need for continuing educational services was evident: he was nonverbal, had few functional skills, and had no employment skills. This serious problem is discussed in section S above in greater detail.) The individual was going to be moving to a group home that was closer to his mother's home. His mother was highly involved in his transition, but had chosen to not become guardian, perhaps due to the financial cost. He had made progress since his admission to LSSLC about three years prior. For example, he no longer needed a PBSP or psychiatric medications. Then each discipline presented its updated assessment. There was minimal, but appropriate discussion. One topic was regarding his food being cut into quarter-sized pieces. The OT stated that the provider should not try to him to cut his own food because they had tried doing that at LSSLC and the individual was not patient and grabbed all of the food creating a choking hazard for himself. This was an example of good information provided to the provider, however, it also begged the question of whether some type of intervention would be	

#	Provision	Assessment of Status	Compliance
		appropriate. During the discussion of essential and nonessential supports, the APC went through the typical list as described above. Based on discussion earlier in the meeting, pursuit of guardianship was added as a nonessential. The monitoring team suggested that the PST consider the addition of a specific support that would require the provider to conduct training and instruction in communication procedures. It was clear during the CLDP that the individual was somewhat social, but had very limited verbal skills. For example, during the CLDP meeting, he said "Hi" repeatedly. This indicated that some sort of communication system should be developed, be it sign language, further verbal skills, or a picture icon system. It was surprising that he did not have this type of training while at LSSLC. Even so, this was an opportunity for the PST to think outside of the typical list of essential and nonessential supports and individualize the types of supports and services that could be required of the new provider. Other suggestions are to (a) have a draft CLDP for participants to work from during the meeting, and (b) implement occasional monitoring of CLDP meetings in order for the APC to receive feedback and suggestions.	
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.	As noted in section E (Quality Assurance) in this report, there was no quality assurance process in place at LSSLC and, therefore, there was no organized quality assurance process regarding this section T of the Settlement Agreement. Even so, LSSLC had engaged in a number of quality assurance and monitoring activities regarding section T. The QA program compliance monitor assigned to provision T provided the monitoring team with a one-page summary that described all QA activities related to provision T that were occurring at LSSLC. The monitoring team appreciated receiving this summary. QA-related activities were conducted by the APC, the PMM, and this QA staff member. These three staff had begun to use the monitoring team's checklist tools for provision T. During the onsite review, the monitoring team had the opportunity to talk with them about the tools, their purpose, and their limitations for use by the facility (see section E above for more detail). As of the week of the onsite monitoring review: • the APC had completed a review of three CLDP documents, using the tool for sections T1 and T4. • the PMM had completed a review of section T2 for three individuals for whom she had done post-move monitoring.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• the PMM had conducted an interview of staff and individuals as per the checklist tools for one individual. • the PMM had conducted monitoring of the LOD section of three PSP meetings during the month of October. This was recently discontinued and she was awaiting direction from the new policy and procedures. • the QA program compliance monitor had completed some checklist tools for individuals for sections T1, T2, and T4. The QA department, he reported, was learning these new tools and, therefore, was not using the results to do any trending yet. The monitoring team was encouraged by the interest and energy of these three staff in having quality assurance be an active part of their admissions and placement department.	
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	LSSLC was not in compliance with this provision item. LSSLC was not gathering, and was not analyzing, information related to identified obstacles to individuals' movement to more integrated settings. Please also see the discussion in section T1b1 above. LSSLC did not have a facility-wide needs assessment related to the provision of community services to people with developmental disabilities and obstacles to such placements. Further, as indicated in this provision item, a comprehensive assessment of obstacles is required, rather than solely a listing of obstacles for individuals. At the time of the onsite monitoring visit and subsequent preparation of this report, DADS developed an initial report designed to ultimately meet the requirements of this provision item. The statewide report provided an overview of how obstacles were to be identified, a definition of each of 12 different categories of obstacles, and a description of 11 steps the state and facility might take to address some of these obstacles. As discussed with DADS management, the goal was for the state to gather all of the data on the 12 categories of obstacles and create a statewide plan. In addition, the statewide report would include • an appendix for each of the SSLC that provided data specific to that facility, • additional information specific to that facility, such as related to location, population, staffing , and • steps to overcome that facility's specific obstacles. This appeared to be a reasonable approach to reaching substantial compliance with the	Noncompliance

#	Provision	Assessment of Status	Compliance
	from other agencies or the legislature.	requirements of this provision item.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	A number of documents were given to the monitoring team that had the title "Community Placement Report" at the top. None of these documents, however, met the requirements contained in this provision item, that is, to include these three lists: • those individuals whose PSTs have determined, through the PSP process, that they can be appropriately placed in the community and receive community services (i.e., those individuals who have been referred for placement), • those individuals who have been placed in the community during the previous six months, and • those individuals whose PSTs have determined that they can be placed, but have not been referred (e.g., due to LAR preference). To meet this provision item, the facility needs to put this information into one report. Comments regarding the list of individuals who would fall under the third bullet in the above list are provided throughout other sections regarding provision T above.	Noncompliance
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of	LSSLC was implementing the post-move monitoring process. The APC and the post-move	Noncompliance

#	Provision	Assessment of Status	Compliance
	the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	monitor (PMM) maintained a post-move monitoring schedule that listed each individual's name, the new provider, and the dates by which the three required post-move monitoring visits were required to be completed. LSSLC was fortunate to have a post-move monitor who was committed to conducting post-move monitoring in the most effective way possible. Further, she invited suggestions from the monitoring team as to how to improve the process. For example, the PMM readily welcomed the suggestion to make the post-move monitoring checklists cumulative, that is, that comments from previous checklists would be included in the newest checklist resulting in a single document that includes all of the information from all three post-move monitoring visits. Post-move monitoring checklists for the most recent 11 placements were reviewed by the monitoring team. Across these 11 sets of post-move monitoring checklists, all but one of the 28 required visits were completed within the required timelines. This was quite an accomplishment given the many different and somewhat distant locations of homes, day programs, and provider offices. One visit was two weeks late, but this was understandable (and acceptable) because the individual had recently moved to a new residence since he first moved to the community; the delay allowed for a more meaningful post-move monitoring visit to occur. All of the checklists followed the requirements of Appendix C of the Settlement Agreement. Six of the 11 individuals were placed by LSSLC. Three were placed by Mexia SSLC, one by Denton SSLC, and one by Brenham SSLC. Discussion with the PMM and review of checklists indicated that not all post-move monitoring visits included a visit to the home when the individual was present. All three post-move monitoring visits need to include an observation of the individual while at home. Visits to day program or employment sites and attendance at meetings may also need to occur, based upon the supports as per the individual's CLDP. A number of positive changes had occurred since the baseline monitoring review and other changes were planned to be implemented. First, the most recent of these 28 post-move monitoring checklists indicated that the PMM was putting more focus on documenting what evidence she obtained or observed that indicated the presence of many (but not yet all) of the essential and nonessential supports. Second, there was more indication of the PMM taking an active role in requesting (perhaps even requiring) the provider to take actions (e.g., psychiatry consultation for Individual #186, possible readmission to SSLC for Individual #206) and in bringing facility PST involvement when necessary (e.g., SSLC psychologist following Individual #340 behavior problem, training objectives for Individual #269). Third, a new post-move monitoring checklist form was developed, but not yet	

