United States v. State of Texas

Monitoring Team Report

Lufkin State Supported Living Center

Dates of Onsite Review: April 18-22, 2011

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Submitted By:	Alan Harchik, Ph.D., BCBA-D Monitor
Monitoring Team:	Helen Badie, M.D., M.P.H, M.S. Carly Crawford, M.S., OTR/L Daphne Glindmeyer, M.D. Gary Pace, Ph.D., BCBA-D Carolyn Smith, R.N., CDDN Teri Towe, B.S.

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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, recordkeeping, and quality assurance. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, at-risk individuals, and for a variety of other sections of the report.

The Monitor's role is to assess and report on the State and the Facilities' progress regarding compliance with provisions of the Settlement Agreement. Part of the Monitor's role is to make recommendations that the Monitoring Team believes 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. The recommendations for some provisions include a subsection of additional suggestions for the facility. These are presented in an effort to assist the facility in prioritizing activities as the facility staff work towards achieving substantial compliance with the provision.

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. This was especially noted given the recent onsite regulatory survey activity that had occurred at the facility over the previous month. The facility director, Gale Wasson, was, as always, supportive of the monitoring team's activities throughout 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 new Settlement Agreement Coordinator, Sherry Roark. She 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. The monitoring team was impressed with her professionalism and capabilities, given her brief time in this new role.

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, providing a broad sampling from all homes and across a variety of individual needs and supports. 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, management, clinical, and direct care professionals continued to be 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, the Settlement Agreement required the facility to complete a self-assessment, and to submit it to the Monitor 14 days prior to the onsite review. The facility did so and, in the monitoring report below, the Monitor describes and comments upon the self-assessment steps the facility undertook to self-assess compliance and the results of this self-assessment. This is provided for each of the 20 provisions of the Settlement Agreement. At LSSLC, the self-assessment document was called the POI (Plan of Improvement). The format of the POI was revised since the last onsite review and was a major and noticeable improvement from the previous more lengthy version.

Fourth, LSSLC was working to implement the many new service provision changes that were occurring across all of the DADS SSLCs. These changes included

- New PSP documents and new style PSP meetings
- New Community Living Discharge Plan activities and documents
- New assessment and management of individual at-risk procedures
- New Physical and Nutritional Management Team procedures
- At risk and aspiration initiative
- Nursing department training in assessment

Fifth, as detailed in the full report below, LSSLC had made progress in some areas, but a lot of work was still required in order for the facility to achieve substantial compliance in the many provisions of the Settlement Agreement. As the reader will see below, the requirements across provision items vary greatly. Some require full organizational system actions, whereas others only require the creation of a document or the hiring of qualified staff. Below are some comments on a few general topics that affected all areas of operation at the facility.

- At-risk and aspiration: LSSLC was just beginning to implement the statewide initiative on the new at-risk policy and procedures, with a specific focus on aspiration and pneumonia issues. Implementation was not yet adequate as evidenced by meeting contents and staff interview as noted in this report (see sections F, M, and O). In addition to observing during PSP meetings, the monitoring team held meetings with two PSTs to discuss how each team assessed and managed risks for two specific individuals. The monitoring team greatly appreciated the efforts of two QMRPs, Martha Jeffries and Suzanne McWhorter, to lead these discussions. Both did an outstanding job, especially given the large attendance that included all members of the monitoring team, department heads from most clinical disciplines at LSSLC, and facility administration. From this discussion, the monitoring team learned more about how the facility approached risk issues, and was able to provide feedback and suggestions that may be useful as the QMRPs and PSTs move forward.
- Integration of services. There was a lot of discussion and comment around the facility regarding a desire to meet the provision of integrated clinical services (see section G) and integrated individual program plans (see section F). Managers and clinicians were already engaging in some activities towards greater integration. Further work will be required to include all disciplines, and to set the occasion for disciplines to work closely together when needed (e.g., psychology and psychiatry, pharmacy and medical). The medical director had lead responsibility for the integration of clinical services (section G) and the Director of QMRPs had responsibility for PSPs (section F), however, achieving substantial compliance will require participation by all clinical and programmatic departments. The monitoring team recommends that senior administration take a more active role in ensuring that the requirements of provisions G and F are addressed in a facility-wide manner. As discussed while onsite, these two provisions should be considered by the QAQI Council as areas of focus because obtaining substantial compliance with these two provisions will be pivotal in the facility's ability to meet many items in many of the other provisions of the Settlement Agreement.
- Reviews of serious events: LSSLC was working towards substantial compliance with section D, Protection from Harm: Abuse, Neglect, and Incident Management. In addition, the monitoring team recommended that some events receive more in depth review, such as serious medication errors, and failed community placements. Treating these, and perhaps other, serious events with thorough review, such as a root cause analysis is more in line with generally accepted professional standards of care and will, most likely, result in improved service provision.

- Engagement and activities. A performance improvement team project identified lack of engagement and low participation in day and work activities as possible contributing factors to aggressive incidents between individuals. Initial work showed some success with focusing upon specific homes and specific individuals. This was good to see. Overall, as noted in section S (and others) below, continued work is needed across the facility regarding engagement and activities in homes and day programs, and during evening and weekend times.
- Staff training. The facility director and the residential unit directors noted a variety of new training initiatives, including an additional five days of new employee orientation, a hands on "lab" with mannequins for practicing a variety of care skills, and off home training in engagement for every residential staff member. The residential unit directors also reported that the overnight shifts were receiving more training, role playing was being used, and staff were to be carrying laminated cards that indicated each individual's long term goals. Finally, QMRPs were about to receive training in leading teams and facilitating good meetings. The instruction guide, "Q Construction: Facilitating for Success" was to be used during an upcoming off campus training session.
- Monitoring tools. DADS central office had distributed self-monitoring tools that lined up with most provisions of the Settlement Agreement. These tools were meant to be more user-friendly and appropriate for use by facility staff than were previous versions. Additional attention will need to be made to ensure the tools are updated and that they are implemented reliably (see section E below).

Sixth, 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

- Trend reports showed that a total of 329 restraints were utilized, involving 100 different individuals, from 9/1/10 through 2/28/11. This was a slight increase from the 322 restraints noted in the previous six months. Of these 329, 162 were used for crisis intervention for 27 different individuals.
- Even so the monitoring team saw positive progress in the way the facility:
    - implemented a new review where psychology and residential staff met to review restraint incidents.
    - developed a new restraint monitoring tool.
    - made progress in addressing dental restraints, including evaluating the past use of restraints and developing desensitization strategies.
    - expanded training for new staff on restraint usage.
    - psychology and nursing staff were meeting to discuss restraint use.
- Two areas of focus were identified by the monitoring team during the review week that will be essential in reducing restraints incidents at the facility.

    - Consistent alternative behavioral strategies for crisis intervention need to be clearly stated. Staff should be trained to implement alternative behavioral strategies for individuals who they support. The effectiveness of strategies needs to be monitored and strategies revised when not effective.
    - The facility should focus on expanding options in day programs to include a wider variety of meaningful work and recreational activities both at the facility and in the community based on individual's assessed needs and preferences.
- Inadequate documentation of restraints made it difficult to track activities that individuals were engaged in prior to the behavior resulting in restraint and learn from previous restraint incident.

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

- Investigation of 105 cases of abuse, neglect, or exploitation were conducted by DFPS at the facility from 9/1/10 through 3/31/11. Of these 105 cases, 16 (15%) were confirmed allegations by DFPS, 47 (45%) were unconfirmed allegations, 12 (11%) were unfounded allegations, 14 (13%) were inconclusive and 16 (15%) were referred back to the facility because they did not meet the DFPS definition of abuse or neglect. There had been a decrease in the number of abuse and neglect allegations from FY10 1st quarter (52) to FY11 2nd quarter (41). The facility investigators conducted investigations for 44 additional serious incidents during the same time period.
- There were a total of 1191 injuries reported during FY11 1st quarter. This was an increase from 1073 injuries reported in the previous quarter. Trends were not yet available for injuries reported during FY11 2nd quarter. A log of serious injuries at the facility in the past year indicated that 14 resulted in fractures and nine required sutures or dermabond. The facility needs to further explore trends of injuries at the facility and develop a plan of action to address any trends identified in order to reduce the significant number of injuries.
- The facility had many processes in place to review serious incidents, but there was not a coordinated effort made to systemically identify and address incident and injury trends. Incidents and injuries were reviewed daily, Monday through Friday, at meetings held by each unit director, then reviewed daily by the Incident Management Review Team. Both groups briefly reviewed incidents and tracked follow up to the incident. PSTs routinely met to discuss incidents and put protections into place. The medical doctors and psychiatrist met each morning to review injuries and illnesses.
- Surveillance videos were being used in a greater number of investigations than during the time of the previous review, and investigators reported that they were useful in being able to substantiate or not substantiate abuse and neglect allegations.

Quality Assurance

- The facility did not have a facility-specific QA policy, a completed QA plan, or any type of QA report. QA staff collected a variety of data, conducted a variety of audits, played a large role in the running of human rights committee, conducted all unusual incident investigations, and handled follow up and monitoring of plans of correction following DADS and CMS regulatory reviews. QA staff reported positive working relationships with most of the departments at LSSLC, however, attention needs to be paid to improving the relationship between QA and the nursing department.
- The QA department needs to take a more comprehensive approach to managing data at the facility. This includes
    - Creating a listing of all data collected at the facility that includes data collected by each service department and by QA department staff, and that is in line with the areas in the guidelines written by the Assistant Commissioner.
    - Determining which of these data are to be submitted to the QA department for tracking and trending, included in the QA report, and presented to QAQI Council.
- Satisfaction measures had not progressed since the last review, however, data were obtained from the new statewide DADS family/LAR survey. The data had not yet been reviewed or responded to by the facility. Self-advocacy activities were weak and poorly organized at LSSLC. This is an area in need of improvement.
- The facility was beginning to use a set of self-monitoring tools that were designed to be used at all of the SSLCs. The monitoring team, however, recommends that the facility and state work with the monitoring teams to review and update the state-created tools so that they are based upon the most recent findings and activities of the monitoring teams.
- The QAQI Council had been meeting regularly since the previous onsite review. The meeting was led by the facility director and included the review of data, such as the trend analysis and data presented by various department heads. The QAQI Council was a good forum for future development and implementation of many of the requirements of this provision, such as data review, setting of corrective actions, and formation of performance evaluation and/or improvement teams.

Integrated Protections, Services, Treatment, and Support

- Plans will need to be developed that offer clear directions for staff to provide supports deemed necessary through the assessment process and then a plan to monitor progress will need to be implemented so that plans can be updated and revised when outcomes are completed or strategies for implementation are not effective. Monitoring of plans will need to include a mechanism for ensuring that assessments are revised as an individual's health or behavioral status changes, and then outcomes and strategies will need to be revised in

plans to incorporate any new recommendations from assessments. Finally, a service delivery system will need to be in place that addresses supports determined necessary by each PST.

- At the PSP meetings observed, team members discussed supports needed in relation to the individual's preferences and interests. The new format of the plans 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 supports that the individuals needed throughout the day was more clearly stated in the newer PSPs.
- Teams, however, were restricted by the lack of program options offered at the facility and very little consideration was given to programming in the community. The facility offered very few options in terms of programming. Individual's schedules were not driven by their preferences, but instead by options offered for programming at the facility. Many behavioral issues at the facility appeared to be a result of boredom or lack of active treatment in line with individual's preferences. The facility had begun to appreciate the importance of this and had formed a performance improvement team to look at engagement and individual-individual aggression.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- LSSLC was not in compliance with this important provision. The facility's sole focus regarding section G had been implementation of the new at-risk and aspiration/pneumonia policies and procedures. A focus on this area was good to see, however, much more work will be needed if integrated clinical services are to be provided.
- A number of specific examples were provided to, or observed by, the monitoring team that showed some ways in which LSSLC was making service provision more integrated across clinical service departments. These examples are provided below. On the other hand, there were a number of areas in which integrated services could be, but were not being, provided.
- Direct involvement of the facility director will likely be required if this provision is to achieve substantial compliance because, in part, it requires involvement from all of the clinical, and operational, departments at the facility, not only medical and nursing. Achieving the provision of integrated clinical services might make for a good facility wide performance improvement project.
- A draft of a state policy was reviewed. It addressed a combination of the requirements of both provisions G and H. The content related to section G, however, was merely a restating of the wording from the Settlement Agreement and will, most likely, be insufficient to guide the facility. As a result, the monitoring team recommends specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring.

At-Risk Individuals

- Each individual's PST was responsible for risk assessment and management, as well as ongoing risk review and addressing changes in status. Not only would the PST identify health and behavioral risks and their level of severity, but would assure appropriate plans were developed and implemented as planned in order to reduce risks and improve quality of life. The revised at-risk process identified collaboration and assistance with the BSC and PNMT in developing plans for individuals at high risk, who were not stable or for whom the team has requested assistance.
- Implementation of the revised process began in late January 2011. Training on the new process was provided to all PST members by 1/13/11. Training was not competency based, even for the PST leaders, the QMRPs. An onsite review of two PSP meetings was conducted by DADS state office representatives on 2/22/11 to observe the risk assessment process and offer technical assistance to the facility.
- The hope is that this process will more accurately describe risks for particular individuals and ensure services and supports necessary to protect each individual will be put into place. The monitoring team did not find that PSTs were accurately identifying risk for individuals, even with the new process. 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

Psychiatric Care and Services

- Although psychiatry consultations were occurring, there was a reduction in the available full-time equivalent psychiatrists from 2.25 to 1.45. Additional staff including a psychiatric nurse, psychiatric assistant, and psychiatric administrative assistant, however, had been hired and trained.
- 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. Unfortunately, psychology was not present in this discussion, so while the physicians were integrated in this area, the integration did not expand to the remainder of the team.
- The psychiatrists had begun comprehensive psychiatric assessments per Appendix B (16 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.
- 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 for all but newly prescribed psychotropic medications, 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).

Psychological Care and Services

- Although only one of the items in this provision was found to be in substantial compliance with the Settlement Agreement, several improvements were noted since the last onsite review. These include the establishment of internal peer review, development of a simplified data system, the use of a more flexible data system, consistent graphing of target behaviors, and evidence that Positive Behavior Support Plans (PBSPs) were modified when data indicated a lack of progress.
- The areas that the monitoring team suggest that LSSLC work on for the next onsite review are ensuring that data are reliably collected, ensuring that PBSPs are implemented with integrity, ensuring that all functional assessments have a clear summary of the variable or variables hypothesized to affect target behaviors, and ensuring that all Positive Behavior Support Plans (PBSPs) are based on the hypothesized function of the target behavior, and specify clear, concise antecedent and consequent interventions.

Medical Care

- Limited progress was seen in medical services since the last onsite review. Routine and preventive services were being provided, but work was needed in increasing compliance rates in areas, such as colorectal and breast cancer screenings. Follow-up of clinical issues, labs and diagnostics remained problematic. The quality of documentation in the integrated record was not adequate.
- An external medical review had been completed and corrective action plans developed. The process for mortality reviews made no strides as mortality reviews continued to produce no formal recommendations, even when the clinical leadership believed corrective action was warranted.
- The medical director began collecting data on preventive services, such as breast, colorectal, and prostate cancer screenings. It was not always clear which set of guidelines was being followed. Medical policy had been developed and implemented, but the need for clinical guidelines remained outstanding.

Nursing Care

- 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 was 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 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. The forms, processes, and plans in place at the time of this review, however, were being reviewed and revised in order to promote progress toward the achievement of this provision. Model plans were developed for the priority area of aspiration. 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.
- A new Program Compliance Coordinator position was added to the nursing department to address monitoring and follow-up for targeted areas. The nursing department had targeted seven areas for quality improvement. There were yet to be implemented plans for summary and analysis of results. Training initiatives included the nurses training DCS on the Aspiration Triggers and completion of the accompanying data sheet as well as on seizure documentation.
- 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. Designation as one of two SSLCs to serve children would also require re-evaluation of population needs and resources particularly associated with the acuity of the children's population to be served.
- There were several areas of medication administration practice that did not meet acceptable professional standards, such as administration of medications without knowledge of potential side effects, pre-pouring medications, appropriate administration and follow-up for response to treatment with PRN medications, and consistent vital sign monitoring related to administration of antihypertensive and other medications with potentially negative effects on blood pressure.

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

- The facility had made little progress in the provision of pharmacy services and safe medication practices. The pharmacy director and medical director both appeared to have little involvement in many of these systems based on responses during interviews. That lack of clinical leadership may have contributed to the limited progress noted during the review.
- The facility had revised only one policy since the last onsite review: Adverse Drug Reactions. The facility's policy and procedure manual contained several policies that were not congruent with the Health Care Guidelines and many policies and procedures had not been reviewed or revised in 8 to 10 years.
- Physician orders were being reviewed as part of the entry into the WORx software. There was very little documentation of interactions between the pharmacists and the medical practitioners independent of notations made on the physician orders.

- Drug regimen reviews were completed, but very often these lacked any substantive review of the necessary information due to the integrated record not being available for review. When the record was not available for review on the scheduled day, there was usually no documentation attempts to repeat the review. Formatting of the drug regimen reviews made it difficult to recognize recommendations and this may have contributed to physicians consistently indicating that no change was necessary. The MOSES and DISCUS rating instruments were completed, but the medical staff did not appear to use this information in therapeutic decision-making. Moreover, the medical staff's response to QDRR recommendations and data derived from the MOSES and DISCUS tools was frequently inadequate. Two Drug Utilization Evaluations were completed, but concerns related to data accuracy and generation of corrective actions were noted. One ADR was reported since the last onsite review.
- Medication variance data were being collected and reviewed. The pharmacy accounted for a significant percentage of errors. There were recurrent wrong patient, wrong drug, wrong dose errors, yet there was no evidence that any substantial process analysis had occurred to determine contributory and causal factors. Corrective actions were most often labeled as teaching and coaching.

Physical and Nutritional Management

- There was a new Habilitation Therapies Director who appeared to be a strong leader with an intuitive understanding of what needed to be accomplished. The PNMT process was not initiated, other than to begin to identify team members. An RN had been hired, but had not yet started work.
- There had been no individual-specific reviews completed. The risk assessment process and aspiration initiatives were also new processes and will require significant and thorough review in six months.
- Two dietitians were insufficient to address the nutritional needs for nearly 400 individuals. One of these was to be assigned to the PNMT leaving a huge responsibility for the remaining dietitian. At the time that the resigning RD is replaced, strong consideration should be given to additional staffing in order to more adequately address needs in this area.
- There continued to be implementation errors during meals and related to position and alignment. Of particular concern was the implementation of dining plans in Woodland Crossing, position and alignment, use of special techniques and monitoring by the PNMPCs. Many of the problems observed should have been identified by professional staff as well. A significant focus should be directed toward professional support for training and oversight, as well as to the environmental barriers in this dining area.

Physical and Occupational Therapy

- A very limited number of individuals were provided with OT or PT services beyond the PNMP (only six were in direct therapy). A number of individuals had participated in the TIR (Tone, Inhibition, and Relaxation) program provided by therapy technicians, however, this program did not include any functional or measurable outcomes.
- The OT/PT assessments inconsistently addressed movement, mobility, range of motion, independence, and functional status. The clinicians did not generally document functional examples of systems level findings, such as range of motion, strength, and muscle tone. Observation of activities outside of the clinic setting was not documented. There was no discussion of potential for skill acquisition across a variety of areas, including eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning. Specific health risk ratings established by the PST were not identified and interventions, primarily the PNMP, were not specifically linked to these ratings.
- In some cases, there was no evidence of follow-up for some consults and it was unclear if the supports and services were completed.
- There continued to ongoing concerns related to positioning and alignment of individuals in wheelchairs. Direct support staff did not demonstrate sufficient knowledge and skills to implement plans appropriately. There were several levels of oversight by home managers, PNMPCs, and therapy clinicians that failed to adequately address this issue.
- Monitoring was not clearly driven by level of risk. While the PNMPCs had recently been shifted to the Habilitation Therapies Department for direct supervision, they continued to require more training and oversight in order to ensure that monitoring provided the appropriate data to evaluate the efficacy of individual-specific plans as well as the training provided to staff related to implementation of PNM. There had not been any system of trend analysis established to date.

<u>Dental Services</u>

- Progress was noted: staffing had been increased, a comprehensive dental procedures manual was developed, an oral hygiene maintenance program was implemented, and data on dental services were collected. The addition of the clerical support resulted in development of databases for tracking the work being done in the clinic. The dental director was very enthusiastic about this process and stated that a significant amount of data had been collected and reviewed. The staff found this information very useful in assessing progress and determining causal factors of problems.
- Failed appointments continued to be problematic and presented significant barriers to the provision of dental care. Desensitization appointments accounted for slightly more than 20% of all clinic visits. There were more than 150 individuals considered to be enrolled in desensitization programs. In spite of this, these plans resulted in successful treatment for just one individual.