#	Provision	Assessment of Status	Compliance
		implemented. The monitoring team reviewed this new form. For the most part, it was the same as the previous form, but included improvements, such as a place to indicate where the visit occurred (e.g., home, day program), and a column for "evidence" for each support. It seemed this column was to indicate the evidence as per the CLDP. The PMM will need to enter the evidence found in the comments section. The completed checklists indicated a number of problems of which the facility and state were well-aware, and all of which were being addressed via the new CLDP and post-move monitoring formats. First, most of the essential and nonessential supports were not defined in a way that specified what evidence needed to be observed by the post-move monitor. This, not surprisingly, led to inconsistency and errors in the way items were rated. For example: • For Individual #340, his vocational support was rated as being in place (a yes rating), but little activity had been accomplished to find a job for him. Similarly, his participation in social activities was scored as being in place, but there was no criterion set regarding type, frequency, or duration of activity. The leisure activity support was rated as not being in place because his TV was not available. The absence of definitions and criteria made the provision of the ratings a mostly subjective, rather than a mostly objective, exercise. On the other hand, the post-move monitor looked at vehicle maintenance records, including documentation from the auto service shop, in order to determine whether safe and reliable transportation support was available. • For Individual #346, as for all individuals, staff inservices were listed as essential and nonessential supports. The provision of this support was rated as being in place, but the post-move monitoring checklist read, "An inservice was completed prior to her pre-placement visit but new staff have been hired who require the inservice." The monitoring team believes that this support should have, therefore, been rated as not being in place. Further, reliable transportation was rated as being available and that transportation appeared to be in good condition, but there was no indication as to how this was determined. • Individual #186 only had one essential support: provision of 24 hour staff. This was rated as being in place and that appeared to be the case, but it was surprising that an individual with complicated behavioral challenges only had one essential support (see more discussion below). Second, SSLC PSTs will have a larger and more lengthy role in the placement process, including reviewing all post-move monitoring. This will be especially helpful to those post-move monitors who are monitoring the placements of individuals from other facilities. This problem was particularly evident at LSSLC. Five of the 11 individuals reviewed by the monitoring team were from other facilities. The placements of four of	

#	Provision	Assessment of Status	Compliance
		these five individuals were fraught with problems and had failed, or were nearing failure. Below are some details regarding the four individuals placed by other facilities. In the opinion of the monitoring team, many of these problems indicated a lack of proper thorough planning by the placing facility, an issue that was brought to the state's attention and one that will improve, it is hoped, with implementation of the new CLDP process. • Individual #206 had to be moved to two different homes with the provider with whom he was placed due to behavior outbursts, problems interacting with his housemates, and difficulties at his work and day placements, including running away from his home and day program. Then, after continued behavior problems, he was transferred to a different community provider, in part, to be closer to his family. Behavior problems continued and he requested to return to the original community provider. He was referred to a local psychologist and relaxation therapy was recommended (in the opinion of the monitoring team, this was an inadequate response and one that was unlikely to be effective). The PMM raised the possibility of him being returned to Mexia SSLC or having the Mexia SSLC PST do training and consultation to the provider. At the time of the onsite monitoring review, this case was not stable and questions about placement and transfer remained. • Individual #186 was moved to a second new home by his community provider following multiple tantrum incidents, mostly over food items, such as muffins. One of these incidents led to police involvement. • Individual #443 was placed in a home and assigned to a day program in which there were no appropriate housemates or coworkers, that is, no one with whom he could talk or develop a mutual friendship. After the individual made comments to the PMM, and after prompting from the PMM, the provider found a new day program and enrolled him in the local school district. Further, the provider was going to identify a more appropriate home for him and have him move when a space became available. Even though the individual was stable at the time of the 90-day post-monitoring visit, the appropriateness of the choice of this home and day program raised questions about the type of planning that occurred for this individual. • Individual #63 had a history of alleged sexual offending. His placement, however, was in a home near a school bus stop, a couple of blocks away from an elementary school, and next door to a family with children. Although the individual was stable at the time of the post-monitoring visit, the placement was made without thoughtful planning and may have set the occasion for exhibition of a serious incident. Fortunately, after this was brought to the attention of facility and state staff, actions were initiated and a more appropriate home for the individual was identified.	

#	Provision	Assessment of Status	Compliance
		Third, PSTs and PMMs can, and should, take a more active role in determining supports, determining criteria, and getting assistance when needed. Some examples and comments are provided below. • Individual #340 had few behavioral problems at LSSLC, but during his first week or so at his new home, he had a behavioral outburst that included threatening staff while holding a kitchen knife. No one was hurt, but the PMM arranged for the LSSLC psychologist to meet with the provider. From this meeting, a list of appropriate actions was generated for the provider to enact. This was good to see. The actions, however, should become part of the PMM's follow-up during subsequent visits. • Individual #443 was moved to a more appropriate day program due, in part, to the actions and advocacy of the PMM. • The provider for Individual #269 refused to implement training objectives. The post-move monitoring checklist said, "Provider indicates that HCS programs do not provide multiple formal training programs as was outlined by the team and are hesitant to put in place." The PMM stepped in. She spoke with the LSSLC PST and, based on that discussion, directed the provider to implement the training objectives as per the CLDP. Training objectives were listed as nonessential supports in the CLDP, so this should not have been questioned by the provider. If implementing training objectives was beyond their capability, they should not have agreed to be a provider for this individual. As noted above, the CLDP presents the PST with the opportunity to include important training objectives as essential and nonessential supports and it was good to see that occurring for some of the individuals being transitioning from LSSLC. • The monitoring team recommends that the state consider allowing PSTs to extend the length of post-move monitoring beyond 90 days if the PST has good reason to do so, such as if the individual was recently moved into a new home by the provider; the individual was transferred to a new provider; if there were ongoing unresolved psychiatric, behavioral, or medical problems; and/or if the individual, his or her LAR, or PST were dissatisfied with service provision. The monitoring team also recommends that the post move monitor have the opportunity to network with other post move monitors and with DADS central office to ensure support, exchange of ideas and best practices, and problem solving. The APC and PMM reported that they had a very good working relationship with the providers and had not needed to resort to notifying the MRA, DADS, or any regulatory agency in order to gain their compliance in providing any of the required supports.	

#	Provision	Assessment of Status	Compliance
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.	As noted above in section T2a, post-move monitoring visits were occurring at LSSLC. The monitoring team had the opportunity to accompany the post-move monitor on a visit to the home of Individual #63, who was placed by Mexia SSLC within the previous 60 days. The home was operated by Innovative Homes, Inc. This was not an official post-move monitoring visit because the 45-day visit had occurred recently and the PMM wanted to wait until the date was closer to 90 days to do the 90-day visit. The monitoring team wishes to thank the PMM and the community agency for making arrangements for this visit to occur. The purpose of this visit was to learn about the post-move monitoring process, see the community home, meet the individual, learn about transition and services, and see the status of some of the essential and non-essential supports. The visit began at the provider's offices where the PMM demonstrated the way she conducted post-move monitoring, that is, a number of the documents that needed to be reviewed were kept at the office. Therefore, the visit started at the office and then continued at the home. The PMM and monitoring team were given a tour of the home and then talked with the individual, with the program director, and, later, with program staff. The individual was pleasant and engaging. He talked about being bored at home and wanting to be able to walk around the neighborhood, meet people, and make friends. The PMM told him that he would have to work with his PST and that he needed to follow all of the rules. The individual agreed with this. The program director remarked about how well he had been doing. During discussion with the program staff, the monitoring team inquired about the neighborhood and neighbors. The program staff said that a family with children lived next door, and that the staff followed all supervision requirements for the individual. Although staff reported they were following supervision, the placement location was of concern to the monitoring team and the PMM given the individual's history of problem behaviors, including allegations of sexual offending. Following the visit, the monitoring team raised this concern to DADS administrators. Within the two weeks following the onsite review, state administrators and staff from the referring facility (Mexia SSLC) and LSSLC met to review the case. They then met with the individual. According to follow up emails and to documentation of a PSPA meeting, a decision was reached to change his placement to a provider more suited to providing supports in a more appropriate community location. The new provider and home had been identified and, according to information submitted to the monitoring team, the individual was in agreement with the change in provider. The monitoring team was pleased with the state's quick response to this information. On the other hand, this problem was not identified via post-move monitoring or, more importantly, during the	Noncompliance

#	Provision	Assessment of Status	Compliance
		CLDP, placement, and transition processes by Mexia SSLC, DADS, and the community provider. Obtaining substantial compliance with this provision item will require implementation of a more thorough review of evidence and placement concerns (such as in the case described immediately above) as well as review of placement and post-move monitoring by PSTs. This will only be able to occur if the description of supports is made more detailed and observable as indicated in sections T2a and T1e above.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.	This provision item did not apply to any individuals at LSSLC.	
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the	The APC noted in discussion and in reviewing the POI with the monitoring team that very few individuals were discharged under the alternate discharge process. She added that proper procedures were followed, but there were no procedures or policies to ensure that this was the case. She noted that new procedures and policies were being developed and that this provision item should be in substantial compliance by the next onsite	Noncompliance

#	Provision	Assessment of Status	Compliance
	provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	monitoring review.	

Recommendations:

1. Implement updated policies and procedures when they are disseminated.

2. Remove or update facility policies. If the facility maintains its own policies, ensure that any facility policies are in line with state policies, and obtain documentation from state office regarding the approval of state policies that add to, or supplement, state policies.

3. Ensure that the opinions of professionals (i.e., PST members) are considered when determining most integrated settings. The opinions of these professionals for appropriateness of referral for placement should be considered separately from LAR preference. Further, ensure that the PST follows state and facility policy regarding referrals, reporting of obstacles, and acting when there is a lack of team consensus.

4. Ensure that a thorough and meaningful discussion of optimistic optimal living characteristics occurs during the PSP meeting. Ensure that the optimistic vision section of the PSP addresses the individual's needs for success in the community, not only his or her preferences.

5. Provide competency-based training for QMRPs regarding how to facilitate and lead a meeting of this type.

6. Identify and address the identified obstacles to individuals' movement to the most integrated setting within the PSP for each individual.

7. Identify and address obstacles across the facility by conducting a comprehensive assessment and analyzing the information as required by provision item T1g.

8. Review the list of individuals who have requested placement, but were not referred to ensure that the reasons are current and that any actions that could have been taken, were taken. This information should be reported as part of the admission and placement department's data/QA activity.

9. Create a list of individuals for whom LAR preference is the only reason a referral has not occurred (whether or not the individual himself or herself requested placement). This information should be reported as part of the admission and placement department's data/QA activity.

10. Continue to work on the education of individuals and LARs regarding most integrated setting practices.
    a. Determine measureable outcomes for the provider fair.
    b. Assess the outcome/effectiveness of the CLOIP.
    c. Improve the system of community tours as described in provision item T1b2.
    d. Use the self-advocacy group as an opportunity to educate individuals about community placement.

11. Create an assessment for placement as required by provision item T1b3.

12. Create and use a checklist to ensure that all required assessments (and updates) are received and included in the CLDP.

13. Improve the way important essential and nonessential supports are included in the CLDP:
    a. Begin developing the list of supports prior to the CLDP meeting.
    b. Ensure that all important supports are directly taken from professional assessments and recommendations, discussions at relevant PST meetings, and the individual's records.
        i. define each support in observable and measureable terms.
        ii. define the manner in which the presence of each support will be verified.
    c. Ensure all professional disciplines are included in the transition and placement process, including, but not limited to, physicians and psychiatrists.
    d. Split the typical lengthy medical-related essential and nonessential supports into separate items.

14. Develop a quality assurance process for this provision. Ensure that relevant information is submitted and monitored by the QA department. Ensure that quality assurance processes are applied for all of section T, including but not limited to T1g. Consider the use of the APC's weekly report.

15. Implement the new post-move monitoring checklist, including detail regarding

a. each of the sites visited
b. how the presence or absence of supports was assessed (i.e., evidence), and
c. follow-up activities for both essential and nonessential supports.

16. Ensure all three post-move monitoring visits include an observation of the individual at his or her home.

17. Create a Community Placement Report as described in provision item T1h.

18. Review the rescinded placement of Individual #449 to ensure the referral was not rescinded due to there not being an available provider.

The following are offered as additional suggestions to the facility:

19. Make minor edits to the new CLDP form as follows: (a) add psychiatry to the list of assessments, (b) reword or remove the comment on page 12 regarding action plans, and (c) include the standard items from page 6 in the pre-move list on page 23.

20. DADS should provide feedback and suggestions on LSSLC's CLDPs to the APC. Consider creating a metric to measure the quality of the CLDPs and consider creating a criterion to indicate that the facility has mastered CLDPs. This might then result in less frequent reviews of CLDPs being necessary.