- While the dental staff had put forth substantial efforts and remained eager to move forward, there was no evidence that support was received in developing and implementing desensitization plans. Missed appointments and refusals resulted in many individuals not receiving appropriate care. These barriers were outside of the reach of the clinic staff. Clinical outcomes documented that 67% of the individuals had poor oral hygiene ratings and several individuals were required to have multiple tooth extractions.

Communication

- There was little progress noted since the previous review. The speech staff reported that not all individuals who needed AAC and other communication supports and services received them. Only 10 evaluations were listed as complete, per the Master Plan. Not only were the clinicians unable to complete assessments in a timely manner, implementation of supports and services was limited. Many of the existing AAC systems in use at this time had previously been in use and did not reflect newly identified supports. There were recommendations made within the last year that had not yet been implemented. Recognition of the priority for the communication needs of individuals living at LSSLC was not reflected in the current staffing allocation and assignment.
- The majority of the AAC systems were portable and intended to be functional in a variety of settings. These were few in number. During observations, devices were not observed to be in use. Staff did not appear to understand how to use these in programming or functionally throughout the day. Direct support staff and classroom instructors were insufficiently trained to integrate informal communication programming throughout the day or to capture those teachable moments that occurred to promote communication skill acquisition.
- Another significant concern involved those individuals who may have been more verbal or partially verbal, but exhibited maladaptive behavior that had a foundation in their difficulty with communication skills. These significant problem behaviors emphasized the necessity for a strong collaborative approach by PSTs, led by psychology and speech clinicians, in order to develop effective interventions.

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.
- There were several improvements since the last review. These included modification to PSP to attempt to better ensure that SAPs are based on need and preference, consistent graphing of skill acquisition plan outcomes, development of a new engagement tool, establishment of individual engagement goals, training of all direct care professionals (DCPs) in the implementation of individual engagement, and development of a data system to track and improve training of individuals in the community

- The monitoring team believes that these improvements could result in a dramatic improvement in this provision if they are coupled with a reorganization and simplification of how skill acquisition programming is organized, implemented, and monitored at the facility.

Most Integrated Setting Practices

- The specific numbers of individuals who were in the referral and placement process, however, remained very low, given the size of the facility (i.e., 20 out of 400, that is, 5%).
    - Nine individuals were placed in the community since the last onsite review
    - Two of these nine were readmitted after failed community placements.
    - 20 individuals were on the active referral list.
    - The referrals of four individuals were rescinded since the last review.
- The two failed placements, four rescinded referrals, and the re-admission inquiries of a one individual who was placed two years ago, raised some important issues for the facility. Six of these seven cases were due to behavioral and psychiatric reasons. Given that two of the nine placements failed (22%), and four of 24 referrals (17%) were rescinded, each of these cases should receive a thorough review. Given that placement is the most important activity of this department, these should be considered the equivalent of sentinel events by the APC. A thorough review (e.g., root cause analysis) of the actions taken by the facility may help to determine what led to the failed placement, what might be done when the individual is referred again sometime in the future, and possible recommendations for the overall referral and placement processes at LSSLC.
- It appeared that the opinions of the professionals on the PST were often not adequately incorporated into discussion, documentation, and decision-making as required (as was noted in the previous monitoring report). Professionals need to provide their opinions regarding community placement and these opinions need to be explicit in the written PSP. Obstacles to referral and placement were not adequately identified or addressed in the PSPs in any type of consistent manner across the facility. A plan to address the obstacle via an action plan as a service objective or training objective was not explicitly noted in most cases. PSTs may need to describe obstacles to referral separately from obstacles to making a placement happen (e.g., provider capability).
- The facility opened a small home on campus for up to four individuals as a transition home. This was for individuals who were on the referral list and provided an opportunity for them to live in a small home. The home can provide another opportunity for individuals and LARs to visit a community-like site. Further, the experiences of the individuals and managers at this home might provide ideas to the PSTs regarding the types of skills and activities they might target doing for many of the individuals on the main part of campus.

- The lists of supports in the CLDPs were improved from the last onsite review, but remained inadequate and indicated problems in the planning of this aspect of each individual's transition. Problems in identifying essential and nonessential supports were identified in the baseline and previous monitoring reports.
- Post move monitoring was done well and was rated as being in substantial compliance. Post move monitoring reports were thoroughly completed, detailed, and done in a manner that made it easy for the reader to understand the individual's transition into his or her new home. The post move monitor was assertive in ensuring that all needed supports were in place. The monitoring team's observation of an actual post move monitoring visit concurred with the quality and contents of the written documents that were reviewed.

Consent

- The facility did maintain a prioritized list of individuals needing an LAR, however, not all individuals at the facility were included on the list and not all PSTs were adequately addressing the need for an LAR or advocate. The facility had pursued guardianship for a small number of individuals at LSSLC.

Recordkeeping and General Plan Implementation

- The active records and individual notebooks were organized according to the required format. Overall, the new records were neat, entries were made as required, and most required documents were contained in the record. The nursing section, however, was very large and consideration should be given to either reducing the size or subdividing so that it is more manageable for all staff. Further, It would be helpful for there to be information as to what consents are appropriate and required for each individual, and an indication of what medical consultations should be in each individual's record.
- Individual notebooks were in place for each individual. There were mixed reports from staff, managers, and clinicians regarding the usefulness, and occasional counter-therapeutic nature, of the individual notebooks. A determination will need to be made as to whether the individual notebooks can be eliminated. If so, the facility will need to ensure that the original intentions for creating the individual notebooks are met via other processes.
- The master records were being organized according to a newly revised table of contents. The master records, however, contained a great number of documents, many of which appeared to be unnecessary to include in a master record (e.g., recent psychiatric consultation, ARD/IEP form).
- The conduct of quality assurance reviews of the unified record was another area where continued improvement occurred since the last review. Thorough reviews of all three components of the unified record were conducted by the unified records coordinators. Items needing correction were listed, the relevant manager or clinician was notified via email, and follow up was done one week later.

- LSSLC had taken some first steps towards ways to determine whether and how the unified records were used in making treatment decisions. The one activity occurring was that the URCs asked one or two PST members how they used the records. More work will need to be done and assistance from central office will be required.

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: o LSSLC Use of Restraint Policy o List of all restraints for the past six months o Restraint documentation for the last six months for the three individuals with the highest number of restraints o Restraint documentation for the last 10 medical restraints o List of individuals with dental desensitization plans o Restraint Reduction Committee meeting minutes 9/16/10 – 1/31/11 o List of restraint related injuries 1/1/10 – 1/27/11 o LSSLC restraint trending since 9/1/10 o List of all individuals who had a Safety Plan o List of individuals for whom restraint was implemented more than three times during any rolling 30-day period o Training Curriculum for RES0105 Restraint: Prevention and Rules for Use at MR Facilities o PMAB Training Curriculum o Training transcripts for 24 LSSLC employees o Incident Management Review Team Meeting Minutes o Physician order and monitoring schedule for protective medical restraints for: • Individual #520, Individual #298, Individual #306, Individual #203, Individual #310 o A sample of restraint documentation for medical restraints including: • Individual #285 dated 3/9/11 • Individual #569 dated 3/10/11 • Individual #177 dated 3/10/11 • Individual #308 dated 3/9/11 • Individual #174 dated 3/17/11 • Individual #530 dated 3/14/11 • Individual #97 dated 3/3/11, 3/7/11, and 3/8/11 • Individual #234 dated 3/3/11 o PBSPs, safety plans, functional assessments, and personal support plan addendums (PSPAs) for: • Individual #166, Individual #410, Individual #170

- A sample of restraint documentation for behavioral intervention including:

Individual	Date/Type	Restraint Checklist and Face to Face Assessment	PSP	PBSP	Safety Plan
#166	10/3/10 Physical	x	10/4/10	10/4/10	11/22/10
	10/5/10 Physical	x			
	11/9/10 Physical	x			
	11/9/10 Physical	x			
	11/23/10 Physical	x			
	12/29/10 Physical	x			
	1/4/11 Physical	x			
	1/4/11 Physical	x			
	1/12/11Physical	x			
	2/9/11 Physical	x			
	2/17/11 Physical	x			
#170	10/22/10 Physical	x	2/15/11	1/15/11	1/31/11
	10/22/10 Physical	x			
	10/28/10 Physical	x			
	12/19/10 Physical	x			
	12/20/10 Physical	x			
	2/8/11 Physical	x			
	2/11/11 Physical	x			
	2/18/11 Physical	x			
	2/26/11 Physical	x			
	1/2/11 Physical	x			
#410	11/24/10 Physical	x	2/15/11	2/18/11	2/17/11
	11/14/10 Physical	x			
	11/27/10 Physical	x			
	1/24/11 Physical	x			
	1/30/11 Physical	x			
	2/2/11 Physical	x			
	2/6/11Physical	x			
	2/6/11 Physical	x			
	2/8/11 Physical	x			
	2/11/11Physical	x			
	2/16/11Physical	x			
	2/18/11 Physical	x			
	2/24/11 Physical	x			

#203	2/17/11 Physical	x			
#538	2/17/11 Physical	x			
#300	2/19/11 Physical	x			
	2/24/11 Physical	x			
#245	11/24/10 Chemical	x			

Interviews and Meetings Held:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QMRPs in homes and day programs;
- Sylvia Middlebrook, PhD, Director of Psychology
- Luz Carver, QMRP Coordinator
- Stacie Cearley, Incident Management Coordinator
- Michael Ramsey, Facility Investigator
- Jason Peters, Human Rights Officer

Observations Conducted:

- Observations at residences and day programs
- Morning Medical Meeting 4/19/11
- Castle Pines Morning Unit Meeting 4/19/11
- Daily Incident Management Review Team Meeting 4/19/11, 4/20/11, and 4/21/11
- Human Rights Committee Meeting 4/20/11
- Annual PSP meetings for Individual #593 and Individual #162

Facility Self-Assessment:

The facility's Plan of Improvement for section C indicated that the facility was not in compliance with the provision items in Section C, but had taken positive steps towards identifying problem areas and addressing these areas. The monitoring team agreed with the facility's compliance assessment. Positive steps taken by the facility are noted in the summary section.

Summary of Monitor's Assessment:

Trend reports submitted to the monitoring team showed a total of 329 restraints were utilized involving 100 individuals from 9/1/10 through 2/28/11. This was a slight increase from the 322 restraints noted in the previous six months. Of these 329, 162 were used for crisis intervention across 27 individuals.

Some areas where the monitoring team saw positive progress in addressing section C of the Settlement Agreement included:

- The facility had implemented a new review process where psychology staff and residential staff met to review restraint incidents.
- The facility had developed a new restraint monitoring tool.

	• The facility had made significant progress in addressing dental restraints. The dental staff were focusing on strategies to reduce the need for restraint during routine dental procedures through evaluating the past use of restraints and developing desensitization strategies for individuals at the facility who required the use of restraint during dental appointments. • Training for new staff on restraint usage had been expanded and was now being taught by supervising psychology staff. • Psychology and nursing staff were meeting to discuss restraint use. The facility indicated that it was looking at restraint reduction. In particular, the psychology department relayed to the monitoring team that restraint reduction was an ongoing focus at the facility. Two areas of focus were identified by the monitoring team during the review week that will be essential in reducing restraints incidents at the facility. 1. Consistent alternative behavioral strategies for crisis intervention need to be clearly stated. Staff should be trained to implement alternative behavioral strategies for individuals who they support. The effectiveness of strategies needs to be monitored and strategies revised when not effective. 2. The facility should focus on expanding options in day programs to include a wider variety of meaningful work and recreational activities both at the facility and in the community based on individual's assessed needs and preferences. As discussed further in C1 below, inadequate documentation of restraints made it difficult to track activities that individuals were engaged in prior to the behavior resulting in restraint and learn from previous restraint incident.

#	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	Based on information provided by the facility in a list of all restraints used for crisis intervention, between 9/1/10, and 2/28/11: • 27 individuals were subjected to restraints, • 167 restraints occurred, • 14 (8%) of these were mechanical restraints • These mechanical/protective restraint incidents involved the use of helmets and/or wristlets for individuals with self-injurious behavior, • 147 (88%) of these were physical holds, • 6 (4%)of these were chemical restraints, The facility provided a list of medical pretreatment sedation and medical restraints between 8/1/10 and 2/14/11: • 84 individuals were the subject of restraints, • 161 incidents of restraint occurred. The facility indicated that there had been no incidence of dental pretreatment sedation in	Noncompliance

#	Provision	Assessment of Status	Compliance
	accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	the past six months. A list provided by the facility identified 120 individuals with written dental desensitization plans in place. The facility had made progress in addressing dental restraints. The dental staff were focusing on strategies to reduce the need for restraint during routine dental procedures by evaluating the past use of restraints and developing desensitization strategies for individuals at the facility who required the use of restraint during dental appointments. <u>Prone Restraint</u> Based on facility policy review, prone restraint was prohibited. Based on review of other documentation, including a list of all restraints and a sample of restraint checklist prone restraint was not identified. A sample, referred to as Sample #C.1, was selected. This included seven individuals and was selected to ensure that some of the individuals with the highest numbers of restraint were included (three in this case). The individuals in this sample included: Individual #166, Individual #410, Individual #170, Individual #300, Individual #245, Individual #203, and Individual #538. The sample did not include all restraints for these individuals. Based on a review of 38 restraint records for individuals in Sample #C.1 involving seven individuals, 0 (0%) showed use of prone restraint. <u>Other Restraint Requirements</u> Based on document review, the facility policies stated that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample #C.1 that included 38 restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: • In 34 of the 38 records (89%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. Restraint checklists that did not indicate that the individual posed an immediate and serious threat to self or others included: o A restraint checklist for Individual #170 indicated he was restrained because he was "trying to put trash, clothes, books in big trash outside,	

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		throwing puzzles, active treatment material away." o The restraint checklist for Individual #410 documented a chemical restraint on 11/14/10. The checklist did not document behavior that the individual was exhibiting at the time of restraint. o The restraint checklist for Individual #166 dated 1/23/11 indicated that the restraint occurred because she was aggressive towards staff. The event leading to the restraint indicated that she was "saying she was gonna hurt other people, throwing stuff at other individuals." o The restraint checklist for Individual #245 dated 11/24/10 indicated that she was aggressive, grabbing, and hitting while in bed in the infirmary. A chemical restraint was administered. • Aggression towards staff and/or peers, self-injurious behavior, and property destruction was indicated as the reason for the restraint on all forms that described behavior leading to the event. • For the 38 restraint records in the sample, a review was completed of the description of events leading to behavior that resulted in restraint. A majority of the checklists reviewed described the individual's behavior prior to the restraint, but not all described events leading up to or causing these behaviors. Twelve of the checklists (32%) did not give a brief description of events that occurred prior to the restraint. This information would be useful for direct care staff to know to avoid future restraint incidents. Restraint checklists that did not give a description of events leading to the behavior included: restraints for Individual #166 on 11/9/10 (2), 1/4/11 (2), and 1/12/11; restraint for Individual #300 on 2/19/11; restraints for Individual #410 on 2/6/11, 2/2/11, 2/6/11; and restraints for Individual #170 on 10/22/10, 11/27/10, and 11/14/10. Examples of good documentation included: o The restraint checklist for Individual #166 dated 2/9/11 indicated that "she got upset when a peer called her retarded. Staff tried to talk to her, but would not listen. She began cursing, yelling, pushing and kicking property." o The restraint checklist for Individual #300 dated 2/24/11 indicated that he became aggressive when he could not get in touch with his mother. o The restraint checklist for Individual #410 dated 1/30/11 indicated that prior to the behavior leading to the restraint, his mother was visiting and told him that she was getting ready to go. o The restraint checklist for Individual #410 dated 2/24/11 indicated that he became upset when staff asked him to slow down while drinking. o The restraint checklist for Individual #410 dated 1/24/11 indicated that he became aggressive over lack of communication, that is, staff were trying to understand what he was saying.	

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		Examples where this was not the case included: o In the area for the description of events on the restraint checklist for Individual #410 on 11/14/10, staff documented "sedation was given, Ativan. He is unsteady and refused to lie down." o On the restraint checklist for Individual #410 dated 2/2/11 the description of events leading to the behavior noted that the individual "started banging his head, trying to bite staff, biting himself, kicking, screaming, property destruction and hitting. He spilled his chocolate milk." Staff did not document what activity the individual was involved in at the time of the incident. o On the restraint checklist for Individual #300 dated 2/19/11 staff did not indicate what precipitated the individual's behavior that necessitated restraints. The area to describe events leading to the behavior stated that he was "kicking staff – tore staffs shirt, trying to bite staff." • In 32 of the records (84%), staff documented that restraint was used only after a graduated range of less restrictive measures had at least been attempted or considered in a clinically justifiable manner. o The restraint checklist for Individual #166 dated 11/23/10 did not indicate that other interventions were attempted prior to the implementation of a physical restraint. o On the restraint checklist for Individual #166 dated 1/4/11, staff had checked the spot beside interventions in Safety Plan were attempted, but did not describe action taken. o The restraint checklist dated 2/2/11 for Individual #410 indicated that staff asked him to stop and calm down prior to restraint in the description of actions taken. The staff had checked interventions in PBSP and Safety Plan on the checklist of actions. His PBSP instructed staff to use the least amount of physical intervention possible and to use a blanket or sheet by lightly covering his whole body, while blocking his body from harmful contact, or use cold wet rags on his neck, face, and arms. o The restraint checklist dated 2/8/11 for Individual #410 indicated that staff tried to talk to him prior to implementing a horizontal restraint. There was no indication that other interventions were attempted. o The restraint checklist for Individual #410 dated 2/16/11 indicated that his PBSP and Safety Plan were followed prior to implementing a physical restraint. Staff did not describe actions taken. o The restraint checklist for Individual #410 dated 11/14/10 did not indicate that other interventions were attempted prior to the	

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		administration of a chemical restraint. It was not clear that all restraints used were the least restrictive intervention necessary. Without good documentation of what preceded the behavior, it was difficult to identify whether adequate steps had been taken to address the behavior before the restraint was applied to allow a determination to be made that the procedures were the least restrictive necessary. It was also not evident that restraints were not used in the absence of or as an alternative to appropriate programming and treatment. Although as noted above, documentation did not always indicate what activities individuals were involved in prior to restraint, PSPs offered little guidance on engagement of individuals throughout the day and ensuring that individuals had opportunities to engage in preferred activities. Some examples where it was not evident that adequate programming and treatment were implemented to reduce the behaviors leading to restraint: • For Individual #166, her PBSP noted that triggers to her aggression were "disorganized living environment/loud and disruptive individuals, periods of time following the promise of something she wants e.g. move to group home." Environmental conditions should be limited to areas where the level of stimulation is not disturbing to her." Her PBSP recommended that she should have opportunities to leave home or work when it becomes congested and disorganized and to encourage her to go to a peaceful or quiet area. Nine of the 10 restraints in the sample occurred in the living room at home. There was no indication that she was engaged in activities based on her interest at the time of the restraints. She had clearly indicated that she wanted to move to a group home where there is a quieter environment. Her PSP listed "behavior" as the only barrier to moving into a group home, yet, her frustration at the team's refusal to move forward with placement contributed to her behavior, according to her PBSP. Her PBSP stated that "there may be a correlation in her episodes of physical aggression requiring crisis intervention/physical restraint following visits from her Advocacy Inc. representative. Visits with her Advocacy, Inc. representative have typically included conversations about her probable placement in a community residential facility." Rather than looking at appropriate behavioral supports available in the community, the PST had "put a hold" on discussion of community placement to try to decrease aggressive behavior. This individual had 39 restraints between 9/1/10 and 3/1/10. The team needs to consider environmental modifications based on her functional assessment to reduce the likelihood that her behavior will result in the need for restraints. • For Individual #170, eight of 10 restraint checklists in the sample indicated that	

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		he was being destructive towards property. His PBSP noted that triggers to his behavior were requests or instruction; frustrating events; others getting female attention; or when he was tired, hungry, or otherwise stressed. None of the restraint checklists in the sample indicated that any of these events had occurred prior to restraint. It was not clear from documentation if he was engaged in any activities prior to the behavioral outbursts. The psychiatrist has also noted the possibility that his aggressive behavior might be related to seizure activity. The restraint checklists did not include any information about his behavior prior to the aggression that might help determine if seizure activity could be related to the aggressive episodes. Facility policies identified a list of approved restraints techniques. Based on the review of documentation for 38 restraints, 37 (97%) were documented as approved restraints techniques. On the restraint checklist for Individual #203 dated 2/17/11, staff indicated other under physical restraint with the comment "head." The facility was not in compliance with this provision item. Restraint documentation needs to clearly indicate what was occurring prior to the behavior that led to restraint and document all interventions attempted prior to restraint. As noted throughout this report, it was not evident that adequate treatment and programming was being consistently implemented that might reduce the number of behavioral incidents leading to restraint.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The restraint records involving the eight individuals in Sample #C.1 where physical restraint was used were reviewed. Of these, three of the individuals had a Safety Plan that defined the use of restraint. A sample of 31 restraint records for three individuals with Safety Plans was reviewed to determine if the individual was released from restraint according to criteria set forth in the Safety Plan: • For Individual #170, his Safety Plan included instructions to release him from restraint as soon as he was calm, but no longer than 30 minutes. His Safety Plan defined calm as saying he was calm, a brief absence of struggle, slowed breathing, muscle relaxation, and so forth. Of 10 restraint incidents reviewed, nine (90%) indicated that the individual was released from restraint according to the criteria set forth in the Safety Plan of release at 10 minutes. One restraint on 2/26/11 lasted 49 minutes before he was released. • For Individual #166, her Safety plan stated that she should be released from restraint when she was "calm – not struggling against the physical hold and not yelling, screaming or threatening others." Of 10 restraint incidents reviewed, 10 (100%) indicated that she was released from restraint when she was calm and no longer an immediate or serious risk to herself or others. The restraints in the	Substantial Compliance