21. Re-institute monitoring by the PMM of the living options/integrated discussion of the PSP meetings.

22. Make the post-move monitoring checklist reports cumulative for each individual, that is, add new information to the previous report to result in a single document.

23. Consider allowing PSTs to extend the 90-days of post-move monitoring if warranted.

24. Provide opportunities for the post-move monitor to network with other post-move monitors at other facilities.

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o PSPs listed in Section F of this report Interviews and Meetings Held: o Royce Garrett, Director of Individual and Family Relations o Luz Carver, QMRP Coordinator o Jason Peters, Rights Officer Observations Conducted: o Observations at residences o Observations at the onsite workshop and day program o Daily Incident Management Meeting 10/19/10 o Daily Incident Management Meeting 10/20/10 o PSPA Meeting for Individual #600 10/19/10 o PSP Annual Meeting for Individual #140 and Individual #167 o Woodland Crossing Morning Meeting 10/20/10 o Human Rights Committee Meeting 10/20/10 o Health Status Team Meeting 10/20/10
	Facility Self-Assessment: The facility's POI indicated that the facility did not have a written plan in place to address this provision. Guidance and outreach services had been provided to families, organizations, and entities on becoming LARs. The facility rated itself as being in noncompliance for items in section U. The monitoring team agreed with this assessment, but found that the facility was taking positive steps towards substantial compliance.
	Summary of Monitor's Assessment: Although the facility had made minimal progress on prioritizing a list of individuals who needed guardians, there had been some activity around recruiting guardians at the facility. Since the baseline review, LSSLC had conducted Parent Association Meetings to educate parents on the guardianship process. A judge presented information to parents at a meeting on 7/31/10 on the responsibilities, process, and cost of obtaining guardianship. Additionally, a letter had gone out to all families encouraging them to pursue guardianship. The letter provided contact information for social workers at the facility that could assist them with guardianship issues. According to the Director of Individual and Family Relations, there were 14 families activity pursuing

	guardianship at the time of the monitoring visit. Five individuals at the facility had acquired guardians since 4/18/10.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The facility had a Director of Individual and Family Relations that was responsible for the development of a process to address this provision item. In regards to this item of the Settlement Agreement, the Director of Individual and Family Relations noted that instruments or processes to determine the functional capacity of an individual as per this provision item had not been finalized, approved, or distributed by the state office to the SSLCs for use. The facility, however, provided the monitoring team with a Priority Listing for Adults Without Guardians, which prioritized need for guardianship based on: • Individuals with active correspondents, • Individuals with potential guardianship resources, that exceeded $1,200, • Individuals with High Risk Medical Status, • Individuals receiving psychotropic medications, • Individuals with behavior support plans, • Individual's ability to express his or her own wishes, and • Individuals with restrictive programming. Each individual received a priority score based on the number of factors present that would warrant need for guardianship, with ratings of 5 indicating the greatest need for guardianship and ratings of 0 indicating the least need for guardianship. There were five individuals at the facility whose priority rating was a level 5. Thirty-one individuals were rated as a level 4 priority, 72 were rated as a level 3 priority, 69 were rated as a level 2 priority, and 38 were identified as a level 1 priority. Twelve individuals were rated as level 0 priority. A total of 227 individuals (52%) had been ranked for need of guardianship. While the facility was not in substantial compliance yet with this provision item, staff were taking positive steps to put procedures in place to do so.	Noncompliance
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	The facility had made some efforts to obtain LARs for individuals through contact and education with family members as described in the monitor's summary for section U above. There was no indication that efforts were targeted towards those individuals rated as high priority for guardianship. The facility was not in compliance with this provision item.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.		

Recommendations:

1. Continue to prioritize the list of individuals who need LARs at the facility.
2. Develop a list of LAR providers in the area.
3. Continue to provide information to primary correspondents/families of individuals in need of an LAR regarding local resources and the process of becoming a LAR.
4. Consider ways of teaching individuals to problem-solve, make decisions, and advocate for themselves. Some of these skills might be addressed with a formal instructional teaching plan.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o LSSLC policy: Management of Protected Health Information, Administrative-03, dated March 2009. o LSSLC policy list, 9/23/10 o Updated policies since April 2010 o LSSLC POI, updated September 2010 o LSSLC POI Supplement, September 2010 o LSSLC Recordkeeping Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 10/18/10 o Table of contents for the active record and the individual notebook o Description of how documents make their way to the various records, dated 9/23/10 o List of all staff responsible for management of unified records: • Unified records coordinators (three), home clerks (five), and night home managers and night staff o Completed audit sheets of 13 active records done by the URCs for August 2010, September 2010, an October 2010, and accompanying related email correspondence and memos. o Active records of many individuals who lived at LSSLC o Review of active 20 individual records listed in section M. o Review of active records and individual notebooks of: • Individual #203, Individual #15, Individual #526, Individual #370, Individual #434, Individual #374, Individual #476, Individual #468, Individual #257, Individual #305 o Review of master records of: • Individual #425, Individual #300 Interviews and Meetings Held: o Rita Inman, Unified Records Coordinator o Sheila Thacker, Unified Records Coordinators o Records clerk: Emma Strait o Numerous staff and clinicians at all levels, including Nikki Derbonne, Raymond Young, Lottie Richard, Sally Hamilton, Crystal, Jacob Derry o QA staff program compliance monitors: Tabitha Anastasi, Elizabeth Canley, Stacie Cearley, Gena Hanner, Marvin Stewart, Stephen Webb o Settlement Agreement Coordinators: Nikki Yost and Sherry Roark o Residential Unit Directors: Rotley Tankersley, Glenn Heath, Kenneth Self, Keith Bailey, Todd Miller Observations Conducted: o Records storage areas in residences

	o Records storage areas in administration building o Master records storage area
	Facility Self-Assessment: The facility's self-assessment, called the POI, for this provision indicated that all four provision items were self-rated as being in noncompliance, except for V4 (use of records to make treatment decisions). Very little additional information was provided regarding the methods, activities, and criteria used to make these determinations. Even though a lot of activity had occurred towards this provision of the Settlement Agreement, the monitoring team concurred with the facility's self-assessment regarding the provision items being in noncompliance. The monitoring team, however, disagreed with the facility's self-assessment rating V4 as being in substantial compliance. The facility did not have any method to determine whether this provision was or was not being met, thereby making the self-rating invalid. The review that follows below provides some direction for the facility towards continuing to develop its recordkeeping practices to meet the requirements of this provision. Corrective action plans should also be included in the self-assessment actions for these provision items where appropriate.
	Summary of Monitor's Assessment: LSSLC made great progress towards meeting this provision of the Settlement Agreement. The new policy and record keeping practices were implemented across the facility. The unified record for every individual was created, including a reformatted active record and a brand new individual notebook. The unified records consisted of a multi-volume active record, an individual notebook, a master record of historical and legal documents, and an overflow record of thinned and purged materials that were stored for future use if needed. The new records followed the state's policy. The active records and individual notebooks were organized according to the required format. A master record existed for each individual, but it appeared to contain a lot of information that was not, and should not be, in a master record, such as numerous PSPs and assessments. Other recommendations for modifications to the records are made below and include addressing inconsistencies across individual's active records, such as by determining what should be in the record sections for consent, habilitation, and skills assessments, as well as assessing the individual notebooks for duplication (e.g., PNMPs) and unnecessary components (e.g., activity schedules). The Unified Record Coordinators were committed to having an organized, user-friendly record keeping system. They were knowledgeable about the records, had many years of experience at LSSLC, and were interested in improving the records as implementation of this new system moved forward. Comments from staff at all levels indicated an overall satisfaction with the new recordkeeping practices.

	Many staff liked the new individual notebooks and found them to be useful and easier to use than the previous systems. Medical staff, however, noted that sometimes needed information had been purged from the active record and that, at other times, important information was with the individual in his or her individual notebook and not available to them when needed, such as to review the most current seizure information. A further indication of progress in this area was that audits of the active records by the recordkeeping department had commenced in August 2010. Through the time of the onsite monitoring review, 13 audits had been completed. Useful information was obtained during these audits. A system, however, was needed to ensure that corrections were made to the records based on the audits. Further, an additional audit tool was needed to ensure that all contents of all components of the record were audited. LSSLC should ensure that record keeping is tied into the facility's quality assurance program and that quality assurance activities occur related to record keeping. Moreover, it will be important for LSSLC to obtain feedback and suggestions from those who use the records regularly in order to make relevant and useful changes to the record keeping system.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	The monitoring team looked to see if LSSLC had established and maintained a unified record for each individual consistent with the guidelines in Appendix D of the Settlement Agreement. DADS had developed a policy on recordkeeping called Recordkeeping Practices. It was numbered 020.1 and was dated 3/5/10. It was slightly updated from a previous version in order to more thoroughly define each of the components of the unified record for each individual. In addition, LSSLC had its own policy, called "Management of Protected Health Information." It was labeled Administrative-03 and was dated March 2009. As noted in the baseline report, LSSLC should review this policy and either remove it, or update it so that it is in line with the new state policy. If the facility management decides to maintain this (and/or other) additional policy, review approval from state central office should be obtained. LSSLC made considerable progress in meeting this provision since the baseline review. At the time of this onsite monitoring review, all of the records at the facility had been converted, and every individual was reported to have an active record that was in the new format, as well as an individual notebook. The completed unified record consisted of the following, as required: • Active record • Individual notebook	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Master record • Overflow files The conversion of the old records to the new active records, and the creation of the individual notebooks was a very large task and required a great deal of effort from the recordkeeping department staff as well as from other departments and operations at the facility. The monitoring team wishes to acknowledge this as well as the ongoing efforts at the facility to meet this provision of the Settlement Agreement. The records were completed only a few weeks prior to the onsite review and more work was needed (and was going to be done) to ensure they were useable, of a manageable size, and that all aspects of Appendix D were being followed. Therefore, this item was rated as being in noncompliance, however, it is likely that the facility will achieve substantial compliance in the near future. Earlier this year, the recordkeeping staff engaged in a number of activities to transition the facility to the new recordkeeping systems. They reported that they conducted training for all staff at the facility on the new records, beginning in June 2010 with overnight managers, overnight direct care staff, campus administrators, and campus coordinators regarding the individual notebooks. The overnight home managers and their staff had a lot of responsibility in creating the new individual notebooks. Then, the recordkeeping staff did training for day and evening staff, and for the many departments at LSSLC, including psychology, habilitation, employment, nursing, and physicians. In mid-June 2010, they did training of the home clerks, preparing them for the transition to the new multi-volume active records. To do so, they did a record transfer together with the clerks. This appeared to be a reasonable and organized way of creating the new unified records. The recordkeeping staff told the monitoring team that some re-training was already needed, especially regarding the upkeep of individual notebooks, and end-of-month thinning and filing. This was not surprising given the recency of implementation. LSSLC was fortunate to have experienced staff as their unified records coordinators. Their experience at LSSLC ranged from 13 to 28 years and included many years in the role as file clerk at the residences. They were supervised by the director of quality assurance. Their current duties were broad and included filing of documents in each individual's master record, providing census reports, responding to Advocacy Inc. requests for records, auditing active records, providing various departments with documents as requested (e.g., social work, medical), completing guardianship-related paperwork, and sending out letters for PSP meetings. In addition, they were going to be involved with the development of the new electronic medical records system at LSSLC. In addition to the URCs, other staff were responsible for various aspects of recordkeeping	

#	Provision	Assessment of Status	Compliance
		at LSSLC. These included the home clerks (there were five at LSSLC, one for each unit), and night home managers and night staff. This appeared to be a reasonable amount of staffing resources for the recordkeeping requirements of this provision of the Settlement Agreement. The monitoring team had the opportunity to speak with records clerks as well as with many staff and clinicians at all levels regarding their experiences with the new record keeping systems. Their comments are summarized later in this section of the report. <u>Active records</u> The new active records varied in size based upon the amount of information in the individual's record. Most records contained three three-inch binders. Some contained only one or two binders, and others contained four binders. The active records were divided across the binders in the same way for all individuals. The active records were constructed following the order of sections from the state's table of contents. In the opinion of the recordkeeping staff, the active records were neater, more organized, and information was easier to find. They reported that the new plastic tabs were sturdier than what they had been using. They noted that keeping the records in reverse chronological order while using two-sided pages for IPNs notes created a great deal of confusion. They solved this by only using one side of each page for the IPNs. <u>Individual notebooks</u> Individual notebooks were in place as per the state's policy. Individual notebooks were observed in day and residential locations. The individual notebooks reviewed by the monitoring team appeared to contain most everything required by the state's table of contents. The purpose of the individual notebooks was to ensure that all relevant information was at hand for direct support professionals. The monitoring team found that staff were very positive about these individual notebooks and did not find them to be burdensome or cumbersome. There were no reports of the individual notebooks being counter-therapeutic for any individuals, distracting to staff and thereby from attending to the individuals, or creating a negative stigmatizing effect. This was encouraging to see. <u>Master records</u> A master record was kept for each individual. Some of the items in the master record were used regularly by some of the departments at LSSLC, such as medicine or psychology. The record keeping staff said that they made sure that documents were available as needed.	