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		sample lasted from one to nine minutes in duration. • For Individual #410, his Safety plan stated that he should be released from restraint when he was "calm – not struggling against the physical hold and not yelling, biting or head banging." Of 11 physical restraint incidents reviewed, nine (82%) indicated that he was released from restraint when he was calm and no longer an immediate or serious risk to himself or others by using the code "P" in the Action/Release section of the restraint checklist. The action/release code section for a restraint on 11/14/10 did not clearly indicate when he was released from restraint. The restraint checklist dated 1/24/11 indicated "Q" for other, but did not describe what other meant. This restraint lasted 40 minutes. The action/release section of the restraint checklist dated 11/27/10 did not clearly indicate when he was released. The restraint began at 4:00 am and staff documented in this section until 4:15 am the following day. Restraints in his sample lasted from 10 minutes to 65 minutes. The facility remained in substantial compliance with this provision. Restraint checklists should be reviewed and staff retrained on clearly documenting the details of the restraint when documentation is not completed correctly.	
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	The facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. Review of the facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: • Policies governing the use of restraint, • Approved verbal and redirection techniques, • Approved restraint techniques, and • Adequate supervision of any individual in restraint. Sample #C.2 was selected from a current list of staff. This sample included 24 current employees at the facility A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that • Twenty-four of 24 (100%) had current training in RES0105 Restraint Prevention and Rules. o Four of the 24 (17%) staff did not complete the refresher training within 12 months of the previous training. • Twenty-four of 24 (100%) had completed PMAB training within the past twelve months.	Noncompliance

#	Provision	Assessment of Status	Compliance
	supervision of any individual in restraint.	o Four of the 24 (17%) did not complete refresher training within 12 months of previous restraint training. The facility needs to ensure that employees complete training on the all elements of restraint use at least every 12 months. The facility is not in compliance with this provision item.	
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.	Based on a review of 38 restraint records (Sample #C.1), 38 (100%) indicated that restraint was used as a crisis intervention. Facility policy did not allow for the use of restraint for reasons other than crisis intervention or medical/dental procedures. All staff were trained that restraint should only be used as a "last resort" measure. While the facility had begun to aggressively focus on the reduction of restraints necessary to complete dental treatment, there was no evidence that a similar focus was occurring in regards to restraint utilized to complete medical treatment. Plans reviewed during the monitoring visit did not address strategies to reduce the use of medical restraints. The facility did identify individuals for whom dental restraint had been historically used and the dental staff were evaluating the use of restraint for each individual at the facility. Attempts were being made to complete routine dental work without the use of restraint and desensitization programs were being implemented for those who had needed pre-sedation or restraint to have work completed in the past. The facility did not maintain a "Do Not Restrain" list. The facility will need to develop a system to track the use of restraints used to complete medical treatment to ensure that teams have discussed restraint use and developed desensitization plans to try to reduce the use of restraint. Each individual's PST should discuss risk associated with restraint for the individual based input from PNMT and medical staff. A list of individuals where restraints would be contraindicated due to medical or physical conditions should be developed and maintained by the facility. For example, PSPs for individuals at risk for aspiration or fractures should clearly state that the individual should not be physically restrained or offer clear guidelines for safely restraining the individual. The facility is not in compliance with this provision.	Noncompliance
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and	Review of facility training documentation showed that there was an adequate training curriculum on the application and assessment of restraint. This training was competency-based. Based on a review of 38 restraint records (Sample #C.1), a face-to-face assessment was	Noncompliance

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	document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	conducted as follows: • In 38 out of 38 incidents of restraint (100%), there was assessment by a restraint monitor. • In 35 out of 38 instances of physical restraint (92%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. o The restraint assessment for Individual #203 dated 2/17/11 indicated that the restraint monitor did not arrive until 20 minutes after the restraint was initiated. o The restraint assessment for Individual #300 dated 2/19/11 indicated that the restraint monitor arrived over two hours after the restraint was initiated. o The restraint assessment for Individual #245 dated 11/24/10 indicated that the restraint monitor arrived 50 minutes after the restraint was administered. • In 38 instances (100%), the documentation showed that an assessment was completed of the application of the restraint. • In 38 instances (100%), the documentation showed that an assessment was completed of the circumstances of the restraint. Based on a review of 38 behavioral restraint records for restraints that occurred at the facility there was documentation that a licensed health care professional: • Conducted monitoring at least every 30 minutes from the initiation of the restraint in 27 (71%) of the instances of restraint. Restraint records where this did not occur as required included: o The nurse did not document the time of assessment on the restraint checklist dated 12/29/10 for Individual #166. o There was no documentation of assessment by a healthcare professional on the restraint checklist for: ▪ Individual #245 on 11/24/10; ▪ Individual #203 on 2/17/11; ▪ Individual #410 on 11/14/10, 11/24/10, 11/27/10, 1/24/11, 2/8/11, and 2/2/11. o The restraint checklist for Individual #300 on 2/19/11 indicated that the assessment by the nurse did not occur until 58 minutes after the restraint was initiated. o The restraint checklist for Individual #170 on 2/26/11 indicated that the assessment by the nurse did not occur until 56 minutes after the restraint was initiated. • Monitored and documented vital signs in 30 (79%). • Monitored and documented mental status in 30 (79%).	

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		Based on a review of 10 pretreatment sedation for medical restraint records there was documentation that a licensed health care professional: • Conducted monitoring at least every 30 minutes from the initiation of the restraint for a minimum of two hours in nine (90%) of the instances of restraint. Restraint records where this did not occur as required included: o The restraint checklist for Individual #97 on 3/3/11 indicated that he received pretreatment sedation for a medical appointment at 6:15 am. He was assessed every 30 minutes prior to his appointment. The nurse assessed him once following the appointment at 7:50 a.m. No further post treatment assessments were documented. Documentation was requested of the physician's order and monitoring schedule for five individuals identified as having medical restraints. Based on a review of five medical restraints, there was documentation that: • Physician orders were written for the use of the restraint in three (60%) records, o Documentation provided to the monitoring team did not include physician's orders for the use of knee pads and helmet for Individual #306. o Documentation was not provided of the physician's order for restraints for Individual #203 or Individual #298. • Physician orders specified the frequency of monitoring in one (20%) record. Exceptions included: o Individual #520 had a health care plan that described monitoring of skin condition under his helmet that was ordered for protection due to falls. His nursing assessment dated 4/20/11 noted that the plan would be discontinued because he wore the helmet cooperatively and had not had any skin impairments. He was to wear the helmet when out of bed, but there was no schedule for monitoring skin integrity. o Individual #306 wore knee pads and a helmet due to seizure activity. Documentation indicated that nursing staff monitored skin integrity under his knee pads and helmet monthly, but there was no documentation that support staff monitored his skin integrity more frequently. o Documentation of a written schedule for monitoring was not provided to the monitoring team for Individual #203 or Individual #298. Monitoring and post restraint review should be consistently documented on the restraint checklist. Not all restraints were being monitored as required by this provision. This is a repeat recommendation from the last monitoring review. Physician's orders including	

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		the method and frequency of monitoring should be maintained for all instances where medical (protective) restraints are being utilized. 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 Appendix A.	A sample of 38 Restraint Checklists for individuals in non-medical restraint was selected for review for required elements in C6. The following compliance rates were identified for each of the required elements: • In 38 (100%), continuous one-to-one supervision was indicated as having been provided. • In 38 (100%), the date and time restraint was begun were indicated. • In 38 (100%), the location of the restraint was indicated. • In 26 (68%), information about what happened before, including the change in the behavior that led to the use of restraint, was indicated. Twelve did not indicate what events were occurring that might have led to the behavior (see section C1 for a list of exceptions). • In 38 (100%), the specific reasons for the use of the restraint were indicated. • In 38 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. • In 37 (97%), the names of staff who applied/administered the restraint was recorded. Documentation of a horizontal restraint (which would require more than one staff person to administer) on Individual #410 dated 2/8/11 indicated that only one staff person applied the restraint. • Observations of the individual and actions taken by staff while the individual was in restraint for three physical restraints were recorded, including: o In 37 (97%), the observations were documented every 15 minutes and at release. For Individual #410 dated 11/27/10 this information was not documented for physical restraint o In 37 (97%), the specific behaviors of the individual that required continuing restraint were recorded. For Individual #410 dated 11/27/10 this information was not documented for physical restraint • In 37 (97%) of physical restraint incidents, the date and time the individual was released from restraint was indicated. For Individual #410 dated 11/27/10 this information was not documented for physical restraint • In 30 (79%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects were recorded. Exception included: o Individual #410 dated 1/24/11, 11/27/13, 2/2/11, 2/16/11, and 11/24/10. o Individual #203 dated 2/17/11. o Individual #245 dated 11/24/10.	Noncompliance

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		o Individual #166 dated 10/5/10 • Restraint documentation reviewed did not indicate that restraints interfered with mealtimes or that individuals were denied the opportunity to use the toilet. In a sample of 38 records (Sample #C.1), restraint debriefing forms had been completed for 38 (100%). A sample of six individuals subject to medical restraint was reviewed and in nine (90%), there was evidence that the monitoring had been completed as required. See section C.5 for details of this finding. Monitoring of restraints as required should be documented on the restraint checklist for each restraint incident. As noted in the review of documentation above, the facility was not in compliance with the requirements of 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:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to LSSLC documentation, during the six-month period prior to the onsite review, a total of six individuals were placed in restraint more than three times in a rolling thirty-day period. Three of these individuals (i.e., Individual #166, Individual #410, and Individual #170) were reviewed (50%) to determine if the requirements of C7 were met. PBSPs, safety plans, functional assessments, and personal support plan addendums (PSPAs) were reviewed for all three individuals. The results of this review are discussed with regard to Sections C.7.a through C.7.g of the Settlement Agreement. All three of the PSPAs minutes reviewed (100%) reflected a discussion of the individuals' adaptive skills, and biological, medical, or psychosocial factors affecting the behaviors provoking restraints. None of these discussions (0%), however, reflected a plan or discussion of how relevant variables affecting target behaviors provoking restraint would be addressed. In the discussion of adaptive skills factors, all three PSPAs indicated that staff attention was likely affecting the target behavior that provoked restraint. In order to achieve substantial compliance with is item, however, the PSPA would also need to reflect a discussion of how the individual's adaptive skills deficit contributed to	Noncompliance

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		his/her restraints and a plan or discussion to address the skill deficit problem. An example of a PSPA that achieves substantial compliance with item would be one that documented a discussion of how the individual used physical aggression to gain staff attention, and the plan was to better ensure that the team was increasing her skill repertoire of attaining staff attention by more desirable ways. Each individual's PSPA should reflect a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	
	(b) review possibly contributing environmental conditions;	All three of the PSPAs reviewed reflected a discussion of possible contributing environmental factors to the behavior or behaviors provoking restraint. Two of the three PSPAs reviewed (67%), however, did not reflect a discussion of how identified environment factors could be modified to prevent the future probability of restraint. For example, Individual #170's PSPA identified other individual's outbursts as a potential contributing environmental condition. No discussion, however, of how this environmental factor could be addressed (e.g., attempt to move Individual #170 to another part of the residence when other individuals become upset, etc.) was apparent in the PSPA reviewed. All PSPAs should reflect a discussion of possible contributing environmental factors, and suggestions for modifying potential factors to prevent the future probability of restraint.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	This item is concerned with a review of potential antecedents to the behavior that provokes restraint. All of the PSPAs reviewed (100%) included a section of potential structural assessments of the behavior provoking restraints. Two of the PSPAs reviewed had N/A in this section. The third PSPA (i.e., Individual #410) clearly indicated that the team could not identify any consistent antecedents that might lead to the behaviors that resulted in the use of the restraints. The monitoring team understands that some potential factors identified in this provision item may not be relevant to every individual's restraints. It is suggested, however, that a statement that the treatment team entertained each factor (as in Individual #410's PSPA), and did not believe that it was relevant to better understanding why an individual was restrained is preferable to simply putting N/A. Examples of issues that could be discussed here would be the role of antecedent conditions, such as placing demands, or the presence of novel or unfamiliar staff on the behavior that provoke restraint. This discussion should also include how relevant antecedent conditions would be removed or reduced (e.g., the elimination or reduction of demands placed) to decrease the future probability of the dangerous behavior	Noncompliance

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	(d) review or perform functional assessments of the behavior provoking restraints;	This item is concerned with review of the variable or variables that may be maintaining the behavior provoking restraints. Possible functions of dangerous behavior that could be discussed here are escaping demands or accessing desired activities. This discussion should also include how these functions will be addressed to prevent restraints in the future. For example, if it is hypothesized that escape is maintaining physical aggression, then a discussion of how to ensure that physical aggression does not result in escape should be reflected in the PSPA minutes. Two of the PSPA minutes reviewed indicated that functions of the behavior provoking restraint were not applicable. The third PSPA (i.e., Individual #410) indicated that the team concluded that his target behavior was resulting in attention that was maintaining the behavior. No discussion, however, of how attention associated with his target behavior could be minimized (e.g., avoids eye contact, maintain flat affect) was reflected in the discussion. Therefore, this item was rated as being in noncompliance.	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, 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;	All three individuals reviewed (100%) had PBSPs to address the behaviors provoking restraint. The following was found: • Three (100%) were based on the individual's strengths; • Three (100%) of the PBSPs reviewed specified the objectively defined behavior to be treated that led to the use of the restraint ; • Three (100%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint (the specific method for teaching the alternative behaviors, however, was not present in any of the five plans); and • Three (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. One of the three PBSPs (33%) to weaken or reduce the behaviors that provoked restraint, however, was determined to be inadequate (i.e., Individual #170) because it did not contain clear, precise interventions based on a functional assessment (see K9). The three Safety Plans of the individuals in the sample were reviewed. The following represents the results: • In all three of the Safety Plans reviewed (100%), the type of restraint authorized was delineated; • In one (i.e., Individual #170) of the safety plans reviewed (33%), the maximum duration of restraint authorized was specified; • In all (100%), the designated approved restraint situation was specified; and • In all (100%), the criteria for terminating the use of the restraint were specified.	Noncompliance

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	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	For none of the individuals reviewed (0%) were integrity data available demonstrating that the PBSP was implemented with a high level of treatment integrity (see K4 and K11 for a more detailed discussion of treatment integrity at the facility).	Noncompliance
	(g) as necessary, assess and revise the PBSP.	There was no evidence in the PSPA minutes reviewed, or PBSPs of these three individuals, indicating that any individual's PBSP was modified (when necessary) to decrease the future probability of an individual being restrained.	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.	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 Team (IMT) meetings, Daily Unit meetings, and Human Rights Committee (HRC) meetings. Observation of the Daily Incident Management Team (IMT) meeting confirmed that restraint incidents were reviewed by the team the following working day. Restraint incidents were reported to the IMT and referred to the PST for follow-up. PSTs met following restraint incidents to review restraints, but as noted in section C7, supports and prevention strategies developed by teams were often not consistently implemented and revised when not effective. A sample of Face-to-Face Debriefing and Review Form related to 15 incidents of non-medical restraint for was reviewed by the monitoring team. The review form had an area for signature indicating review by the Unit Director and the Incident Management Team. In review of 15 restraint review forms for sign off by the Unit Director and IMT Designee, the following was found: • Restraint documentation for Individual #410 dated 2/16/11 was reviewed by the Unit Director the following day. It was reviewed by the IMT two weeks after the restraint incident. • Restraint documentation for Individual #410 dated 11/14/10 was reviewed by the Unit Director the following day. It was reviewed by the IMT five days after the restraint incident. • Restraint documentation for Individual #410 dated 1/24/11 did not indicate review by either the Unit Director or the IMT. • Restraint documentation for Individual #410 dated 11/27/10 was reviewed by the Unit Director two days after the incident. It was reviewed by the IMT four	Noncompliance

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		days after the restraint incident. • Restraint documentation for Individual #410 dated 2/2/11 was not signed off on by the Unit Director. The IMT designee had signed, but not dated the form. • Restraint documentation for Individual #170 dated 2/8/11 did not indicate review by either the Unit Director or the IMT. • Restraint documentation for Individual #170 dated 12/20/10 was reviewed by the Unit Director 24 days after the restraint. It was reviewed by the IMT 18 days after the restraint incident. • Restraint documentation for Individual #170 dated 2/26/11 did not indicate review by either the Unit Director or the IMT. • Restraint documentation for Individual #170 dated 12/19/11 indicated that the documentation was reviewed by the Unit Director 11 days following the restraint incident and reviewed by the IMT three days following the incident. • Restraint documentation for Individual #203 dated 2/17/11 did not indicate review by either the Unit Director or the IMT. • Restraint documentation for Individual #245 dated 11/24/10 indicated that documentation was reviewed by the IMT five days following the restraint. • Restraint documentation for Individual #300 indicated that documentation was reviewed by the IMT three days after the restraint incident. As noted throughout Section C, restraint documentation was often inadequate. Thirty-five (92%) of the Restraint Review forms in the sample indicated errors or incorrect procedures in documentation, application, or monitoring of the restraint. • The restraint review documentation for Individual #170 dated 12/19/10 noted his behavior program was not followed. • The restraint monitor noted on the restraint review for Individual #245 dated 11/24/10 that the "chemical restraint did work, but psychologist should have been notified first as well as restraint monitored." • The restraint monitor noted on the review of a restraint dated 10/5/10 for Individual #166 that the restraint monitor should be notified prior to restraint. All restraints should be reviewed within three days of the restraint and documentation should reflect corrective action to be taken when errors are found in documentation or implementation. The facility is not in compliance with this provision.	

Recommendations:

1. 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 in preferred activities when indicated.

2. Ensure that all staff are trained on accurately completing restraint documentation.

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

4. Physician's orders for medical restraints should specify the type and frequency of monitoring required.

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

6. When restraints are not applied, monitored, or documented correctly, the restraint monitor should include this information in the follow-up assessment. Develop a plan of correction to address any problems noted in the review of restraints. Continue to monitor restraints and retrain staff as necessary.

7. The PST should attempt to identify the reason(s) for the lack of improvement in the individual's behavior and then implement appropriate corrective action when data do not indicate a decrease in behaviors necessitating restraint.

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 DADS Policy: Incident Management #002.2, dated 6/18/10 o LSSLC Policy: Reporting, Documenting, and Review of Unusual Incidents dated 10/5/10 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021 dated 6/18/10 o LSSLC Policy: Investigation of Client Abuse/Neglect/Exploitation o Information used to educate individuals and their LAR on identifying and reporting unusual incidents. o Abuse and Neglect: Identification, Reporting and Prevention Training Curriculum o Texas State Mental Retardation Facilities Essential Elements for Incident Management o DFPS Criteria for Establishing a Pattern of Spurious Allegations o Incident Management Committee meeting minutes for each Monday of the past six months o LSSLC Observation Notes Monitoring Too. (POI D.2.i – Protection From Harm) o Log of employees reassigned due to allegations of abuse and neglect since 9/1/10 o Three most recent five-day status reports o Training transcripts 24 employees o Acknowledgement to report abuse form for a sample of 24 employees o Acknowledgement to report abuse for all employees hired in the past two months o Training and background checks for the last three employees hired o Training transcripts for facility investigators (six) o Training transcripts for DFPS investigators (six) o Spreadsheet of all current employees results of fingerprinting, EMR, CANRS, NAR, and CBC if a fingerprint was not obtainable o Results of criminal background checks for last three volunteers o List of applicants who were not hired based on background checks o A sample of acknowledgement to self report criminal activity for 24 current employees o Injury reports for three most recent incidents of peer-to-peer aggression incidents o List of all serious injuries for the past year o A sample of documentation for 18 serious injuries including documentation of investigation. o List of Injuries by individual since 3/1/10 o Log of all ANE allegations since 9/1/10 including case disposition log of employees reassigned due to ANE allegations o PSPs for • Individual #170, Individual #166, Individual #498, Individual #349, Individual #410, Individual #29, Individual #146, Individual #144, Individual #290, and Individual #573.