#	Provision	Assessment of Status	Compliance
		The master records at LSSLC were all kept in a room in the administration building. The room was managed by the recordkeeping staff. Two master records were reviewed in some detail. One was for an individual who had lived at LSSLC for many years (Individual #425) and the other record was for an individual who had been placed at LSSLC more recently (Individual #300). There were no discernible differences between these two master records other than Individual #425's master record being larger than Individual #300's master record. The master records contained a lot of information and, as a result, the files were quite large. It seemed to the monitoring team that a portion of what was contained in the master records was unnecessary, such as many years of PSPs and numerous assessments. These documents were available elsewhere (e.g., active record, overflow file) and did not need to be in the master record. Managing all of this unnecessary information created a great deal of work for the URCs, as well as for home clerks and home staff. The purpose of the master record is to be a repository for important historical and legal documents that need to be stored separately from the active record due to the importance of the documents. Further, the URCs were not using any type of table of contents or checklist to inform them as to what was supposed to be in each master record. There were two lists on the wall in the storage room, but they were decades old. Interestingly, the facility's own 2009 policy included a table of contents for the master records, but it was not being used. It may, however, include items that should no longer be part of the master record. The facility should address this so that the master records contain the appropriate contents and so that URCs time is not wasted. The facility should work with DADS central office as well as consider finding out what the other SSLCs are doing. The monitoring team recommends that LSSLC contact the coordinator of consumer records at San Antonio SSLC. <u>Overflow files</u> Documents taken from each individual's records were stored and managed by the home clerks according to the record thinning schedule provided by the state. The overflow documents were kept in the office of the home clerks for two years. <u>Other Comments on unified records</u>: LSSLC had made progress in the manner in which two components of the unified record were being completed: the integrated progress notes in the active records, and the observation notes in the individual notebooks. As per the Settlement Agreement's Appendix D, and LSSLC policy and practice, handwritten entries needed to be in black ink and with no blank spaces. Overall, this appeared to be the case in the records reviewed by the monitoring team. These were the entries that were current at the time of the	

#	Provision	Assessment of Status	Compliance
		onsite review, that is, October 2010. The individual notebooks included a separate tag divider for each skill acquisition plan. Although this was not required, it was a good addition because it made it easier for direct care staff to see each SAP and to find each SAP when it was time to implement it and record data. Although a tremendous amount had been accomplished, the monitoring team found LSSLC still had work to do to meet the requirements of this provision beyond the transfer of records into the new formats and the creation of the individual notebooks. For example: • The consents section contained varying numbers of consents. There was no way to know if the consents in this section represented all of the consents that should have been present. Some sort of checklist should be created so that the records clerk (and program auditors) can determine if all consents were present. Further, there was inconsistency across records in what was contained in the consents section. For example, Individual #476 had only one consent (for medication and behavioral management program), Individual #257 had only one consent, but it was a different one (rights restrictions), Individual #468 had three consents (dental clinic medication, medical procedure meds, and PBSP and medication), Individual #305 had two consents (rights restrictions and PBSP and medication), and Individual #203's record contained no consents. • The habilitation section contained a lot of information. Similar to the comments immediately above regarding consents, the monitoring team was unable to determine if any habilitation consultations or notes might have been missing. • The same question applied to the skills assessment section, that is, more guidance needs to be provided so that recordkeeping staff and auditors who what to look for. Most records had the PALS, others had something called the functional life skills assessment (e.g., Individual #468). • There should be tab dividers within the consultation section for each of the required consultation areas. This was not the case in the LSSLC records (e.g., Individual #476, Individual #468). • Many of the individual notebooks contained the same document (the PNMP) in two places (in the PNMP section and in the profile section). It didn't make sense to have this duplication. The facility should examine and correct this (e.g., Individual #374, Individual #476). • The individual notebooks included a daily schedule. These did not appear to be functional or accurate. The facility should examine whether it is necessary to have a schedule of activities in the individual notebook. • Most records contained the most recent documents, however, in one case, the	

#	Provision	Assessment of Status	Compliance
		most recent PSP was not in the active record or individual notebook; the one available was 16 months old (Individual #434) • One home had put their individual notebooks into larger hard binders rather than the smaller soft binders used through the facility (e.g., Individual #526, Individual #370). The URCs were informed of this, looked into it, and were planning to correct this during the week of the onsite review. <u>Comments from staff</u>: Below are summarized comments from the many staff who spoke with the monitoring team. LSSLC management and the recordkeeping department should consider these comments as it moves forward with continued development of the new recordkeeping practices at the facility. LSSLC should be pleased with the positive response of staff to the new recordkeeping practices at the facility. • A home clerk noted that she and the staff were still getting used to the new records, however, she said that she thought records will be easy to use, once everyone is used to them. • A house manger said that the individual notebooks were better than the recording system they used before. She didn't see much difference in the active records. • Another house manager and direct care staff member said they liked all of the new record systems. • A direct care staff member liked the individual notebook, especially that everything he needed was now in one place. • Two direct care staff members liked the individual notebooks and found them to be especially useful because they did not always group the individuals in the same way. • QA staff liked the new active records and individual notebooks. They noted that some of the individual notebooks were already becoming worn out, therefore, it would be important to ensure that they were replaced as soon as necessary. • The unit directors also liked the new system. They highlighted the important role of the overnight shift in the daily and weekly upkeep of the active records and individual notebooks.	
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	Over the past few months, DADS wrote and distributed new policies to address many, but not yet all, of the provisions of Part II of the Settlement Agreement. More work will be needed to complete the additional policies, and to develop a regular process for the review, updating, and modification of each policy. DADS maintained a spreadsheet indicating the status of policies, protocols, and procedures for each provision in Part II of the Settlement Agreement (i.e., sections C	Noncompliance

#	Provision	Assessment of Status	Compliance
	policies, protocols, and procedures as necessary to implement Part II of this Agreement.	through V). Facility policies are likely to be developed as DADS completes its set of statewide policies. Then, as noted throughout this report, the facility will need to ensure that any facility-specific policies are in line with the state policy and that approval is obtained from the DADS central office.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	Quality assurance procedures to meet the requirements of this provision item were not yet in place, but the facility had made some good progress in this area. Most importantly, the three URCs had begun to do reviews of a sample of unified records each month. They began in August 2010 and 13 had been completed through the week of the onsite monitoring review. This represented a great start to the quality assurance process required by this provision item (also see section E above regarding quality assurance). The URCs used the monitoring team's checklist tool for provision V and they scored the section for V1. Specific comments and detail were provided at the end of each of the audits detailing the items that were missing or inadequate. In addition, an email detailing the findings was sent to the house manager, unit director, and home clerk following each review. The URCs were thoughtful in their wording of the emails to ensure that the reader understood their role in trying to help them meet the requirements of the Settlement Agreement. A lot of useful information was thus provided for program managers and clerks. A method, however, needs to be put in place to ensure that the feedback was received by the program and that the items noted in the audit have been corrected. Below are examples of their findings and the topics of feedback to the program: • blank lines between entries • correct chronological order • thinning of the records • HMPs that were missing • adding a tab for Medicare part d tab • using only one side of the IPNs • using the proper seizure form • a missing MOSES • a missing quarterly drug regimen review • adding staff's title after the signature • including most recent documents in the individual notebook The monitoring team had the opportunity to discuss the auditing process at length with the URCs. The monitoring team appreciated their interest in improving their service and	Noncompliance