- Documentation from the following completed investigations including follow up:

Case #	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
Sample D.1					
#19	Neglect	Inconclusive	9/21/10 6:11 pm	9/22/10 2:10 pm	11/1/10 Methodological Review
#42	Neglect	Confirmed	10/21/10 1:25 pm	10/22/10 12:12 pm	12/9/10 Methodological Review
#49	Neglect	Inconclusive	10/25/10 9:34 pm	10/26/10 12:15 pm	12/7/10 Methodological Review
#54	Neglect (2)	Confirmed (1) Unconfirmed (1)	11/3/10 3:44 am	11/5/10 2:15 pm	11/24/10 2 extension
#79	Neglect	Unconfirmed	12/9/10 9:38 am	12/9/10 2:00 pm	12/17/10
#87	Emotional Verbal Physical Abuse	Unconfirmed Unconfirmed	12/17/10 4:19 pm	12/20/10 3:00 pm*	12/27/10
#88	Emotional Verbal	Confirmed	12/17/10 6:32 pm	12/20/10 4:00 pm	12/27/10
#89	Emotional Verbal Abuse (2) Physical Abuse(2)	Unfounded Unfounded	12/18/10 7:48 am	12/21/10 8:00 am	12/28/10
#92	Physical Abuse	Unconfirmed	12/20/10 4:27 pm	12/23/10 9:30 am	1/7/11 1 extension
#95	Neglect (4)	Confirmed (2) Unconfirmed (2)	1/3/11 5:33 pm	1/5/11 8:30 am*	1/13/11
#98	Neglect (2)	Unconfirmed (2)	1/8/11 9:02 am	1/10/11 4:45 pm	1/18/11
#104	Neglect (3)	Unconfirmed (3)	1/15/11 7:20 pm	1/18/11 5:40 pm*	1/26/11
#107	Physical Abuse	Unconfirmed	1/20/11 7:35 am	1/21/11 2:15 pm	1/31/11
#108	Emotional Verbal Abuse (1) Physical Abuse(1)	Confirmed Confirmed	1/20/11 9:03 am	1/20/11 4:15 pm	1/31/11
#119	Emotional Verbal	Confirmed	2/6/11	2/8/11	2/15/11

	Abuse		6:33 pm	2:00 pm	
#126	Neglect	Confirmed	2/17/11 6:11 pm	2/19/11 3:00 pm	3/1/11*
#130	Neglect (2)	Confirmed (2)	2/23/11 11:08 am	2/25/11 3:00 pm	3/5/11
Sample D.2	**Type of Incident**	**DFPS Disposition**	**Time of Incident**	**Began Investigation**	**Closed Investigation**
#4	Neglect	Inconclusive	9/3/10 4:32 am		9/14/10
#38	Physical Abuse	Administrative Referral	10/14/10 3:05 pm		10/21/10
#80	Neglect	Administrative Referral	12/13/10 10:23 pm	Unknown	12/23/10
#90	Neglect (2)	Administrative Referral	12/19/10 6:55 am	12/19/10 8:00 am	12/21/10
#102	Medical Neglect	Administrative Referral	1/11/11 12:47 am	Unknown	1/20/11
#120	Rights Issue	Administrative Referral	2/7/11 9:09 am	Unknown	2/14/11
#17	Serious Injury Determined Cause	n/a	9/20/10 11:11 pm	9/20/10 Unknown time	9/27/10
#20	Serious Injury	n/a	9/24/10 9:56 am	9/24/10 9:00 am	9/27/10
#24	Serious Injury Determined Cause	n/a	9/28/10 12:45 pm	9/28/10 Unknown time	10/8/10
#47	Serious Injury Determined Cause	n/a	10/23/10 5:30 pm	Unknown	10/29/10
Sample D.3					
#16	Death	n/a	9/18/10 2:55 pm	Unknown	9/24/10
#18	Sexual Incident	n/a	9/21/10 9:35 am	Unknown	9/28/10
#93	Other – Unauthorized Departure	Unknown	12/21/10	Unknown	12/29/10
#121	Serious Injury	n/a	2/7/11 1:30 pm	Unknown	2/14/11
#129	Serious Injury	n/a	2/19/11	Unknown	2/22/11

			2:50 pm		
#131	Serious Injury	n/a	2/24/11 10:20 am	Unknown	2/28/11

* = late

Interviews and Meetings Held:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QMRPs in homes and day programs;
- Sylvia Middlebrook, PhD, Director of Psychology
- Luz Carver, QMRP Coordinator
- Stacie Cearley, Incident Management Coordinator
- Michael Ramsey, Facility Investigator
- Jason Peters, Human Rights Officer

Observations Conducted:

- Observations at residences and day programs
- Morning Medical Meeting 4/19/11
- Castle Pines Morning Unit Meeting 4/19/11
- Daily Incident Management Review Team Meeting 4/19/11, 4/20/11, and 4/21/11
- Human Rights Committee Meeting 4/20/11
- Annual PSP meetings for Individual #593 and Individual #162

Facility Self-Assessment:

The facility POI indicated that LSSLC had taken steps towards substantial compliance in areas cited during the last monitoring visit. The facility had implemented new procedures to address delinquent training in abuse and neglect. While this appeared to have impacted the number of staff in compliance with training requirements, the facility was still not in compliance with this item. The facility POI indicated that LSSLC was in compliance with the mandate to trend incidents and develop a plan to address any trends noted, however, the monitoring team did not find this process adequate to meet the requirements of the Settlement Agreement. As detailed throughout section D, the facility had made progress in a number of areas. While some of these areas remained out of compliance due to documentation, the facility was close to achieving substantial compliance with a majority of the provision items in this section.

Summary of Monitor's Assessment:

According to a summary of abuse, neglect, and exploitation trends provided to the monitoring team, investigation of 105 cases of alleged abuse, neglect, or exploitation were conducted by DFPS at the facility from 9/1/10 through 3/31/11. Of these 105 cases, 16 (15%) included confirmed allegations by DFPS, 47 (45%) included unconfirmed allegations, 12 (11%) were unfounded allegations, 14 (13%) were inconclusive and 16 (15%) were referred back to the facility because they did not meet the DFPS definition

	of abuse or neglect. There had been a decrease in the number of abuse and neglect allegations from FY10 1st quarter (52) to FY11 2nd quarter (41). The facility reported the same number of investigations during the previous six months. The facility investigators conducted investigations for 44 additional serious incidents during the same time period. There were a total of 1191 injuries reported during FY11 1st quarter. This was an increase from 1073 injuries reported in the previous quarter. Trends were not yet available for injuries reported during FY11 2nd quarter. A log of serious injuries at the facility in the past year indicated that 14 resulted in fractures and nine required sutures or dermabond. The facility needs to further explore trends of injuries at the facility and develop a plan of action to address any trends identified in order to reduce the significant number of injuries occurring at the facility. The facility had many processes in place to review serious incidents, but there was not a coordinated effort made to systemically identify and address incident and injury trends. Incidents and injuries were reviewed daily, Monday through Friday, at meetings held by each unit director, then reviewed daily by the Incident Management Review Team. Both groups briefly reviewed incidents and tracked follow up to the incident. PSTs routinely met to discuss incidents and put protections into place. The medical doctors and psychiatrist met each morning to review injuries and illnesses. The monitoring team identified a concern during the previous monitoring visit regarding the limited use of surveillance videos in investigations at the facility. It was evident that surveillance videos were being used in a greater number of investigations and investigators reported that they were useful in being able to substantiate or not substantiate abuse and neglect allegations.

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D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The facility's policies and procedures did: • Include a commitment that abuse and neglect of individuals will not be tolerated, and • Require that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. In practice, the facility's commitment to ensure that abuse and neglect of individuals was not tolerated, and to encourage staff to report abuse and/or neglect was illustrated by the following examples: • There were posters regarding this mandate posted throughout the facility. This was found not to be the case during the previous monitoring visit. The facility	Substantial compliance

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		had implemented a plan to ensure posters were placed in all buildings and monitoring occurred to ensure they were replaced as necessary. • In informal interviews throughout the facility, it was clear that staff had been trained on reporting abuse and neglect. When the monitoring team questioned staff regarding what action they would take if they witnessed or suspected abuse or neglect, all staff consistently stated that they would report the incident to DFPS by calling the 800#. • Competency-based training on abuse and neglect (ABU0100) was required annually for all employees. Training transcripts for 24 current employees at the facility were reviewed for current ABU0100 training. Of these, 24 (100%) had completed the course ABU0100 in the past 12 months. • All employees involved in confirmed cases of abuse in the sample reviewed by the monitoring team received disciplinary action following completion of investigations by DFPS. In practice, the facility did adhere to the policy for zero tolerance for all employees at LSSLC. The facility was rated as being in substantial compliance 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	According to LSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy, staff were required to report abuse, neglect, and exploitation within one hour by calling DFPS. This was consistent with the requirements of the Settlement Agreement. With regard to serious incidents, the facility policy entitled Incident Management required that all serious incidents be reported to the facility director immediately, reported to DFPS immediately if abuse or neglect was suspected, to DADS regulatory within 24 hours, and to DADS state office the next working day, if required. It further specified requirements for reporting certain types of incidents to other outside agencies. This policy was consistent with the requirements of the Settlement Agreement. According to a summary of abuse, neglect, and exploitation trends provided to the monitoring team, investigation of 105 cases of abuse, neglect, or exploitation were	Substantial Compliance

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	incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	conducted by DFPS at the facility from 9/1/10 through 3/31/11. Of these 105 cases, • 16 (15%) included confirmed allegations by DFPS, • 47 (45%) included unconfirmed allegations, • 12 (11%) were unfounded allegations, • 14 (13%) were inconclusive, and • 16 (15%) were referred back to the facility because they did not meet the DFPS definition of abuse or neglect. The facility investigators conducted investigations for 44 additional serious incidents during the same time period. The 44 incidents included: • Serious Injuries – 23 (14 fractures, 9 sutures) • Choking Incidents – 4 • Deaths – 4 • Suicide Threats – 2 • Life Threatening Medication Errors – 1 • Sexual Incidents – 1 • Other – 8 • Unknown - 1 Based on an interview of eight staff responsible for the provision of supports to individuals, eight (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation and other serious incidents. Two samples of investigations were selected for review. These included: • Sample #D.1 which included a sample of DFPS investigations of abuse, neglect, and/or exploitation. See the list of documents reviewed for investigations included in this sample. • Sample #D.2 which included a sample of facility investigations. Some of these were investigations that had been referred to the facility by DFPS, while others were investigations the facility completed related to serious incidents. See the list of documents reviewed for investigations included in this sample. In addition to the investigation reports contained in Sample #D.1 and Sample #D.2, additional incident reports were selected for review. Sample #D.3 was the sample of those additional serious incidents investigated by the facility. Based on a review of the 17 investigative reports included in Sample #D.1: • Seventeen (100%) of reports in the sample indicated that DFPS was notified within one hour. • Seventeen (100%) indicated, the facility director or designee was notified within	

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		one hour. • Nine of nine (100%) indicated OIG or local law enforcement (when appropriate) was notified within the timeframes required by the facility policy. o The facility and the DFPS investigative report for UII #87 and UII #107 did not include the OIG notification date and time, though an email in the investigation packet from OIG did indicate that they were notified of the allegation. • Two (12%) investigation reports in the sample indicated when or if DADS regulatory or the state office was notified by the facility. Based on a review of 10 incident reports included in Sample #D.2: • Six (100%) showed evidence that serious incidents were reported to DFPS when abuse or neglect was suspected. • Ten (100%) indicated the facility director or designee was notified within one hour. • Three (100%) investigation reports in the sample indicated DADS regulatory was notified when required. • One (10%) indicated the state office was notified as required by state policy. o UII #38 was the only report in the sample that included the date and time of state office notification. The facility had a standardized reporting format. The facility used the Unusual Incident Report Form designated by DADS for reporting all unusual incidents. This form was adequate for recording information on the incident, follow-up, and review. Based on a review of 15 incident reports included in Sample #D.2 and Sample #D.3: • Fifteen (100%) utilized the standardized reporting format. The facility remained in compliance with this item, however, the investigator needs to document all notifications, including notification to the state office in the notification grid in the UII.	
	(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	According to LSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy the facility was mandated to assure the safety and protection of individuals by immediately removing alleged perpetrators. Based on a review of 13 investigative reports with known alleged perpetrators (AP) included in Sample #D.1, 23 (100%), alleged perpetrators were removed from direct contact with individuals immediately following the facility being informed of the allegation when the AP was known.	Substantial compliance

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	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.	Based on a review of 14 investigation files in which the AP was identified and the facility Abuse and Neglect Employee Reassignment Log, 14 (100%) indicated that staff that had been removed from direct contact were reinstated only after a well-supported preliminary assessment showed that the employee posed no risk to individuals or the integrity of the investigation or the conclusion of the investigation allowed their return to direct contact duties, or the employee was not returned to the position due to the outcome of the case. The following cases are examples that showed documentation that the facility was in substantial compliance with this provision: • In DFPS cases #119 and #130, the investigation file included documentation of the AP's dismissal following DFPS's determination of confirmed abuse or neglect allegations. • In DFPS cases #88, #98, #108, and #126, the investigation file included evidence that the AP received disciplinary action following the outcomes of the investigation prior to returning to work with direct support contact. • In DFPS case #42, #49, #87, #89, #93, #95, #104 and #107, the investigation file included evidence that the AP was not allowed to return to a position requiring contact with individuals until the case was completed and allegations were unconfirmed. The facility did have a system in place for assuring that alleged perpetrators were not returned to regular duty until notification was made by the facility investigator. The facility maintained a log of all alleged perpetrators reassigned with information about the status of the case. A review of the 10 UIRs in sample D.2 was completed to determine if adequate action was taken to protect individuals involved in serious incidents. All (100%) indicated that some type of immediate action was taken to protect the individual following the incident. • Section 10 of the UII is the portion of the UII designated to describe correction action taken immediately following the incident. Not all immediate action taken was documented in Section 10, though documentation of action taken was found throughout the report. For example: o The report for UII #4 indicated that a nurse arrived quickly to complete a head to toe assessment for injury, however, this was not included in Section 10. o The report for UII #3 indicated that the individual was taken to the hospital for medical care, however, this was not included in Section 10 of the report.	

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		o The report for UII #20 indicated that an initial medical assessment was completed and the individual was taken to the orthopedist for x-rays. This information was not included in Section 10. o Following an injury documented in UII #24, immediate action taken to prevent further injury included rearranging furniture in the individual's room, the PST convened to discuss the incident, consultation with the psychiatrist, and increased supervision. These precautions were not included in Section 10. • In all cases where appropriate, a medical assessment was completed immediately to assess for further injury. UII #24 was an investigation initiated following a serious injury obtained from a fall. The investigation report indicated that the individual had 17 falls during the past year. The PST met and increased her supervision, along with implementing some additional protections, however, there was no indication that a referral had been made to the PNMT for assessment. Follow up medical care was not addressed in the UII. The facility needs to address any concerns that may have contributed to the incident with recommendations for assessment when appropriate. Investigation files should include documentation of any follow up action taken, including disciplinary action, in the correct section of the facility report.	
	(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 state policies required all staff to attend competency-based training on preventing and reporting abuse and neglect (ABU0100) and incident reporting procedures (UNU0100) during pre-service and every 12 months thereafter. This was consistent with the requirements of the Settlement Agreement. It further mandated that all supervisors must ensure that required training is appropriately documented by certification and date of completion as directed by the Health and Human Services Commission's Facility Support Services' Competency Training and Development Department. Documentation of training was kept by the facility and a sample of 24 staff training transcripts was reviewed. Not all training had been completed as required, though there had been an increase in the percentage of adequately trained staff since the last monitoring visit. A review of the training curricula related to abuse and neglect and incident management was reviewed for: (a) new employee orientation and (b) annual refresher training. The results of this review were as follows: Review of 24 staff records (Sample #C.2), showed that;	Noncompliance

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		• 24 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 20 (83%) employees with current training completed this training within 12 months of the date of previous training. • 18 (75%) 24 employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • 9 (50%) of the 18 employees with current training completed this training within 12 months of the date of previous training. Based on interviews with 10 staff: • Ten (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. 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.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	All staff were required to sign a statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation during pre-service and every 12 months thereafter. A sample of this form was requested for 24 current employees at the facility and all staff hired within the past two months. • Twenty four of 24 (100%) had signed a form acknowledging their obligation to report within the past 12 months. • Fifty-two of 55 (95%) new staff hired in the past two months had signed a form acknowledging their obligation to report. The three employees that did not have this form in place were employees that had returned to work at the facility. A review of training curriculum provided to all employees at orientation and annually thereafter emphasized the employee's responsibility to report abuse, neglect, and exploitation. The facility was in substantial compliance with this item.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual	A review was conducted of the materials to be used to educate individuals, legally authorized representatives (LARs), or others significantly involved in the individual's life. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. The guide was a clear easy to read guide to recognizing signs of abuse and neglect and included information on how to report suspected abuse and neglect.	Noncompliance

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	who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	In interviewing a sample of three individuals, all three (100%) said that they would tell staff if someone hurt them, or if they had a problem with which they needed help. There were 19 cases of alleged abuse or neglect reported to DFPS by five individuals at the facility since 9/1/10. In 18 cases, DFPS concluded that the allegations were either unconfirmed or unfounded. One case was referred back to the facility for administrative review. Two individuals were on the frequent caller list for making repeated spurious allegations. Based on a review of 10 individuals' PSPs (listed in Documents Reviewed above), four (40%) indicated the individual, or his or her LAR and/or other significantly involved individual, had been informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation. The PSPs for Individual #170, Individual #410, Individual #144, and Individual #290 included this information. QMRPs will need to be reminded to include this information in the new PSP plan development process. The facility was in compliance with this provision during the last monitoring visit. This was not maintained in the new PSP process. The facility was not in compliance with this provision. Documentation that information on identifying and reporting unusual incidents was shared with the individual and/or their LAR will need to be maintained by the facility.	
	(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.	A review was completed of the posting the facility used. It included a brief and easily understood statement of: • individuals' rights, • information about how to exercise such rights, and • Information about how to report violations of such rights. Observations by the monitoring team of all living units and day programs on campus showed that all but one of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. An assistant ombudsman position had been created at the facility. There was also a rights officer position. Information was posted around campus identifying the rights officer and ombudsman. The facility was rated as being in substantial compliance with this provision item.	Substantial Compliance

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	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	Documentation of investigations confirmed that DFPS routinely notified appropriate law enforcement agencies of any allegations that may involve criminal activity. DFPS investigative reports documented notifications. OIG provided the facility with an email notifying the facility of the conclusion to their investigation. Based on a review of 17 allegation investigations completed by DFPS (Sample #D.1), in seven for which a referral to law enforcement was necessary/appropriate, DFPS had made referrals in seven (100%). The DFPS investigative report did not always document contact with law enforcement or OIG on the first page of the investigation as the format required. It was typically listed as an activity completed in the investigation in the narrative section. OIG investigated two of the seven cases (29%) referred in the sample. In the one case where OIG conducted an investigation, there was evidence of criminal activity found by OIG (physical abuse, UII #108). The facility investigator reported that the facility had a cooperative working relationship with both OIG and local law enforcement. The facility is in substantial compliance with this 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.	According to LSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy, the facility prohibited any retaliatory action towards person(s) reporting suspected abuse, neglect, or exploitation. The following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: • LSSLC policy addressed this mandate. • Both initial and annual refresher trainer stressed that retaliation for reporting would not be tolerated by the facility and disciplinary action would be taken if this it occurred. Based on a review of investigation records (Sample #D.1), there were no concerns noted related to potential retaliation. The facility reported that there had been no staff who had alleged that they were retaliated against for in good faith reporting an allegation since the last monitoring visit. The facility was in substantial compliance with this item.	Substantial compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Sample #D.2 included investigations completed on a sample of injuries. As noted throughout section D, these investigations appeared to be routine for significant injuries. Additionally, a sample of injury reports and supporting documentation was reviewed for	Substantial Compliance

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		18 serious injuries since 9/1/10. This included serious injuries for Individual #235, Individual #305, Individual #417, Individual #460, Individual #573, Individual #102, Individual #41, Individual #507, Individual #394, Individual #14, Individual #203, Individual #423, Individual #410 (three injuries), Individual #502, Individual #392, and Individual #141. • Seven were discovered injuries. • 10 were witnessed injuries. • 17 (100%) included documentation of investigation within 24 hours. A sample of Daily Unit Meeting minutes since the last monitoring were reviewed and indicated that injuries of both known and unknown cause were reviewed the next working day following the injury or discovery of the injury. Minutes from the meetings included a list of all injuries, the most likely cause, and recommendations or action taken in regards to the injury. Observation of both the Daily Unit Meeting and Daily Incident Review Team meeting during the monitoring visit confirmed that injuries were reviewed by both teams and follow up recommendations were made when warranted. The Incident Management Coordinator reported that the facility had recently implemented a review system to address this provision. A monitoring tool was developed to review a sample of serious incident investigations, including injuries. The IMC had begun to generate a random sample of incidents monthly and assigned review to Campus Administrators. The IMC then planned to address trends addressed in these reviews with a plan of compliance for correction. The initial round of monitoring indicated that nurses were not completing injury reports on all injuries. The facility was in substantial compliance with this provision, progress was achieved by implementing the described procedures. The monitoring team will look at the effectiveness of this process during the next monitoring visit.	

D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The LSSLC Incident Management Policy • described a comprehensive manner of the conduct of all such investigations; • addressed training requirements for investigators including training in working with people with developmental disabilities; and • required that investigators be outside of the direct line of supervision of the alleged perpetrator. DFPS reports its investigators are to have completed APS Facility BSD 1 & 2, or MH &MR Investigations ILSD and ILASD depending on their date of hire. According to an overview of training provided by DFPS, this included training on working with people with developmental disabilities. Six DFPS investigators were assigned to complete investigations at LSSLC. The training records for DFPS investigators were reviewed with the following results: • Six investigators (100%) had completed the requirements for investigations training. • Six DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. LSSLC had six designated facility investigators. The training records for facility investigators were reviewed with the following results: • Six (100%) facility investigators had completed CIT0100 Comprehensive Investigator Training; • Six (100%) had completed UNU011 Unusual Incidents within the past 12 months; • Six (100%) had completed Root Cause Analysis according to training transcripts reviewed; and • Six (100%) had completed the requirements for training regarding individuals with developmental disabilities.	Substantial Compliance

		The six designated investigators at LSSLC included the Lead Investigator, the Incident Management Coordinator and four Campus Administrators. None of the staff designated as investigators had supervisory responsibilities and therefore were not in the direct line of supervision of anyone subject to investigation. The facility was in substantial compliance with this provision.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Review of the investigation files in Sample #D.1 showed that in 17 out of 17 investigations (100%), facility staff cooperated with DFPS investigators. Although OIG did not provide a detailed report to the facility, there was no indication that staff had not cooperated with OIG in investigations. Mike Ramsey, lead investigator reported that the facility had a cooperative relationship with both DFPS and OIG. Interagency meetings with LSSLC, OIG, and DFPS were held quarterly. The facility is in substantial compliance with this 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.	The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect, and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS, the following was found: • Of the 17 the investigation completed by DFPS (Sample #D.1), seven had been referred to law enforcement agencies. OIG completed investigations in two of the cases referred. For two out of these two (100%), it appeared that there was adequate coordination to ensure that there was no interference with law enforcement's investigations. • Neither the facility UII nor the DFPS investigative report documented referral of UII #87 to law enforcement or OIG. An email to the facility indicated that OIG was contacted and did open an investigation. • OIG found evidence of criminal activity in one of the two cases investigated.	Substantial Compliance

		The facility was found to be in substantial compliance with this provision.	
	(d) Provide for the safeguarding of evidence.	The LSSLC policy on Abuse and Neglect mandated staff to take appropriate steps to preserve and/or secure physical evidence related to an allegation. Documentary evidence was to be secured to prevent alteration until the investigator collected it. Based on a review of the investigations completed by DFPS (Sample #D.1) and the facility (Sample #D.2): • There was no indication that evidence was not safeguarded during any of the investigations. Video monitoring footage was provided to DFPS as requested and reviewed by facility investigators in six (35%) of the investigations reviewed in sample #D.1. Photographs were taken of injuries as necessary. The facility was in substantial compliance with this item.	Substantial compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	The facility Incident Management policy mandated investigations of serious incidents: • were to commence immediately for all unusual incidents; • were to be completed within five working days of the incident; • did require a written extension request from the facility director or Adult Protective Services Supervisor to be completed outside of the 10-day period; and • were to document results in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • Four out of 17 (24%) commenced within 24 hours or sooner. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. o <u>Please note</u>: DFPS and the monitoring teams have discussed this issue and DFPS indicated that it planned to make the commencement of the investigation more explicit in the investigation report. In this way, actions taken by DFPS to commence an investigation will be clearly	Noncompliance

		indicated. New procedures and forms were recently drafted and were expected to be in use by the time of the next onsite review. DFPS reported that this policy will require that all case activities that occurred within the first 24 hours, which could include seeing the victim face-to-face, would be documented in the investigative report. o The following investigations involving allegations of neglect that did not document commencement within 24 hours included UII #49, UII #54, UII #104, UII #119, UII #95, UII #98, and UII #130. DFPS later reported that documentation was available to indicate that one of these, UII#49 did indicate face-to-face interview with the individual within 24 hours. o There was no documented evidence that the DFPS investigation for an allegation of physical abuse in UII #107 commenced within 24 hours. o The investigation of an allegation of physical abuse in UII #108 documented an attempt to interview the victim the following day but a written statement was not obtained. The next face-to-face contact was documented three days later. The allegation was confirmed. o For UII #87, the witness was not interviewed by DFPS until five days after the allegation of physical abuse was reported. The allegation was unconfirmed. o For UII #88, the DFPS report indicated that the investigation commenced three days after the allegation of verbal abuse was reported with an interview of the victim. o UII #89 indicated that the investigation was deemed unfounded and the victim was placed on the spurious allegation list. There were no documented interviews conducted with the victim or the alleged perpetrator. o For UII #92, the DFPS report indicated that the first evidence taken was an interview with a witness two weeks after the initial report. OIG did initiate an investigation which may have resulted in witnesses not being available for interview. An allegation of physical abuse was unconfirmed. • Twelve of 17 (71%) were completed within 10 calendar days of the incident. o The original report for UII #49 was completed within 10 days, though the facility requested a methodological review because only two witnesses were interviewed by DFPS during the investigation. The final report was completed over 30 days from the initial report. o DFPS requested two extensions during the investigation of UII #54. The original investigation was completed in 21 days. The facility requested a review of findings by DFPS. o DFPS filed an extension for UII #92 because witnesses were not available. OIG investigated the allegation which may have been the reason that witnesses were unavailable.	

		o The DFPS investigation of UII #107 was completed in 11 days. There was no documentation of an extension filed. o DFPS filed an extension for UII #126 due to "IMPACT error when addressing allegation" according to the DFPS report. The final report was submitted in 12 days. DFPS noted that this was a legitimate reason for an extension. The monitoring team did not disagree about this. • All 17 (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below in section D3f. • In six (35%) of the 17 investigations reviewed, concerns or recommendations for corrective action were included. The following are examples of investigations that included concerns or recommendations: o For UII #19, the investigator documented concerns regarding medical follow up related to the incident. o For UII #42, the investigator noted concerns regarding support provided by direct care staff during mealtime. o In UII #79, the investigator expressed concern over staff carrying out the individual's PNMP as observed in video surveillance. o In UII #95, the investigator documented concern over inaccurate documentation reviewed during the investigation. A recommendation was made for LSSLC to investigate the matter further and make corrections. o IN UII #107, the investigator expressed concern over contradictory statements made by witnesses in the case. o In UII #130, the investigator documented concern regarding the clarity of the individual's supervision plan. She recommended that the facility investigate this issue further. <u>Facility Investigations</u> The following summarizes the results of the review of facility investigations from sample #D.2 and #D.3: • Two out of 15 (13%) of the UIIs reviewed indicated when the investigation commenced. Thirteen of the UIIs did not include the date or time of actions taken by the investigator. The monitoring team was unable to determine if investigations commenced within 24 hours of the incident. UII #38 and UII #120 did include this information. • Eleven of 15 (73%) indicated that the investigator completed in report within 10 days of notification of the incident or following referral back to the facility by DFPS. o UII #80 indicated that the report was completed in 12 days, however, there was no sign-off from the facility director indicating that the report	

		was finalized. o UII #90 indicated that the investigator completed the written report 17 days after the incident occurred. DFPS referred the incident back to the facility two days after it was reported. o UII #102 indicated that the case was referred back to the facility on the ninth day and the investigation was completed by the facility on the 20th day following the report. o UII #120 indicated that the investigation was completed in 23 days and reviewed by the director and IMC for finalization on the following day. • No written extensions to provide for additional time for investigations to be completed were in place. • Twelve (80%) of the investigations completed in the sample indicated that the facility director had reviewed the report upon completion. The exceptions were UII #80, UII #90, and UII #102. • All 15 (100%) investigations resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below in section D3f. • In 15 investigations reviewed, recommendations for corrective action were included in six of the investigations (40%). Examples of documentation that did not support that appropriate recommendations were made included: o UII #16 was completed for a death under unusual circumstances. The initial UII indicated that the corrective action section would be completed in an addendum UII when the autopsy review was complete. The addendum did not include recommendations for corrective action. o UII #129 was completed following a serious injury. Follow up care for a fracture sustained in the incident was not included in the investigative report. o UII #80 indicated that an injury possibly resulted from broken tiles in the bathroom. The UII did not include repair of the floor with specific timelines assigned in the corrective action plan. o UII #102 did not include recommendations for corrective action following an incident involving a medication error to ensure that procedures were in place to prevent reoccurrence. The facility needs to ensure that documentation reflects the time and date of investigation activities; investigations should commence within 24 hours and be completed within 10 days. DFPS reported that it had made changes to the IMPACT system such that it now provided a typed approval by the DFPS supervisor that included the supervisor's name and the date the approval was provided. The investigator was to signs the completed report, however, the supervisor's signature would be provided	

		electronically. Recommendations to prevent reoccurrence of the incident should be included in all facility reports. The facility was not in compliance with this provision.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	Based on a review of LSSLC Incident Management Policy, it did require that a UII be completed for each serious incident. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below; the findings related to the DFPS investigations and the facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations for sample #D.1: • In 12 out of 17 (71%) investigations reviewed, the contents of the investigation report were sufficient to provide a clear basis for its conclusion. o After review of the final report from DFPS for UII #42, the facility requested a methodological review of the findings. Following the review, the findings were changed from confirmed neglect to refer back to the facility for administrative action. o After review of the final report from DFPS for UII #49, the facility requested a methodological review of the findings, as the review team did not agree that the findings were supported by evidence gathered in the investigation. The findings were changed from unconfirmed neglect to inconclusive following DFPS's review of the investigation. o The facility requested a methodological review for the DFPS investigation of UII #54 citing that evidence did not support the original finding. Findings were changed from confirmed neglect to unconfirmed following the review. o The DFPS investigation of UII #89 concluded that there was no evidence to support the allegations of physical or verbal abuse towards the individual. The investigator did not interview the alleged victim, alleged perpetrator or any witnesses to gather information regarding the allegation. Documents reviewed during the investigation were those that would support placing the individual on the frequent caller list, but did not relate to the specific allegation. While the monitoring team agrees that it may be reasonable to streamline the investigative process for individuals deemed chronic reporters, a minimal investigation should be conducted to rule out the possibility of abuse or neglect for allegations reported. o In the DFPS investigative report for UII #98, the investigator found the allegation of neglect to be unconfirmed. The individual reported that his	Noncompliance

roommate injured him. The DFPS investigator concluded that the AP "may have been negligent in her duty to check the victim every 15 minutes" (as required by his level of supervision), but the investigator was unable to determine who had injured the individual while he was unsupervised, so did not confirm the allegation. The DFPS definition of neglect stated that neglect included a negligent act by any individual responsible for providing services to a person served which may have caused physical injury to a person served or placed the person at risk for injury. In this case, the investigation showed that the staff person did not provided monitoring as determined necessary to protect the individual from harm.

- The report utilized a standardized format that set forth explicitly and separately, the following:
  - In 17 (100%), each serious incident or allegations of wrongdoing;
  - In 0 (0%), the name(s) of all witnesses;
    - There was no list of witnesses documented in any of the reports. Names of witnesses interviewed in the investigation were included, however, it was not indicated if there were other witnesses who were not interviewed. DFPS reported that only the names of witnesses interviewed were included. The monitoring teams will need to discuss this particular item and the criterion for scoring.
  - In 15 (100%), the name(s) of all alleged victims and perpetrators (when known);
  - In 17 (100%), the names of all persons interviewed during the investigation;
  - In 17 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made;
  - In 17 (100%), all documents reviewed during the investigation;
  - In 0 (0%), 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 DFPS investigative reports did not include a list of previous investigations considered as evidence. New policy changes from DFPS will indicate how any prior history was used during the investigation.
    - The DFPS report for UII #107 did not indicate that a prior allegation of physical abuse involving the alleged perpetrator and victim two months prior was considered when gathering evidence in this case involving an allegation of physical abuse.
  - In 17 (100%), the investigator's findings; and

		o In 17 (100%), the investigator's reasons for his/her conclusions. According to DADS, DFPS was preparing to implement policy and procedure that will instruct investigators to document the results of the prior case history review in the investigative report whether it was used or not. Currently, this information was stored in the IMPACT case management system, but did not translate to the written report. DFPS reported that it was making arrangements to modify the IMPACT case management system to include information about prior case history in the printed report that is mailed to the facility. This change was scheduled to occur May 2011. <u>Facility Investigations</u> The following summarizes the results of the review of eight facility investigations including UII #17, UII #20, UII #24, UII #47, UII #18, UII #121, UII #129, UII #130 • In eight out of eight investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. • The report utilized a standardized format that set forth explicitly and separately, the following: o In eight (100%), each serious incident or allegations of wrongdoing; o In eight (100%), the name(s) of all witnesses; o In eight (100%), the name(s) of all alleged victims and perpetrators when known; o In eight (100%), the names of all persons interviewed during the investigation; o In eight (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made. o In eight (100%), all documents reviewed during the investigation; o In eight (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. Facility investigations included historical information on previous incidents that might be relevant to the investigation including prior incidents involving the individual and alleged perpetrators. For example, ▪ UII #47 reviewed a serious injury that was not witnessed; it was suspected that the injury resulted from a fall during a seizure. The report included information regarding recent seizure activity and injuries. ▪ UII #18 involving a sexual incident between two individuals included a summary of previous sexual incidents for the individuals involved. o In seven (88%), the investigator's findings (the exception was UII #47); o In seven (88%), the investigator's reasons for his/her conclusions (the	

		exception was UIR #47). DFPS investigations did not include the allegation history relevant to the current case for the victim or perpetrator. According to information provided by DFPS, beginning in May 2011 this information will be added to all DFPS investigative reports. Facility investigations included a thorough review of evidence to support findings in the cases reviewed. As evident by the number of methodological reviews requested by the facility, DFPS investigations were not always adequate to support findings.	
	(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.	Based on review of LSSLC Incident Management Policy, the policy required the facility investigator must complete the Final Facility Investigation Report using the UII format for each incident. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of a sample of 17 DFPS investigations included in Sample #D.1: • In nine investigative files reviewed (53%), there was evidence that the DFPS investigator's supervisor had reviewed and approved the investigation report prior to submission. Files that included approval by the supervisor were UII #79, UII #87, UII #92, UII #98, UII #107, UII #108, UII #119, UII #126, and UII #130. DFPS later reported that the following investigations did have the supervisor approval page printed and included with the investigative report that was sent to the facility: DFPS Case ID# 38308766 (UII # 42), DFPS Case ID# 38352312 (UII #54), DFPS Case ID# 38488354 (UII # 88), and DFPS Case ID# 38546801 (UII #104). This page, however, was not in the investigative report provided to the monitoring team. • UIRs included a review/approval section to be signed by the Incident Management Coordinator (IMC), Director of Facility, and reviewed by the Incident Management Committee. Eight DFPS investigations were reviewed for facility review and approval including UII #24, UII #79, UII #87, UII #92, UII #98, UII #107, UII #108, and UII #130. o All were reviewed by the IMC following completion. o Three of eight (38%) were reviewed by the facility director and Incident Management Coordinator within five days of completion. UII #108, UII #130, and UII #24 were reviewed by the director and IMC. No recommendations or concerns were noted.	Noncompliance

		Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility. <u>Facility Investigations</u> In 10 out of 10 (70%), UIIs from sample #D.2 reviewed for investigations completed by the facility, the form indicated that the facility director and IMC had reviewed the investigative report upon completion. There was no indication that review resulted in identification of any deficiencies in any of the final reports. The facility needs to ensure all investigations are promptly 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 should be noted and addressed by the reviewer. The facility was not in compliance with this provision.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	A UIR was completed for each unusual incident in the sample.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	According to LSSLC Incident Management Policy IX, the Department Director was responsible for ensuring preventative actions are complete and report all delinquent action plans to the Incident Management Review Team. In order to determine compliance with this provision of the Settlement Agreement, a subsample of the investigations included in Sample #D.1 and Sample #D.2 was selected for review. This subsample, Sample #D.4, included the following investigations: UII #20, UII #126, UII #108, UII #104, UII #42, UII #49, UII#88, UII #38, UII #17, UII #87, and UIR #47. Documentation was requested to show what follow-up had been completed to address the recommendations resulting from these investigations. The following summarizes the results of this review: • All (100%) of the investigations in the sample included documentation of disciplinary action for confirmed allegations. For example, the following disciplinary actions had been taken and documented: o For UIR #126, an AP was required to complete retraining on Level of Supervision and Gate Alert Policy. She was also suspended for 10 days following a confirmation of the neglect allegation. Documentation was	Noncompliance

		included in the investigative file verifying that follow up action was completed. o UII #108 resulted in confirmed allegations of emotional and physical abuse. The AP was immediately removed from contact with individuals when the facility was notified of the allegation. The employee was suspended for 10 days. o UII #88 involved a confirmed allegation of emotional abuse. The investigative packet indicated that the employee involved received a written reprimand. • As noted in D3e, recommendations for appropriate programmatic follow up to address the incident were not found in all reports reviewed. Specific examples are given in D3e of action that should have been taken following the investigation. Additional examples found where recommendations were made for programmatic action, but follow up was not documented in the investigation file include: o In UII #108, DFPS confirmed an allegation of emotional and physical abuse. The UII noted that the facility director made recommendations regarding the AP that included attending stress management class, retraining on managing inappropriate behaviors, and move to another unit where the victim did not live. The recommendation did not assign a person responsible for follow up and a date by which the recommendations would be implemented. There was no documentation that recommendations were completed. As noted above, there was documentation that the employee was suspended. o The investigator noted that a change would be made in the level of supervision and procedures for leaving work for an individual following a serious injury. The recommendation was not included in Section 13 of the UII with person assigned responsibility and a date by which the action would be completed, UII #17. o UII #87 did not include recommendations for follow up action in Section 13 of the UII, however it was noted that the ANE Review Team had concerns that will be addressed with the unit director and director of psychology. Specific information regarding those concerns was not included in the report. • Examples where follow up action was completed and documented in the sample reviewed included: o UII #20 included recommendations to update the individual's PNMP and review specific transfer strategies with staff. Follow up documentation included evidence of follow up on these recommendations.	

		o UII #104 included a recommendation for retraining of residential staff. The investigative file included documentation of retraining of staff. o UII #42 included a recommendation for staff involved to receive retraining from Habilitation Therapies on mealtime techniques and client rights. Documentation in the investigation file showed that the employee completed retraining on both subjects. o Recommendations following the investigation of UIR #49 included retraining staff on check and change procedures. Documentation was included in the investigative file to confirm that the in-service was provided to employees. o UII #38 included recommendations for the PST to discuss several issues related to the investigation. The investigation file included minutes from a PST meeting held to address issues noted. o UII #47 was an investigation of a serious injury resulting from a fall during a seizure. The investigative file included follow meeting of the PST to review level of supervision and follow up with the doctor to review antiepileptic medication. The facility needs to ensure that follow up action is taken and documented when appropriate. Recommendations should be documented in Section 13 of the UII including staff responsible and a date that follow up action will be completed. The facility was not in compliance with this provision.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	At the facility, investigation files were maintained in the investigator's office. Files requested during the monitoring visit were readily available for review at the time of request. All facility investigations in the review included information about past allegations for both the individual involved and the alleged perpetrators. With regard to DFPS, DFPS investigations were provided by the facility and available as requested by the monitoring team.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the	The facility had a system in place to track data on unusual incidents and investigations. Data were compiled in a numerous logs requested by the monitoring team that included: • 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	Noncompliance

	incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	• Outcome of investigation. The facility compiled quarterly reports that focused on all unusual incidents, all allegations of abuse and neglect, and all injuries. The Incident Management Coordinator was able to provide data in a variety of formats. Since she had recently been appointed to this position, she was still exploring ways that the facility could best use information gathered in trend analysis at the facility. The monitoring team found that there had been progress made in gathering data, but was still in the beginning stages of using the data to develop quality improvement processes. Reports generated by the facility were somewhat confusing because it was not clear if data related to cases or allegations in regards to abuse and neglect incidents. Since each case may contain numerous allegations, trends were not accurate in terms of the outcome of investigations. 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. For example, it was noted that of the 17 serious injuries reviewed by the monitoring team, four (24%) were suspected to be a result of injuries received during transfer of the individual. When this type of trend is identified, a quality improvement plan should be developed to try to decrease the occurrence of this type of injury. The facility was not yet in compliance with this provision item.	
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	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: • Criminal background check through the Texas Department of Public Safety (for Texas offenses) • An FBI fingerprint check (for offenses outside of Texas) • Employee Misconduct Registry check • Nurse Aide Registry Check • Client Abuse and Neglect Reporting System • Drug Testing Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position, also had to undergo these	Substantial Compliance

	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.	background checks. In concert with the DADS state office, the facility director had implemented a procedure to track the investigation of the backgrounds of facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of employees confirmed that their background checks were completed. The information obtained about volunteers was also reviewed. According to information provided to the monitoring team, • No employees had been terminated since the last monitoring visit based on background checks. • For FYI 11, criminal background checks were submitted for 1089 persons, • 0% had resulted in fingerprint or name-based failures. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees were subject to fingerprint checks annually. Once the fingerprints were entered into the system, the facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Employees were required to sign a form acknowledging the requirement to self report all criminal offenses. A sample was requested for 24 employee's acknowledgement to self report criminal activity forms. The form was available for 24 of the 24 (100%) employees in the sample. The facility was in substantial compliance with this provision of item.	