#	Provision	Assessment of Status	Compliance
		meeting the requirements of this provision item. To do so, the audits should continue, but should include additional information to ensure that all components of the unified record are assessed, as well as the specific required components of each aspect of the unified record (including the master record). One way to do so is to use the table of contents as a guide. It is recommended, as discussed with the URCs, that they contact the URC at San Antonio SSLC to learn about her auditing checklists; these would be useful to LSSLC. In addition, LSSLC should get feedback and suggestions from staff who use the records. This information can be used to improve the record keeping system and components. Implementation of the new record keeping system had only occurred a few months prior to the onsite monitoring visit. Once staff have used the system, useful feedback can be obtained from clinicians, managers, and direct support professionals.	
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.	The facility did not have a means to assess this provision item. The monitoring team discussed this provision item at length with the URCs. The URCs said that following this discussion they had a better understanding of this provision item. The facility will have to come up with a way to determine if facility staff are routinely utilizing the records in making care, medical treatment, and training decisions. The facility should work with DADS central office, as well as with the other SSLCS to determine how to do so. Most likely a set of activities will have to occur, including, for example, interviews of clinical staff to learn how they use the records (e.g., psychology, nursing, habilitation), a review of the contents of IPNs, and an examination of medical consultations. The URCs had planned to attend PSP and PSPA meetings, but the monitoring team commented that this was probably not going to result in their obtaining the information they needed to meet the requirements of this provision item. Some comments, based upon observations of the monitoring team, regarding the use of the records as required by this provision item are provided below. These illustrate some examples of the use of the unified record, but also show some of the challenges for the facility to address in meeting the requirements of this provision item. • During the PSPA meeting for Individual #96, the PST nurse opened up the record and read from a recent entry. This appeared to be useful to the PST. • During the annual PSP meeting for Individual #349, the QMRP asked a number of questions regarding occurrences of behavior problems that were clearly not relevant to the individual (e.g., pulling out his hair). The PST looked through his active record and then the QMRP realized that she was reading off of a	Noncompliance

#	Provision	Assessment of Status	Compliance
		standardized list that was cut and pasted from some other document, rather than referring to characteristics specific for the individual. • In all psychiatry clinic observations, the psychiatrist had the medical section of the active record open, and looked at documents from the record during clinic. The graphs in the record, however, did not include noteworthy events (e.g., medication changes, situational stressors) making these graphs not as useful as they might have otherwise been. • During the annual PSP meeting for Individual #312, the records were not used at all. • The medical director noted that the records were likely to be used more as they went forward because medical staff were getting used to the way the IPNs and consultations were filed, that is, with the most recent IPNs and consultations on top. • The CNE noted that the new records were missing some information that previously available. This information was needed for their provision of treatment, such as seizure flow records and MOSES. In addition, relevant information that was in the individual notebook was with the individual, and not available to medical staff, and thereby, not always readily available to health car staff, such as the current seizure record, and client care flow sheets. • Similarly, physicians noted that the active records were purged yearly, and certain historical information needed to provide consultation was, therefore, at times, unavailable. Information could be requested from medical records, however, the physicians indicated that this sometimes resulted in an unacceptable wait time, especially if the case required urgent review of these records. Some of this might be alleviated by electronic access to prior records. • Within the medical records there were three areas that required attention: (1) documentation of the time of day using the 24-hour clock, or by using am and pm, was not consistently and completely implemented, (2) IPNs often had multiple blank lines at the bottom of pages, and (3) the new 30-day MAR did not provide adequate specified sections to document vital signs or weights, particularly blood pressure and blood glucose measures. • Several versions of some forms were being used. Often the forms were not clearly labeled and at least in the medical records, there was often a return to using old forms (e.g., HMPs and seizure forms). • Habilitation therapies clinicians were observed to refer to the active records of individuals they were reviewing during their wheelchair and PNM assessments as well as during the NMT meeting attended by the monitoring team. Progress notes were present in a number of the records reviewed in the integrated progress note section, though much of the documentation for direct service was limited to attendance sheets only. Many of the progress notes included in the	

#	Provision	Assessment of Status	Compliance
		integrated progress notes section did not clearly refer to the issue or problem being addressed by the therapist and there was inconsistent documentation through to resolution of an identified concern. The notes should identify the specific problem, and when and how it came to the attention of the clinician. Then actions required and taken by the clinician should be outlined with a plan for additional interventions or supports as indicated. Upon resolution of the issue, this should be clearly stated relative to the interventions and their efficacy. • The individual notebook system was an improvement that may lead to more accurate data collection (K4), however it was not consistently implemented across all residences (K4).	

Recommendations:

1. Review facility policy on recordkeeping. Either discard it or update it. If decision is to update it for the facility, ensure this facility policy is in line with state policy. Obtain review approval from DADS central office.

2. Create and use a table of contents or checklist for management of the master records. Remove documents from the master record based on this table of contents or checklist. Consider consulting with other SSLCs.

3. Determine what consents should be in the consent section of the active record of each individual.

4. Determine what should be in the habilitation section of the active record of each individual.

5. Determine what skills assessment documentation should be in that section of the active record of each individual.

6. Add tabs for each consultation area, as per the table of contents for the active record.

7. Complete the development of policies as described in provision item V2.

8. Incorporate record keeping activities into the facility's quality enhancement program, including ensuring the data collected by the URCs during their record audits are included in the QA program.

9. Use an additional checklist audit tool that looks at all of the components of each of the four parts of the unified record. Add to the audit tool detail so that the auditor can determine whether all documents that should be in the record, are in the record, especially for areas such as consent, consultations, and habilitation.

10. Develop a method to ensure that any needs or problems identified in the record audits are corrected.

11. Ensure records are used in making care, medical treatment, and training decisions. Determine a way to assess whether or not this is occurring.

12. Data should be presented graphically, over a period of time reflecting data collection prior to the start of or adjustment of medication as well as following a medication adjustment. The graphs should include noteworthy events (e.g.. medication changes, situational stressors).