Recommendations:

1. Ensure that all employees receive annual training as required by state policies on abuse and neglect and incident management.

2. The facility needs to ensure notification is made to all parties required within required timeframes in regards to investigations and documented in the UII.

3. Ensure DFPS investigation reports include a summary of the investigator's analysis of the history of the alleged victim and alleged perpetrator if relevant to the current investigation.

4. Include evidence in PSPs that information on identifying and reporting abuse and neglect is shared with individuals and their LARs.

5. The facility needs to develop recommendations to address any follow up action that needs to be taken following the conclusion of the investigation. Staff person assigned for follow up and date of completion for follow up action should be documented in the investigation file in Section 13 of the unusual incident report.

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

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 LSSLC Draft FY 2011 QA Plan, undated, estimated 4/11/11 o Organizational chart, undated o LSSLC policy lists, 3/17/11 o List of typical meetings that occurred at LSSLC o LSSLC POI, 4/4/11 o LSSLC QA Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 4/18/11 o LSSLC QA database information and set of tools used by the QA staff (three) o Set of blank statewide self-monitoring tools used by the service departments o LSSLC trend analysis report, for four areas: restraint usage, abuse and neglect allegations, incidents, and injuries o QAQI Council meeting minutes: monthly 10/10 through 4/11 (seven meetings) o Corrective action plans (one) o Performance Improvement Team documents: Engagement, Day Program Participation, and Individual to Individual Aggression, 3/1/11 o DADS LSSLC family satisfaction survey online summary, 35 respondents o QA department monthly one page newsletters about QA activities (four) o LSSLC DADS regulatory and CMS ICFMR review reports o Self-advocacy meeting minutes and notes, monthly, 9/10 to 2/11 (five meetings) <u>Interviews and Meetings Held</u>: o Kathy Thompson, Director of Quality Assurance o QA staff: • Tabitha Anastasi, Elizabeth Carnley, Gena Hanner, Marvin Stewart, Stephen Webb o Gale Wasson, Facility Director o Sherry Roark, Settlement Agreement Coordinator o Mary Stovall, Assistant Independent Ombudsman o Residential Director and Unit Directors: o Keith Bailey, Rotley Tankersley, Glenn Heath, Kenneth Self, Todd Miller <u>Observations Conducted</u>: o QAQI Council Meeting, 4/18/11 o Self-advocacy meeting, 4/19/11 o Many residences, day program, and vocational program

	Facility Self-Assessment: The facility completed its self-assessment for this provision, called the POI. The POI had been extensively revised since the last monitoring review. The facility rated itself as being in noncompliance with all five items of this provision. The monitoring team concurred with the facility's self-ratings for all of these provision items. The narrative portions of the POI provided little detail regarding activities that the QA department had conducted since the previous onsite review. In addition, the presentation book prepared by the facility for this section of the Settlement Agreement was reviewed. Although not a requirement of the Settlement Agreement or the monitoring team, the facility's intention was for the presentation books to be an easy way for the monitoring team to learn about progress and activities of the department in relation to this provision. LSSLC should update its POI based upon the information presented by the monitoring team during the onsite review, at the exit conference, and in this report.
	Summary of Monitor's Assessment: LSSLC was not in compliance with any of the items of this provision, and little progress had been made since the previous review. The facility did not have a facility-specific QA policy, a completed QA plan, or any type of QA report. Recently, an incident management coordinator was hired and that responsibility was no longer to be part of the day to day responsibility of the QA director. This is likely to allow the QA director to devote more time to the requirements of provision E of the Settlement Agreement. QA staff were competent, hard working, and desirous of providing a valuable and valued service to the facility, department heads, and senior management. QA staff collected a variety of data, conducted a variety of audits, played a large role in the running of human rights committee, conducted all unusual incident investigations, and handled follow up and monitoring of plans of correction following DADS and CMS regulatory reviews. The QA staff reported that they gave their findings to the direct care staff and/or managers for whom the information they collected was most relevant. QA staff reported positive working relationships with most of the departments at LSSLC, however, attention needs to be paid to improving the relationship between QA and the nursing department. This state policy was being revised. The monitoring team hopes that the new statewide policy will provide specific direction to all of the SSLCs so that there is consistency in expectation regarding a number of areas, such as the format and content of the QA plan and QA report, and the use of PETs. The QA department needs to take a more comprehensive approach to managing data at the facility. This includes • Creating a listing of all data collected at the facility that includes data collected by each service

	department and by QA department staff, and that is in line with the areas in the guidelines written by the Assistant Commissioner. • Determining which of these data are to be submitted to the QA department for tracking and trending, included in the QA report, and presented to QAQI Council. Satisfaction measures had not progressed since the last review, however, data were obtained from the new statewide DADS family/LAR survey. The data had not yet been reviewed or responded to by the facility. Self-advocacy activities were weak and poorly organized at LSSLC. This is an area in need of improvement. The facility was beginning to use a set of self-monitoring tools that were designed to be used at all of the SSLCs. The monitoring team, however, recommends that the facility and state work with the monitoring teams to review and update the state-created tools so that they are based upon the most recent findings and activities of the monitoring teams. The QAQI Council had been meeting regularly since the previous onsite review. The meeting was led by the facility director and included the review of data, such as the trend analysis and data presented by various department heads. The QAQI Council was a good forum for future development and implementation of many of the requirements of this provision, such as data review, setting of corrective actions, and formation of performance evaluation and/or improvement teams.

#	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; individual staff; and/or individuals receiving services and supports.	LSSLC's QA program had not changed or improved since the previous onsite review. Recently, an incident management coordinator was hired and that responsibility was no longer to be part of the day to day responsibility of the QA director. This is likely to allow the QA director to devote more time to the requirements of provision E of the Settlement Agreement. <u>Policies and QA Planning</u> The DADS statewide policy #003: Quality Enhancement, dated 11/13/09, was adopted by the facility. This state policy, however, was being revised and was likely to be disseminated some time in the next few months. The facility will likely benefit from receiving additional direction via this new policy. The monitoring team hopes that the new statewide policy will provide specific direction to all of the SSLCs so that there is consistency in expectation regarding: • Facility-specific policies • Format and contents of the QA plan o Minimum required types of data • Utilization of statewide self-monitoring tools • Facility-specific self-monitoring tools • Formation and utilization of PETs	Noncompliance

#	Provision	Assessment of Status	Compliance
		• QAQI Council responsibilities • QA reports • Corrective Action Plans LSSLC had not revised its facility-specific policy on QA. Therefore, comments made in the previous monitoring report were still applicable. A facility-specific policy will need to be written and it will need to be in line with the updated state policy. As the facility-specific policy is developed, the QA department needs to think broadly about data collection and data usage. The monitoring team had the opportunity to discuss this at length with the QA director during the onsite review. To summarize, the QA department needs to: • Create a listing of all data collected at the facility that includes the following (also, a number of suggested types of data were detailed in the previous monitoring report and, therefore, are not repeated here): o Data collected by each discipline service department; this includes two categories of data: ▪ Data the discipline service department uses for its own service and operational purposes ▪ Data the discipline service department collects as part of its own self-monitoring and which includes these two categories of self-monitoring tools: • Statewide self-monitoring tools • Facility-specific tools created by the LSSLC service department (if any) o Data collected by the QA department staff: ▪ Data they collect themselves ▪ Data that are the result of the QA department's interobserver agreement (reliability) assessments of the service department's own self-monitoring o Data from the areas listed in the Assistant Commissioner's guidelines for QAQI Council, such as Life Safety Code, ICFMR regulatory activities, and the FSPI. • Determine which of these data are to be submitted to the QA department for tracking and trending. • Determine which of these data are to be o Included in the QA report. o Presented regularly to the QAQI Council. QAQI Council should make this determination, that is, it should not be a decision made by the service department head or by the PET.	

#	Provision	Assessment of Status	Compliance
		• Create and manage corrective actions based upon the data collected and direction from the QAQI Council. <u>QA Department</u> Kathleen Thompson was the QA director and had been so since the baseline review one year ago. The other members of the QA department had not changed since the previous onsite review, except one member had taken the incident management coordinator position. The QA director was interviewing candidates for that vacancy. Overall, the monitoring team found the QA staff to be competent, hard working, and desirous of providing a valuable and valued service to the facility, department heads, and senior management. QA staff collected a variety of data, conducted a variety of audits, played a large role in the running of human rights committee, conducted all unusual incident investigations, and handled follow up and monitoring of plans of correction following DADS and CMS regulatory reviews. The QA staff reported that they gave their findings to the direct care staff and/or managers for whom the information they collected was most relevant. QA staff reported positive working relationships with most of the departments at LSSLC. The habilitation therapies director was new and was working well with her assigned QA staff member. The only exception appeared to be a need for a better working relationship between the QA staff and the nursing department. The QA director and the CNE both told the monitoring team that they had met on this issue and were working towards its improvement. Examples included the need for QA staff to have more data regarding aspects of nursing such as medication errors, responsiveness to QA nursing death reviews, and the use of QA data by nursing to improve services. Although one or two professional development activities had occurred for the QA staff since the last review (e.g., attendance at a behavior analysis training), the QA staff were needing more direction, especially regarding allocation of their time across their many responsibilities. Further, unfortunately, the activities highlighted in the last monitoring report regarding the QA department's efforts to more fully integrate into the facility's programs had fallen off. Only the monthly one page newsletter remained (see previous report for more detail). Sherry Roark, the Settlement Agreement Coordinator, played a lead role in the collection and organization of data and documents at LSSLC so that the monitoring team could conduct its review. Ms. Roark was extremely responsive to the monitoring team's requests and she worked tirelessly during the weeks before, during, and following the onsite review. She was competent, well organized, and professional. She was assisted by Rita Inman who was also helpful and responsive to the monitoring team's many requests.	

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		Because the SAC is involved with a variety of data collection activities, it is important for the SAC and QA director to work together on matters related to this provision. Quality Assurance Plan A QA plan did not yet exist at LSSLC. A beginning draft was presented to the monitoring team. It was based on the Mexia SSLC QA plan and was six pages long. In order to create an adequate QA Plan, guidance will need to be provided from the soon-to-be-revised statewide QA policy (as noted above) regarding content and format. Second, the QA plan should be informed by having the QA director (and perhaps QAQI Council) review the full listing of all the data being collected at the facility (as also noted above) to ensure all relevant data are included in the QA plan. Third, the draft LSSLC QA plan was a spreadsheet listing a variety of data, but it needed to include a brief narrative that told the reader how it was developed, how it was updated, and the meaning of the rows and columns. QA Activities and Indicators The activities of the QA staff were primarily • Collection of data (e.g., mealtime monitoring) • Completion of service department self-monitoring tools for the purpose of assessing interobserver agreement • Participation on various committees and attendance at various meetings The QA department also reported the initiation of databases for the following measures: • Mealtime monitoring: collected by many different managers • Monthly weights: collected by nursing staff • Communication supports: soon to begin • Positioning: soon to begin • Others that were in the planning stages: engagement, PSP attendance, timeliness of assessments, dental appointments. These databases and the data that are collected should be part of the facility's QA plan. The QA director presented the monitoring team with a set of self-monitoring tools that corresponded to many of the provisions of the Settlement Agreement. Each tool consisted of a set of checklist-type items and had an attached set of instructions for completing each item of the tool. These tools were designed to be used at all of the SSLCs, were generated by DADS central office, and were based upon a set of tools originally used by the monitoring teams and developed in 2009. It was good to see that tools had been standardized for use by all the SSLCs and that they were based on the	

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		monitoring team's original tools. The monitoring team, however, recommends that the facility and state work with the monitoring teams to review and update the state-created tools so that they are based upon the most recent findings and activities of the monitoring teams. Further, the quality of the self-assessment tools would likely be improved if DADS obtained feedback and suggestions from QA staff at LSSLC and the other SSLCs. In the baseline report and in the last monitoring review report, the monitoring team recommended that a variety of satisfaction measures be obtained as part of the QA system at LSSLC. Nothing had been done at the facility to address this recommendation, other than the statewide implementation of a family/LAR satisfaction survey. This was good to see, but was not due to any action taken by LSSLC, and further, nothing had been done with the data accumulated to this point. The monitoring team reviewed the family/LAR satisfaction data. There were many positive comments as well as a number of comments that required follow up. Fourth, as also noted in the previous monitoring review report, self-advocacy meetings present another way of obtaining information that may be useful to the QA department and facility management. Self-advocacy minutes were reviewed and a self-advocacy meeting was attended by the monitoring team. The monitoring team's review is discussed below in section T1b2.	
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. LSSLC was not in compliance with this provision item. <u>QA Data Management and Analysis</u> A well-designed QA report may help the QA department to manage all of the data collected via its QA policy and QA plan. At the time of this onsite review, the QA department did not manage, summarize, or analyze data other than the trend analysis (a statewide requirement for all SSLCs) and the newly initiated (but not yet useful) databases described in E1 above. The development of procedures, standards, and criterion to analyze data, summarize the findings, and create a useful QA report will be required for the facility to meet this provision item. <u>QA Report</u> A QA report did not exist at LSSLC.	Noncompliance

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		QAQI Council The QAQI Council had met regularly and was an improvement since the last onsite review. The meeting was held once per month since its inception in October 2010 and was led by the facility director. Minutes from seven meetings were reviewed (including minutes for the meeting attended by the monitoring team) and indicated a range of topics, primarily related to administrative, regulatory, and Settlement Agreement areas. Most impressive was the QAQI Council's review of data from some of the service departments (e.g., nursing) and data from the trend analysis. Although limited, this was a good start. If the QA program develops (e.g., QA plan), it will tie in more directly with the activities of the QAQI Council. The facility's plan was for each QAQI Council meeting to have a standard agenda of regular topics (e.g., status of regulatory deficiencies) and a rotating agenda of a set of Settlement Agreement provisions. The rationale was to allow for a more meaningful discussion of a smaller set of provisions and their related data. This appeared to the monitoring team to be a reasonable way to proceed (though it was not yet being implemented). Performance Improvement Team LSSLC senior management had formed one PIT. It addressed aggression between individuals. The hypothesis was that lack of engagement in activities and lack of attendance at day and work programs set the occasion for behavior outbursts, including aggression. A plan was put in place to focus upon a limited number of high incidence individuals. The plans included general improvements in engagement opportunities as well as individualized engagement plans for the targeted individuals. The outcomes were only just being assessed, but appeared to be promising. The facility director and her managers who were most involved in this (e.g., residential director, coordinator of active treatment) were very proud of this project, as they should be. Corrective Action Plans The QA department had implemented only one corrective action plan. It was to address the need for seizure documentation to be adequately completed. The implementation of the corrective plan led to a number of QA audits and feedback to nurses. The management of corrective actions, as required by provision items E2, E3, E4, and E5 was not being done as required. This was not dissimilar to the facility's inadequate attention to the other aspects of quality assurance as indicated throughout this section of the report.	

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		The monitoring team has a number of considerations for the facility as it moves forward with meeting the requirements of this provision item. These considerations could be included in LSSLC's facility-specific policies regarding QA and the QAQI Council. • How to determine whether or not corrective action is required (e.g., based on scoring of a monitoring tool, based on a level of data submitted, based on discussion at QAQI Council). • If there is a determination that corrective action is required, describe what that action will be. A formal Corrective Action Plan (CAP) is one possibility, but there are other types of corrective actions that might be more appropriate (e.g., development of a new policy, decision by facility director). • Create a method for tracking all corrective actions, not only corrective actions that require a CAP. • A corrective action, whether it be a CAP or not, may involve the formation of a Performance Improvement Team (PIT). A PIT, once formed, might also delegate certain activities to a Performance Evaluation Team (PET). • Specify how the facility's practices for implementing corrective actions will meet the requirements of the items of this provision, that is: o E2: 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 o E3: disseminate corrective action plans o E4: monitor and document implementation and outcomes of the corrective action o E5: modify corrective actions when needed.	
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 new DADS policy once it is disseminated.

2. Revise and implement facility-specific policies based upon the new DADS policy, once it is disseminated.

3. Create a comprehensive approach to organizing the facility's data for QA purposes, as detailed in E1. This includes creating a listing of all data collected at the facility, determining which of these data are to be submitted to the QA department, and determining which of these data are to be in the QA report and presented to QAQI Council. Incorporate the current LSSLC databases into this system.

4. Develop an adequate and comprehensive QA plan.

5. Update all statewide self-monitoring tools.

6. Review and follow up on any specific comments, as appropriate, from LARs and family members to the facility's satisfaction survey; incorporate the data into the QA program.

7. Measure satisfaction of community affiliated agencies, providers, employers, health care providers, and so forth.

8. Fix the current self-advocacy activities; ensure they are meeting the needs of individuals at the facility, including whether they are learning how to make decisions, solve problems, and advocate effectively.

9. Develop a QA report; make it a comprehensive and useable document.

10. Ensure QAQI Council addresses all of the required topics as per direction from the DADS Assistant Commissioner for the SSLCs.

11. Develop a comprehensive system to generate, implement, manage, and track corrective actions, as per E2 through E5, and as described above.