The following are offered as additional suggestions to the facility:

13. Assess and correct duplication in the individual notebooks (e.g., PNMPs).

14. Assess whether the activity schedule is functional and useful. If not, either remove it or create a schedule that is functional and useful.

15. Obtain feedback and suggestions from those staff who regularly use any components of the unified records.

16. Consider an electronic database for psychiatric records.

17. Provide read only access to psychology documentation for psychiatrists in an effort to increase collaboration and integration of services.

18. Nursing management should provide a master medical record in each nurses' station with instructions on where to file/find items and also on how to fill out forms and functionally use them.

19. LSSLC and DADS should label all forms with the version/date. LSSLC nursing management should routinely remove access to all old forms in nurses' stations.

20. The nursing department should continue to coordinate and collaborate with the pharmacy to provide electronic production of monthly MARs that include appropriate and consistent orders for monitoring, such as blood pressure monitoring before administration of an antihypertensive.

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ABLLS-R	Assessment of Basic Language and Learning Skills-Revised
ACP	Acute Care Plan
ADA	Americans with Disabilities Act
ADR	Adverse Drug Reaction
AED	Anti Epileptic Drugs
AED	Automatic Electronic Defibrillators
AIMS	Abnormal Involuntary Movement Scale
ANE	Abuse, Neglect, Exploitation
AP	Alleged Perpetrator
APC	Admissions and Placement Coordinator
APS	Adult Protective Services
ARD	Admissions, Review, and Dismissal
ASHA	American Speech Language Hearing Association
AT	Assistive Technology
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BID	Twice A Day
BMI	Body Mass Index
BSP	Behavior Support Plan
CANR	Client Abuse and Neglect Registry
CAP	Corrective Action Plan
CBC	Criminal Background Check
CC	Cubic Centimeter
CCC	Clinical Certificate of Competency
CDDN	Certified Developmental Disabilities Nurse
CEU	Continuing Education Units
CFNP	Certified Family Nurse Practitioner
CFY	Clinical Fellowship Year
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CMP	Comprehensive Metabolic Panel
CMS	Centers for Medicare and Medicaid Services
CNE	Chief Nurse Executive
COPD	Chronic Obstructive Pulmonary Disease
COTA	Certified Occupational Therapy Assistant
COTAL	Certified Occupational Therapy Assistant, Licensed

CPR	Cardio Pulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CV	Curriculum Vitae
CVA	Cerebrovascular Accident
DADS	Texas Department of Aging and Disability Services
DAP	Data, Analysis, Plan
DARS	Department of Assistive and Rehabilitative Services
DC	Discontinue
DCP	Direct Care Professional
DCS	Direct Care Staff
DDS	Doctor of Dental Surgery
DEXA	Dual-energy X-ray Densiometry
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DL	Deciliters
DNR	Do Not Resuscitate
DOJ	U.S. Department of Justice
DRR	Drug Regimen Review
DSHS	Department of State Health Services
DSM	Diagnostic and Statistical Manual
DUE	Drug Utilization Evaluation
E&P	Exam and Prophylaxis
EDWR	Established Desired Weight Range
e.g.	exempli gratia (For Example)
EENT	Ear Eye Nose Throat
EKG	Electrocardiogram
EMR	Electronic Medical Record
EPS	Extra Pyramidal Symptoms
ER	Emergency Room
FBG	Fasting Blood Glucose
FDA	Food and Drug Administration
FES	Functional Eating Skills and Swallowing Assessment
FOBT	Fecal Occult Blood Test
FSPI	Facility Support Performance Indicators
FTE	Full Time Equivalent
FY	Fiscal Year
G-tube	Gastrostomy Tube
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GJ	Gastrostomy Jejunostomy
GM	Grams

H	Hours
HCG	Health Care Guidelines
HMP	Health Maintenance Plan
HRC	Human Rights Committee
HST	Health Status Team
HTN	Hypertension
HX	History
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
ICN	Infection Control Nurse
IDT	Interdisciplinary Team
i.e.	id est (In Other Words)
IEP	Individual Education Plan
IMC	Incident Management Coordinator
IMT	Incident Management Team
IOA	Inter Observer Agreement
IPN	Integrated Progress Note
ISP	Individual Support Plan
LAR	Legally Authorized Representative
LISD	Lufkin Independent School District
LOD	Living Options Discussion
LODR	Living Options Discussion Record
LSC	Life Safety Code
LSSLC	Lufkin State Supported Living Center
LVN	Licensed Vocational Nurse
MA	Masters of Arts
MAR	Medication Administration Record
MBS	Modified Barium Swallow
MBSS	Modified Barium Swallow Study
MD	Medical Doctor
MERC	Medication Error Review Committee
MG	Milligrams
MMR	Measles Mumps Rubella
MOSES	Monitoring of Side Effects Scale
MOU	Memorandum of Understanding
MRA	Mental Retardation Authority
MRA	Mental Retardation Associate
MS	Master of Science
NA	Not Applicable
NAR	Nurse Aide Registry
NEO	New Employee Orientation
NMC	Nutritional Management Committee

NMT	Nutritional Management Team
NOO	Nurse Operations Officer
OH	Oral Hygiene
OIG	Office of Inspector General
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P&T	Pharmacy and Therapeutics
PAP	Papanicolaou
PALS	Positive Adaptive Living Survey
PBSP	Positive Behavior Support Plan
PCP	Primary Care Physician
PE	Physical Examination
PET	Performance Evaluation Team
PFW	Personal Focus Worksheet
Ph.D.	Doctor, Philosophy
PIC	Performance Improvement Council
PIT	Performance Improvement Team
PMAB	Physical Management of Aggressive Behavior
PMM	Post Move Monitor
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMPC	Physical and Nutritional Management Plan Coordinator
PNMT	Physical and Nutritional Management Team
POI	Plan of Improvement
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Physical Therapy
PTA	Physical Therapy Assistant
QA	Quality Assurance
QAQI	Quality Assurance Quality Improvement
QAQI	Quality Assurance Quality Improvement Council
QMRP	Qualified Mental Retardation Professional
RD	Registered Dietician
RDH	Registered Dental Hygienist
RN	Registered Nurse
ROM	Range of Motion
RTT	Registered Therapist Technician
SA	Settlement Agreement

SAC	Settlement Agreement Coordinator
SAP	Skill Acquisition Plan
SFBA	Structural Functional Behavioral Assessment
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SPOI	Supplemental Plan of Improvement
SSLC	State Supported Living Center
SX	Surgery
TEA	Texas Education Agency
TID	Three Times A Day
TIR	Tone, Inhibition, and Relaxation
TIVA	Total Intravenous Anesthesia
UIR	Unusual Incident Report
URC	Unified Records Coordinator
UTI	Urinary Tract Infection
VNS	Vagus nerve stimulation
WU	Work Up