12. Address the working relationship between the QA department and the nursing department.

The following are offered as additional suggestions to the facility:

13. The QA director should meet regularly with QA staff, at least once per week, perhaps twice per week.

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 Supported Visions: Personal Support Planning Curriculum o DADS Policy #004: Personal Support Plan Process o Supporting Visions Training Curriculum o LSSLC list of PSP development dates and admission dates o Monitoring tool for review of PSP meeting o The following documents for a sample of individuals: • Individual #290 – PSP dated 2/14/11, Assessments, SAPs, Quarterly Review • Individual #470 – PSP dated 2/22/11, Assessments, SAPs, Quarterly Review • Individual #45 – PSP dated 1/4/11, Assessments, SAPs, Quarterly Review • Individual #144 – PSP dated 1/12/11, Assessments, SAPs, Quarterly Review • Individual #504 – PSP dated 1/13/11, Assessments, SAPs, Quarterly Review • Individual #170 – PSP dated 2/15/11, BSP • Individual #29 – PSP dated 9/10/10 • Individual #538 – PSP dated 1/12/11, Assessments, PBSP, SAPs • Individual #410 – PSP dated 2/15/11, Assessments, PSPAs, PBSP, SPCI, SAPs, • Individual #560 – PSP dated 1/5/11, SAPs, Quarterly Reviews • Individual #166 – PSP dated 10/4/10, Assessments, SAPs, BSP, PSPAs, Quarterly Review • Individual #573 – PSP dated 7/6/10, PSPAs, SAPs, Quarterly Review • Individual #498 – PSP dated 2/7/11, PBSP • Individual #203 – PSP dated 10/6/10, Assessments, PSPAs, PBSP, SAPs, Quarterly Review • Individual #146 – PSP dated 11/3/10 • Individual #593 – PSP dated 4/20/10, Assessments, Monthly Review • Individual #267 – PSP dated 5/26/10, PBSP • Individual #258 – PSP dated 3/24/10, PBSP • Individual #475 – PSP dated 10/13/10, PBSP • Individual #300 – PSP dated 3/9/10, PBSP • Individual #349 – PSP dated 10/19/10 o Records listed in sections M, J, O, and P <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, and QMRPs in homes and day programs; o Lisa Currington, Employment Services Director o Sylvia Middlebrook, PhD, Director of Psychology

	o Luz Carver, QMRP Coordinator o Stacie Cearley, Incident Management Coordinator o Royce Garrett, Consumer and Family Relations Director <u>Observations Conducted</u>: o Observations at residences and day programs o Morning Medical Meeting 4/19/11 o Castle Pines Morning Unit Meeting 4/19/11 o Daily Incident Management Review Team Meeting 4/19/11, 4/20/11, and 4/21/11 o Human Rights Committee Meeting 4/20/11 o Annual PSP meetings for Individual #593 and Individual #162 o Annual risk assessment meeting for Individual #166 and Individual #245
	Facility Self-Assessment: The facility's POI and interviews with the QMRP Coordinator indicated some differences in the ratings applied. First, there was agreement on the substantial compliance rating for F2f. In addition, the monitoring team rated F2a6 as being in substantial compliance. The monitoring team, however, did not agree with the facility's self-ratings of substantial compliance for F1a, F2a4, F2d, and F2g. Reasons for the difference in ratings are apparent in the narrative below for each of these provision items. Overall, however, progress in provision F since the last monitoring visit was based on completion of training on the new PSP process and beginning implementation of the process during annual PST meetings beginning 10/01/10. The facility QA department began monitoring this process in January 2011. It was projected that by 9/20/11, all individuals residing at LSSLC will have had annual meetings using the new PSP process. The facility reported that it was focusing on deficits noted in Section F, but acknowledged that many of these efforts are in the beginning stages.
	Summary of Monitor's Assessment: Compliance with section F will require the facility to complete thorough assessments in a wide range of disciplines to determine what services are meaningful to each individual served and what supports are needed to allow each individual to fully participate in those services. Plans will need to be developed that offer clear directions for staff to provide supports deemed necessary through the assessment process and then a plan to monitor progress will need to be implemented so that plans can be updated and revised when outcomes are completed or strategies for implementation are not effective. Monitoring of plans will need to include a mechanism for ensuring that assessments are revised as an individual's health or behavioral status changes, and then outcomes and strategies will need to be revised in plans to incorporate any new recommendations from assessments. Finally, a service delivery system will need to be in place that addresses supports determined necessary by each PST. 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 team's visit. According to the facility's POI, QMRPs had attended training on developing person centered plans and had begun to implement the new process at annual PST meetings on 10/1/10. PST meetings observed the week of the monitoring visit were in the new style format. At the PSP meetings observed, team members discussed supports needed in relation to the individual's preferences and interests. The new format of the plans 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 supports that the individuals needed throughout the day was more clearly stated in the newer PSPs. As noted throughout section F, while there was positive movement towards integrating supports throughout each individual's plan, there was not much progress being made on developing plans that would lead to a more meaningful day for individuals. Teams were restricted by the lack of program options offered at the facility and very little consideration was given to programming in the community. The facility offered very few options in terms of programming. Individual's schedules were not driven by their preferences, but instead by options offered for programming at the facility. The monitoring team noted that many behavioral issues at the facility appeared to be a result of boredom or lack of active treatment in line with individual's preferences. The facility needs to continue to focus on structuring active treatment to include a larger variety of options in line with individual's preferences. The QMRP Coordinator was aware of the challenges facing teams in trying to develop person centered plans with few options for implementation of the plans. QMRPs were the team members designated to facilitate meetings and model the new process during the planning stages. In meetings observed, the QMRPs were attempting to encourage team participation and ensuring that all necessary information was covered during the PST meeting. 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 and then, ensuring that plans are accessible to support staff. Throughout section F, the monitoring team has focused on trying to provide the facility with examples of where, when applicable, changes have been effective in producing desired outcomes, and examples of areas where problems have been identified and will need to be addressed as new procedures are developed. The monitoring team looks forward to seeing how systemic changes will impact specific outcomes for individuals once the facility has had a chance to fully implement these changes. The PSPs that were reviewed were primarily chosen from among the list of individuals for whom the new format/process for PSPs had been used. The monitoring team reviewed a sample of 14 of the new plans to assess compliance with section F. The sample was selected randomly, and included plans for individuals who lived in a variety of residences on campus. Therefore, a variety of QMRPs and PSTs had been responsible for the development of the plans. Since the new plans were so recently developed, additional

	old style plans were added to the sample in order to look at implementation over a longer period of time.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	QMRPs were responsible for facilitating PST meetings at the facility. The QMRPs were also responsible for ensuring that treatments, services, and supports are developed, monitored, and revised. All PST meetings observed during the monitoring visit confirmed that QMRPs were facilitating PSP meetings. A sample of PST attendance sheets were reviewed for presence of the QMRP at the annual PST meeting. At nine out of 10 (90%) annual meetings, there was a QMRP present. The attendance sign in list for Individual #170 did not include the QMRP's signature. In the annual PST meetings attended by the monitoring team, the QMRP facilitated the meeting and did a nice job of encouraging input from all team members. The QMRPs appeared to be familiar with the individuals and contributed to the team meetings. Although the facility's POI indicated that a monitoring process had been put in place to ensure updated plans were accessible to support staff, it was again found that current plans were not always available to staff providing support to individuals. 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. See comments throughout this report regarding plan implementation, monitoring of plans, and revision of treatments, services, and supports. It was found that the planning process did not always result in a plan that was developed and accessible to staff responsible for implementing the plan. The facility was not in compliance with this provision.	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	A sample of attendance sheets was reviewed for compliance with this provision with the following results in terms of appropriate team representation at annual PST meetings. • One (10%) of 10 indicated that the individual attended the meeting; • Seven (70%) of 10 individuals had a LAR; all (100%) participated at the annual PST. For those LARs that were unable to attend the meeting, they were included in discussion by telephone. Staff present by discipline where relevant at the annual PST meeting included:	Noncompliance

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	persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	• In nine of 10 (90%), the QMRP attended the meeting, • In 10 of 10 (100%), residential staff attended, • In eight of 10 (80%), day habilitation staff attended, • In two of two (100%), vocational staff attended, • In nine of 10 (90%), nursing staff attended, • In eight of nine (89%), psychology staff attended, • In two of two (100%), the psychiatrist assistant attended, and • In four of eight (50%), appropriate PNM staff attended. The following are examples of comments regarding participation in PST meetings for the sample of individuals reviewed. • For Individual #504, the signature sheet indicated that the individual did not attend the meeting. His PSP indicated that he was "nonverbal." A communication therapist did not attend the meeting. The individual utilized adaptive equipment for mobility and mealtimes. The OT and PT did not attend his meeting. • For Individual #170, the attendance sheet noted that the individual did not attend his meeting, nor did the QMRP. • For Individual #45, the PSP attendance sheet did not indicate whether or not she attended her annual meeting. The OT or PT was not in attendance though she utilized a wheelchair, gait belt, walker, modified cup, spoon, and dycem mat. The communication therapist was not in attendance though she had limited communication skills. • For Individual #410, the signature sheet indicated there was full representation from all relevant disciplines. • The PSP signature sheet for Individual #498 did not indicate that she attended her annual meeting. Relevant therapy staff were not in attendance at her meeting. • The PSP for Individual #146 indicated a wide range of relevant disciplines participated in her annual PSP meeting. Partial attendance was marked beside the individual's name. There was no active treatment or day habilitation staff in attendance at the meeting. • The PSP attendance sheet for Individual #166 indicated that she was present at her meeting along with her LAR. All relevant disciplines were in attendance at the meeting. • The PSP attendance sheet for Individual #560 did not indicate that she attended her annual meeting. OT and PT staff were also not in attendance at the meeting, though she needed significant mobility supports and was at risk for aspiration. • The PSP attendance sheet for Individual #573 did not indicate that the individual was present at the meeting.	

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		Only one PSP in the sample indicated that the individual attended his/her own PSP meeting. To gain substantial compliance with this provision, the facility will need to demonstrate attempts to involve the individual in the planning process and document those attempts in the PSP document. The facility was rated as being out of compliance 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.	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 lifestyle preferences. In the plans reviewed, this list was individualized and offered a good starting point for plan development. As noted throughout this report the facility routinely completed a variety of discipline-specific assessments (e.g., medical, nursing, habilitation, psychology, vocational, daily living skills) describing the individual's status, his or her needs, and recommendations for actions, and service and/or training objectives. Information gathered from the PFW was discussed in the PST meetings observed. Each QMRP reviewed the individual's list of preferences and members of the team contributed information on how this might be supported. Attempts were made to integrate these preferences into outcomes (i.e., action plans) developed by the team. Assessments for work and community living did not adequately address the lack of exposure to work and living opportunities. It is essential that assessments provide opportunities for individuals to participate in a variety of experiences relative to areas assessed. Vocational assessments were not adequate to address job placement preferences and skills. Vocational assessments should include situational assessment based on the individual's known skills and interests to determine if the individual is truly interested in possible work in an alternative setting regardless of whether or not the preferred job is available at LSSLC. Some examples where adequate assessments were not completed for the individual included: • The OT/PT assessment for Individual #470 found that her current wheelchair was "not adequately accommodating her right lateral lean. She may also need elevating leg rests and a tilt system to assist in management of integumentary, cardiac, and musculoskeletal issues." She was listed as a Priority 2 for a wheelchair assessment. • For Individual #144, his PSP indicated that his last communication assessment was in 2007. According to his PSP, he was only able to "verbalize his wants and	Noncompliance

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		some of his needs using 3-4 word combinations, short phrases, physical gestures, and action." • A situational work assessment should be completed for Individual #170. It was noted in his PSP that work (sorting coat hangers) was important to him for several years, but he had lost interest in attending work. It was not evident that that a vocational assessment had been completed to see if he may be interested in another type of work. ▪ For Individual #166, her PSP indicated that she would like to be employed in the community. It was not evident that an assessment had been completed to identify the type of work that she would enjoy or what type of work environment that she might do best in. ▪ Individual #504's PSP indicated that he attended day programming, but did not work. His vocational assessment was dated 3/26/99. At that time, he indicated that he liked to work. His vocational assessment needs to be updated to reflect his current preferences. The quality of assessments is thoroughly discussed throughout this report. See sections H and M regarding medical and nursing assessments, section I regarding risk assessment, section J regarding psychiatric and neurological assessments, section K regarding psychological and behavioral assessments, sections O and P regarding PNM assessments, section R regarding communication assessments, and section T regarding most integrated setting practices. 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. Compliance will need to be demonstrated in these other areas regarding the development, monitoring, and revising of assessments in order to achieve compliance with section F1c.	
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.	A wide variety of assessments were performed prior to PSP development. As noted in F1c, it was not evident that assessments were always adequate to address needs or were revised as individual's needs changed. A sample of the newer style PSPs, however, indicated that the team was doing a better job at integrating information into a meaningful plan that identified needed supports in relation to the individual's preferences and needs. Information regarding significant diagnosis, risks, and supports was included in most plans.	Noncompliance

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		The facility needs to focus on better organization of the written plan in order to make information more accessible for staff carrying out plans. QMRPs were including more information in the primary narrative section of the plan, but in some cases essential information for providing supports had gotten buried towards the end of the plan in the summary of assessments. Plans could be shortened by taking out duplicative information that was included in both sections. The facility was still in the initial stages of trying out various formats to find which works best; therefore, there was variation in the format across many of the new plans. Some good examples of where integrated information regarding protections, services and supports was included in PSPs were: • Individual #290's plan included a good description of his preferences, adaptive equipment, and supports that he needed throughout his day, along with a schedule of how he spent his day. It included his chronic medical issues and gave a brief description of how those should be supported to minimize his risks. • Individual #170's PSP listed his major diagnoses and described how his support needs should be integrated into his preferred activities. A good example of this was in the discussion regarding work. • Individual #560's PSP was another good example of where the PSP included how supports should be integrated throughout her day. As evidenced by the following examples, assessments often included important information that should have been used as the basis for planning for individuals, however, it appeared that this information was not used to develop and implement protections, services, and supports for the individual. For example, the current annual nursing assessment summaries were not functional for the QMRPs and PST in the development of the individual's PSP, including inadequate summaries of clinical indicators to be considered by the PST in the identification and rating of health risks. Summaries of clinical indicators and the frequency of current and continued monitoring needed were not consistently provided by nurses for all identified risks. ▪ Individual #470's Rights Assessment indicated that she was "not able to give or withdraw consent as she did not appear to have the cognitive ability to understand the implications that can come from such decision." The PSP indicated that her sister would like to pursue guardianship, but did not have the funds to do so. No further action was taken to address her lack of guardianship. Her PFW indicated that visits with her sister were important to her and the PSP stated that she would enjoy more frequent visits with her sister. No plan was put into place to ensure that this would be supported. Nursing and OT/PT assessments indicated that she was at risk for diabetes, polypharmacy,	

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		aspiration, hypothermia, urinary tract infections, cardiac risks due to high blood pressure, constipation, oral hygiene, and skin integrity. Her PSP indicated that the PST had placed her at medium risk for polypharmacy, hypothermia, and dental. It was not apparent from information included in her PSP that she had a plan in place to address the risk of skin breakdown. ▪ The PSP for Individual #504 included information that was "cut and pasted" from most assessments into the narrative section, but it was difficult to determine how supports should be integrated into the individual's day or how preferences should be supported. ▪ The PSP for Individual #498 indicated that her communication assessment included recommendations, but these were not incorporated into her PSP. Her BSP indicated that she exhibited physical aggression, self-injurious behaviors, and inappropriate sexual behaviors, and her vocational assessment recommended that she not be employed due to behaviors, however, her PSP indicated that she was at low risk for challenging behaviors. The PSP did not address her risk for polypharmacy, though she was taking Depakene, Thorazine, and Trazodone for "behavior." ▪ Individual #267's PSP noted that his food texture had been downgraded to "all ground which in most cases is pureed." It further noted that "he has been going for swallowing treatments to help him, but he does not chew since he has been on pureed so long that he does not need to and forgets how. His behavior is greatly affected by the decision of the NMT and he hates going to the dining room for meals. He will have another barium swallow test soon to see if he can be changed, but since the NMT downgraded him when there was no problem with his food, he probably never will go back to the texture he had before." His PNMP stated that he should be offered ground meat in place of "pureed meat with gravy as he HATES this." There was no indication that the team had addressed this issue with his food ▪ Individual #258's PSP did not include outcomes to address recommendations made in his communication assessment. Assessments noted a number of risks that required specialized supports including active seizures, at risk for injury, at risk for choking, and poor dental hygiene. The team concluded that he was at low risk in all risk areas. ▪ Individual #29's rights assessment indicated that she did not have a guardian and was unable to make informed decisions. Her PSP did not include discussion regarding her need for a guardian. Assessments indicated that she was at risk for weight loss, constipation, and dehydration. Her PSP stated that she was at low risk in all risk areas. ▪ The PST determined that Individual #203 was at low risk in all at risk categories, though he had a PBSP to address aggression and self injurious behaviors that	

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		had often resulted in injury. His PNMP and swallow study indicated that mealtime modifications were necessary due to his risk for choking. Medical assessments indicated that he was at risk for weight gain, constipation, aspiration pneumonia, GERD, and poor oral hygiene. His PALS assessment identified numerous need areas in the community awareness section. He had one outcome to address traffic safety relating to a need area indentified in the community. ▪ Individual #290's nursing assessment indicated that he was at "medium risk for aspiration pneumonia." The narrative section of his PSP that addressed medical risks did not include his risk for aspiration. ▪ Individual #203's medical assessment included the statement "he has chronic pulmonary scarring and should not encounter restraint that restricts his breathing in any way." This information was not included in the narrative section of his PSP in the discussion of risks. His quarterly review indicated that he was placed in a horizontal restraint on 11/30/10. While the facility had made progress in addressing this provision, as noted above, plans do not address all assessment results and not all individuals had gone through the new PSP process.	
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).	The new DADS policy #004: Personal Supported Plan Process dated 7/30/10 mandated that Living Options discussions would take place during each individual's initial and annual PSP meeting at minimum. Twelve of 12 PSPs (100%) that were reviewed indicated that individuals and/or their LARs were offered information regarding community placement as required. The following is a summary of the optimal living discussion found in those 12 PSPs. • The optimistic living section of the PSP for Individual #290 summarized interaction with the MRA caseworker. The caseworker indicated that he had not expressed a desire to visit a home in the community, but then noted that he was nonverbal and did not express any issues or concerns regarding his living option. She further noted that he was his own legal guardian and family contact was unsuccessful, so she did not know the family's expectation of his residence. The PSP indicated that his sister did have contact with the facility social worker and did not want him to move. His PSP stated that "behavior" was the only obstacle to community placement. • The PSP for Individual #267 included a lengthy discussion on optimal living options. It included statements that were inappropriate for person centered planning scattered throughout the section. The team acknowledged that his preference would be a smaller group home setting. The plan stated that "until	Noncompliance

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		there is a home which can address his psychotic, destructive behavior or until there is a medication which can offer support and assistance to him, he cannot be recommended." It further noted, that his "quality of life would revolve around his swallowing easily so he does not choke, in a comfortable small setting in which staff understands his delusions and psychosis. He responds to those who tell him what is going to happen, who talks to him with love and understanding, and who do not let it bother them when he goes off on one of his screaming, cursing tangents. The institutional life has already taken its toll on him and he responds to those around him who are screaming, hollering, etc. He vies for attention over all this, so a place which was void of all the noise and confusion would be appropriate for him." The section of the PSP that lists obstacles and barriers to community placement stated, "First and foremost a staff knowledgeable of the moods and aggression he displays when he is upset, and a staff versed in caring for mentally ill individuals more than those who are developmentally disabled. He is more a mental case than disabled." The discussion was summarized as follows, "He resides at present in a safe environment on 506 Park Lane although he hates the older males who live on the home. He does not interact with any of them at all. He should remain here until a smaller setting becomes available based on behavioral needs." Outdated language and inappropriate comments included in this plan should have been noted during the QA process and the plan should have been revised before being implemented. • The optimistic living section of the PSP for Individual #470 summarized her preferences for living with a statement that her LAR was pleased with placement at LSSLC "as it is a midpoint for the family to facilitate visits since part of the family lives in Dallas and others live in the Houston area." She also stated that her "LAR would like for her to live on the same home as her sister," who also resides at LSSLC. In the PSP, the QMRP noted that she gets to visit her sister at LSSLC regularly and "did not appear to show any desire to live at the same home with her sister. " It was stated in her PSP, however, that the CLOIP worker "is not sure if she has the cognitive ability to understand the full scope of alternative placement." The PST listed her health, G-tube placement and recent diagnosis of diabetes as obstacles to living in the community. The team concluded that education of living options was not a priority because she did not appear to understand them. • The optimistic living section for Individual #504 indicated that his two sisters had toured community group homes and were not satisfied with what they found. The next paragraph states that the family had not visited any community living options, but they were considering group home placement. Conflicting information was found throughout the narrative on what would be the best	

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		living placement. The narrative discussed looking for a home for the individual and his close friend in one section. The closing statement in the narrative indicated that the PST determined he should remain at LSSLC because a move would be "disruptive to his bonds of affection and development." • The PSP for Individual #45 indicated that community placement was discussed with her guardian and the guardian expressed her wishes to have her remain at LSSLC. The team noted that there were no identified obstacles to community placement. The PST determined that LSSLC was the most integrated setting for her. • The PSP for Individual #560 documented discussion between the CLOIP MRA and her guardian regarding community placement. The guardian stated that she was pleased with placement at LSSLC and did not want the MRA to discuss placement with her. Obstacles to community placement were not identified, however, the team determined that placement at LSSLC was the most integrated placement. • Individual #498's guardian did not want to consider community placement for her. The team did not identify any obstacles to community placement, however, determined that the least restrictive setting appropriate for her was LSSLC. • Individual #170's guardian was happy with his placement at LSSLC and did not want to consider community placement. A description of his psychiatric diagnosis was listed under obstacles identified by the PST. The team agreed that the most integrated setting for him was LSSLC • Individual #538's guardian had requested community placement for him. She had chosen a community provider and the team had referred him for community placement. The PSP, however, indicated that LSSLC was the most integrated setting for him. • Information regarding community placement was shared with Individual #410's guardian. The PSP indicated that she would contact the facility social worker when she was ready to pursue community placement. His "behavior" was identified as his only obstacle to community placement. It was determined that his current home was the most integrated setting for him. • The PSP for Individual #166 indicated that she wished to move to a group home in the community. The PSP noted that her behaviors were her only obstacle to living in the community. The PST recommended that she receive formal training in regard to the behavioral expectations staff will have of her when she lives in a group home. A more appropriate discussion would have been behavioral supports that she would need in the community. • The PSP for Individual #144 indicated that he had toured group homes in the community and liked one that he had visited, however, it was not wheelchair accessible. The PSP stated that the guardian was satisfied with care and services	

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		at LSSLC and was concerned that his medical needs ("seizures, lethargy, and other medical issues") could not be addressed in the community. There were no obstacles to community placement identified. The PST determined that LSSLC was the most integrated setting at this time. In 10 (83%) instances, the teams concluded that the individual should continue to reside at LSSLC; there was one referral made for community placement. While Individual #267 was not referred for community placement, the PSP did acknowledge that LSSLC was not the most appropriate placement and as soon as appropriate placement could be found, he would be referred. The annual PST meeting was observed for Individual #162. The team engaged in a good discussion around living options and appropriate placement in the least restrictive environment. The team agreed that placement in a community group home would be more appropriate for her. The guardian participated in the meeting by phone and was in agreement with the PST that the team should move forward with exploring community placement. The team, however, did not make a referral for community placement and did not develop an action plan to proceed, so it was not known when the next steps to pursuing placement might be expected to occur. When considering transition into the community, the team should establish outcomes and set deadlines for when those outcomes should occur. The annual PST meeting was observed for Individual #593. The team noted that he enjoyed going into the community on outings. Team members agreed that the ideal living environment for him would be with fewer individuals in the country because he did not like a lot of noise and activity. One team member stated that his current home was "kind of crowded, and he doesn't like it." The CLOIP MRA reported that he was not aware of other living options, so could not make an informed decision. His previous PSP had an outcome to visit group homes in the community, but the outcome was never implemented. Information from the previous PSP indicated that his cousin was against community placement and was going to seek guardianship, in order to have input into the decision. At the time of this PSP meeting, she had still not obtained guardianship and it appeared that the team was hesitant to even implement outcomes to educate him on community options while waiting on guardianship. Some team members agreed that community placement might better meet his current needs. When the QMRP asked the team if there were obstacles to moving, the psychologist noted that he had adjustment problems when he was moved to another home at the facility. The nurse stated, "mainly the back thing. " She reported that although he had not experienced any problems with his back in the past year, he had in the past and may again, so they needed to keep that in mind. The QMRP concluded the discussion by stating "at this point, he should stay here	

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		due to his age." She did not elaborate on why his age might prohibit successful placement in the community. Plans included limited opportunities for community based training. Opportunities to develop relationships and gain membership in the community were not addressed in any of the plans in the sample. Learning in the community was limited to money management and traffic safety in most of the plans reviewed Some examples of priority needs and preferences for individuals that could have been addressed in the community included: • Individual #538 and Individual #410 both enjoyed being in the community and optimal placement was determined to be in the community. Both had the same outcomes for money management and traffic safety. The skill acquisition plans for these goals indicated that they could be taught at the facility or in the community. Their plans did not include outcomes for other learning to take place in the community. • Individual #170's PFW indicated that he enjoyed working, the train at the zoo, visiting the airport, listening to music, hamburgers, van excursions, his family, and swimming. All of these could have been incorporated into activities with opportunities to learn valuable skills in the community. None of his preferences were incorporated into outcomes to be implemented in the community. • Individual #290's PSP indicated that he did not comprehend community living options though he did enjoy trips into the community. His only outcome related to gaining skills in the community was a money management outcome. • Individual #45's PSP indicated that she enjoyed community outings, interaction with others, attending church services and listening to music. Learning opportunities based on her preferences could have been developed by the PST. She did not have any outcomes to be implemented in the community. • Individual #144 also had a wide range of interests that could be supported in the community including going to the movies, eating out, rodeos, going fishing, sporting activities, shopping, going to the zoo, listening to music, and spending time outside. His outcomes included opportunities to attend events, but did not include any training to be implemented in the community other than money management. Although the facility reported that training was occurring in the community, it was not evident in observations and PSP outcome documentation. Plans will need to include community based teaching strategies to ensure that training is consistent and measurable. This provision is discussed in detail later in this report with respect to the facility's	

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		progress in implementing the provisions included in Section T of the Settlement Agreement. There was very little focus on community integration at the facility and teams did not have the knowledge needed to develop plans to be implemented in the least restrictive setting. The facility needs to provide additional training to teams in this area. This is a repeat need also noted in the previous monitoring report.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	The PSPs reviewed included a list of "What's most important to the person?" For most individuals in the sample, this list was used as the basis for outcome (i.e., action plan, training and service objectives) development. As noted below, there were some exceptions to this, particularly around preferences for community participation and living options. In addition, the discipline-specific assessments were also used to identify needs and to list recommendations for action plans and training/service objectives. Many of the individuals in the sample had the same or similar outcomes that were based on training activities that the facility offered even though, as noted below, these were not identified as priorities for the individual. For example, there was a significant focus on self-administration of medication (SAM) and money management outcomes. There was very little focus on priority skills such as communication, socialization, and community awareness. DADS reported that these two outcomes (SAM and money management) have been required areas of training for every individual receiving ICFMR services in Texas. DADS noted that these requirements had recently been relaxed somewhat, however, it was still the expectation that most individuals received training in these areas.	Noncompliance

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		The facility should consider other service and training opportunities that may be more meaningful to individuals at the facility. This would likely lead to more willing engagement in activities and fewer behavioral incidents. Activities based on interest and leisure skills offer many opportunities to provide training in a variety of areas. Although not all leisure activities need to be structured for learning, support staff should take advantage of learning opportunities in more natural settings. For example, training on social skills, reading skills, completing task, and following directions are just a few examples of skills that could be taught (even in an informal manner) while on a community outing. Teams should use the "What's most important to the person?" section of the PSP to develop outcomes, include supports that the individual needs to maintain or increase the occurrence of those things in his or her life, and to address any barriers to their occurrence. For example: • The PSP for Individual #560 listed priority outcomes in the areas of self administration of medication, money management, and communication. Communication was a clear priority, but the outcome established by the team to address communication was using a switch to play music. While this outcome would give her some independence in a preferred activity, using the switch or other assistive technology to interact socially with others or make choices would have better addressed her communication needs. She had an outcome for the self-administration of medication, though she was currently receiving her medication through her G-tube, and self administration was not a priority for her. Money management could have been loosely related to her preferences for dolls, interaction with others, and going into the community, but action steps were not included to ensure that training occurred while she was participating in activities based on those preferences. It appeared that this training was occurring primarily at the facility in a classroom setting with no link to her preferred activities. • The PSP for Individual #290 noted that he "does not have any personal relationships." The team did not address how he could be supported to build relationships in his life. His preferences, however, included helping staff with tasks. It further noted that daily activity and his routine is important to him. There was no indication that the team had considered employment as a possibility for fulfilling these needs. A vocational assessment was completed six years ago. It concluded that he had some valuable work skills, but was not recommended for employment because he required one- on-one assistance with all contracts during the assessment. It further noted that his barriers to employment were that he "had not expressed a desired employment and seemed indifferent to the job tasks that he was offered."	

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		• During the annual PST meeting for Individual #593 observed during the monitoring visit, the team did not discuss how the individual would spend a majority of his day. At the time of the meeting, he was attending the geriatric program for one hour a day. The team agreed that he might benefit from attending an additional hour in the program each day. There was no discussion regarding how he would spend the rest of his day. The teams could have considered action steps that would facilitate community participation while learning valuable skills needed in the community for most individuals in the sample. For example, several individuals in the sample had an interest in music. Outcomes related to that interest could have been developed that included researching music events to attend in the community, buying tickets for events, purchasing music at the store, joining a church choir, or going to the public library to check out music videos. Any of these would have been opportunities for functional learning in the community related to a preference. Little structured training was occurring in the community. The facility had few options to address vocational services, and discussion of real employment opportunities was only addressed in one of the PSPs reviewed. The PSP for Individual #166 indicated that she was interested in community employment, but no outcomes were developed to explore her options in the community. Individuals at the workshop should have been learning work skills that would transfer into employment skills for the community with the opportunity to make real wages in an integrated setting. Progress made on each vocational outcome should have moved the individual closer to community employment, but it did not appear that was a real consideration for the individuals in the vocational program. The Vocational Director at the facility indicated that a statewide committee had been established to look at the vocational assessment process. The committee had developed a standardized assessment and it was currently being reviewed by DADS. There were three individuals in supported employment in the community. One positive step that the facility had taken since the last monitoring visit was the development of a volunteer work program to offer individuals greater exposure to community employment. One individual who had not been successful at the sheltered workshop was now volunteering in the community at the local animal shelter. This individual loved animals and placement was described as successful. It was noted that the number of behavioral incidents displayed by this individual had decreased significantly. The employment services department had also begun a job skills program called "Working Out" to familiarize individuals with community employment. Individuals were scheduled to go into the community to meet with employers and discuss employment	

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		opportunities. The week of the monitoring visit, four individuals were scheduled to meet with managers at three businesses in the community. Another positive development in day programming at the facility was observed in one of the LISD classrooms at the facility. Two individuals who lived in the infirmary and had previously received all day programming in their rooms were now attending school for an hour a day in the classroom. The LISD teacher was adjusting her schedule to allow for programming in the classroom at the optimal time for the individuals. She was hoping to expand the amount of time that the individuals were able to spend in the classroom. While some plans included opportunities to take trips to the community, and minimal training opportunities in the community, none presented opportunities for participation in a manner that would support continuous community connections, such as friendships and work opportunities. Very few meaningful supports and services were put into place to encourage individuals to try new things in the community.	
	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;	Teams were not consistently identifying measurable strategies as specified by this provision item. Some examples of outcomes and goals that were not measurable and/or did not include supports needed to accomplish the goal included: • Individual #410 had teaching strategies that included methods for implementation for the outcomes listed in his PSP that required skill acquisition plans (SAP). He had a SAP to identify sight words, but there was no list of sight words that he would identify, so this outcome could not be implemented consistently. It was unknown what words would need to be accurately identified to constitute successful completion of the outcome. His PSP stated that he would like to live in a group home in the community. Measurable objectives that would move him closer to this preference were not developed for implementation. • The PSP for Individual #504 stated that the only obstacle for community placement was educating the individual and his family on community living facilities and day programming. The team did not establish outcomes to address this need. • Additional examples of where measurable outcomes were not developed to meet specific health, behavioral, and therapy needs can be found throughout this report. As noted in F1e, PSPs indicated that community placement was discussed at PST meetings and, in most instances, the teams concluded that current placement was	Noncompliance

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		optimal for each individual. Plans did not include strategies and supports to be provided in a more integrated setting. Other than going on community outings, plans did not designate that services would be provided outside of the facility, even though a lack of exposure to the community was noted in some of the plans reviewed. Outcomes to go on community outings did not have corresponding SAPs for learning to take place while in the community. Certainly, a SAP is not required for every outing, however, the lack of SAPs in this area were missed opportunities for instruction to have occurred.	
	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. PSPs developed using the new person centered training, however, showed progress in this area. The newer plans were much more comprehensive in identifying and addressing risk for individuals and including supports that were needed by each individual. See section I of this report for specific examples of how risks were being identified and addressed in plans. 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. Then the facility must ensure that plans are developed and implemented in a timely manner. As noted throughout section F, the planning process did not always result in a plan being developed and distributed to staff responsible for implementing plans. This process will be further reviewed when the facility has had an opportunity to fully implement the new person centered planning process.	Noncompliance
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	PSPs and skill acquisition plans for eight individuals (Individual #410, Individual #470, Individual #144, Individual #290, Individual #170, Individual #498, Individual #538, and Individual #504) were reviewed. The following is a summary of what was found: • All identified methods for implementation, however, methods were not adequate as is discussed in greater detail in section S of this report • All outcomes included time frames for completion, • All identified staff responsible for implementation.	Noncompliance
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and	As noted throughout Section F, outcomes in the PSPs reviewed did not always adequately address supports needed by the individual to achieve outcomes and strategies to support functional learning in the community were not included in the PSPs in the sample. As noted throughout other sections of this report, there is need for improvement in the development of plans to address risk for individuals, psychiatric treatment, healthcare	Noncompliance

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	are practical and functional at the Facility and in community settings; and	issues, PNM needs, and behavioral support needs.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	Skill acquisition plans for seven individuals (Individual #410, Individual #470, Individual #144, Individual #290, Individual #170, Individual #538, and Individual #504) were reviewed. The following is a summary of what was found: • All (100%) identified the frequency of data collection • All (100%) identified the data to be collected • All (100%) identified the frequency of data collection • All (100%) indentified the person responsible for data collection • All (100%) identified the person responsible for data review The monitoring team has given this provision item a rating of substantial compliance because the SAPs identified the data to be collected as required by this provision item. Without making improvements as described in all of the other provisions of section F, this substantial compliance rating will not be all that meaningful to the individuals at the facility. Please also see section S of this report for further discussion of SAP data collection.	Substantial Compliance
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.	This provision of the Settlement Agreement will also require compliance with several sections throughout this report including confirmation that psychiatry, psychology, medical, PNM, communication, and most integrated setting services are integrated into daily supports and services as evidenced in sections J, K, M, O, P, R, and T. 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. As noted in F2g, the facility did not have a fully developed quality assurance system in place to effectively monitor the quality of PSPs. While the monitoring team found a lack of coordinated supports and services throughout the facility, it was evident that the facility was attempting to ensure better coordination among disciplines: • Team members from various disciplines met together to develop the PSP and discuss specific issues particularly around behavioral and health care needs. • As evidenced in the newer style PSPs, teams were engaged in more integrated discussions during team meetings. The facility did not have a process to ensure coordination of all components of the PSP. See comments throughout this report regarding the lack of integration of services for	Noncompliance

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		individuals. The facility was not in compliance with this provision.	
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.	The facility reported that mandatory refresher training was provided on active treatment and engagement for all direct support staff during February 2011. Additionally, new employee training on plan implementation was revised to include demonstrations and practice on data collection and assessments. A sample of 38 individual records was reviewed in various homes at the facility. Current PSPs were not available in 11 (29%) of the 38 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. The PSP is a document that is integral to overall service provision, and ensuring it is available in the record seems to be a relatively easy clerical task. 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 individual would remain safe and healthy.	Noncompliance
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	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 teams met when there was lack of progress towards PSP outcomes or when outcomes were completed or no longer appropriate outside of schedule quarterly review meetings. The facility had a quarterly review system in place. The review form had recently been updated and was a much better guide for ensuring that all supports and services were reviewed. The new format included specific data gathered from implementation of outcomes and graphed, so that progress or regression could be easily tracked. The QMRP reviewed progress towards outcomes; changes in health and behavioral status; therapy recommendations; level of supervision; injuries and restraints; family contact; participation in community, social, and religious activities. While this was not occurring monthly, this was a good start to achieving compliance with this provision. The facility will need to implement a system to monitor services and supports monthly and ensure that plans are revised and updated as necessary. When plans are revised, there needs to be a system in place to ensure that all support staff are aware of changes and new plans are being implemented as written.	Noncompliance

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		A sample of quarterly reviews completed by the QMRP was reviewed for compliance with this provision. • The quarterly review for Individual #504 indicated that some outcomes should be continued, but did not describe progress being made towards the completion of the outcome. For example, he had a service objective that stated "will have zero episodes of seizure activity during the month." The objective was to be continued, but there was no notation indicating whether or not he had any seizures during the month. He had an HMP for seizures and osteopenia. The quarterly review indicated that the HMPs would be deleted since his seizure activity and osteopenia were under control with medication. His HMPs should have remained in effect since these were still active diagnoses that needed to be monitored and supports needed to be kept in place to minimize his risk. His action step for money handling was deleted, though no explanation was given and it was not noted whether or not it had been implemented prior to deletion. The individual was hospitalized during the quarter reviewed for aspiration pneumonia. It was not evident that his plan was revised to address this change in risk status. • The quarterly review for Individual #290 dated 11/17/10 indicated that his outcome to tour community living facilities should continue. It was implemented on 2/23/10. The comment on the outcome stated "action referral to be sent to placement coordinator to arrange for a tour before his next annual staffing in February 2012." There was no reason given why progress had not been made (referral submitted) in the previous nine months. His service objectives to address healthcare issues all noted continue without any update on progress or regression. Several of his SAPs were revised due to lack of progress or regression during the quarterly meeting. • The quarterly review for individual #203 dated 1/27/11 included a review of all outcomes, supports, injuries, and illnesses. The team met outside of the quarterly review meeting for a number of incidents and injuries that occurred during the quarter including a severe respiratory infection (possibly related to aspiration) and a serious injury requiring 22 sutures which led to an allegation of neglect. He had five falls documented during the quarter. An OT/PT evaluation was requested and completed prior to the quarterly review. He had a serious head injury, though he wore a helmet for protection at all times. His serious injury was reportedly due to self injurious behavior. He had a total of three restraints during the quarter. The quarterly review noted that his PBSP plan approved on 10/10/10 was effective, so no changes were necessary. There was no indication that his risk status was reviewed or revised during the quarterly meeting. His current PSP indicated that he was at low risk in all risk areas even though he had plans in place to address cardiac issues, constipation,	

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		weight gain, aspiration, GERD, challenging behaviors, ulcerative esophagitis, and wore a helmet to prevent head injuries. He was placed in a horizontal restraint during the quarter reviewed, even though his medical assessment indicated that he should not be restrained in any manner that may restrict his breathing. There was no indication that this was addressed by the PST. • The quarterly review for Individual #573 dated 1/31/11 was in the new format developed by the facility. It included a much more specific format for reviewing injuries, incidents, assessments, guardianship, intervention plans, and training. Review of progress towards outcome completion was more detailed, including specific performance graphed for each outcome. • The quarterly review for Individual #560 dated 11/2/10 did not include specific information on outcome implementation. Most outcomes were continued without any information regarding progress or regression. She had two outcomes discontinued due to changes in health status. During the quarter, she was seen in the ER for bleeding and hypotension. She was hospitalized for aspiration pneumonia in September 2010. Her outcomes related to mealtime supports were discontinued and there was a note under diet changes that she was changed to NPO status on 10/12/10. There was no additional information included regarding this change and no specific information on changes in supports needed to address her change in health status. • The quarterly review for Individual #593 dated 1/18/11 indicated that his outcome to visit group homes should be continued. It did not indicate if it had visited any group homes. The implementation date in his PSP indicated unspecified with a note that stated, "if his cousin seeks guardianship, she will have input." Service objectives were continued with no indication of progress or regression. There was very little information included in the quarterly review regarding his health status during the quarter. He did have some changes in health status, but it was not clear how this was addressed by the team. • Individual #166's quarterly review dated 1/27/11 was completed in the new format. It was a comprehensive review of all the services that she was receiving and included all significant updates and changes in health and behavioral status that had occurred during the previous quarter. The PST had implemented a number of changes in response to events throughout the quarter. Effectiveness of the interventions could be tracked easily with the new format. A trend of injuries was identified and an injury prevention plan was implemented. Her PBSP was revised and the quarterly review documented training of staff by the psychologist. The review included a summary of her supervision level, restrictive practices, incidents and injuries, guardianship status, daily schedule, social interactions, community integration activities, and progress towards outcomes.	

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		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. Recommendation throughout this report regarding implementation and monitoring of treatments should be considered when developing the PSP. The quarterly review process was not adequate to meet this provision, but the new quarterly review process was a positive step towards compliance.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	In order to meet the Settlement Agreement requirements with regard to competency based training, QMRPs will be required to demonstrate competency in meeting provisions addressing the development of a comprehensive PSP document. A review of training transcripts for 24 employees indicated that 24 (100%) of the 24 had completed the new training on PSP process entitled Supporting Visions. As noted in F2f, QMRPs were not ensuring that current plans were developed and distributed to staff responsible for providing supports indicating that support staff had not been trained on plan implementation when plans were updated or revised.	Noncompliance
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	Of PSPs in the sample reviewed, all (100%) had been developed within the past 365 days. The facility provided the monitoring team will a list of all PSP date, previous PSP dates, and admission dates • 383 of 387 were revised within 365 days of the previous PSP • Four were new admissions and had been developed within 30 days of admission.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	As noted in F2c, a sample of plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. It was found that 29% of the plans in the sample were not current. Some plans were over a year old indicating that in some cases, PSPs may never have been distributed if developed. This is concerning for a number of reasons. The PSP should be the plan that ensures all support staff have information regarding services, risks, and supports for individuals in the home. Without it, staff do not have the tools that they need to safely and consistently support individuals. One individual in the sample had been admitted within the past year, and his PSP was developed within 30 days of admission as required by the facility policy. The facility indicated in its POI that all new admissions since October 2010 have had a PSP developed within 30 days.	
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.	The facility had developed a tool to monitor PSPs to ensure the development of a comprehensive PSP that addressed all services and supports. 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. QMRPs should be held responsible for not distributing plans in a timely manner and support staff should be trained to notify supervisors when they do not have the tools necessary to safely and consistently provide supports. As noted throughout this section, plans have not been developed that meet the requirements of Section F. An effective quality assurance system for monitoring PSPs was not in place at the facility.	Noncompliance

Recommendations:

1. Develop a system to ensure that PSPs are in individual records and updated as necessary.

2. When key members of the PST are unable to attend meetings, document any attempts to get input prior to the meeting and include recommendations from each team member not present.

3. Provide additional training to PST members on developing and implementing plans that focus on community integration.

4. Conduct comprehensive assessments that identify the individual's preferences, strengths, and supports needed.

5. Focus on developing PSPs that address community integration that is meaningful for each individual based on his or her preferences, interests, and supports needed.

6. All action steps should include individualized supports based on assessment for each individual.

7. The efficacy of all supports, services, and outcomes should be reviewed on a monthly basis and plans should be revised when supports are not sufficient or progress is not being made on outcomes. Plans should also be revised when there are significant changes in the individual's health or behavioral status.

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 DADS draft policy #005: Minimum and Integrated Clinical Services o Organizational chart, undated o LSSLC policy lists, 3/17/11 o List of typical meetings that occurred at LSSLC o LSSLC POI, 4/4/11 o LSSLC Sections G and H Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 4/18/11 o QAQI Council meeting minutes: monthly 10/10 through 4/11 (seven meetings) o Review of records listed in other sections of this report o Review of documentation regarding psychiatry attendance at PSP meetings Interviews and Meetings Held: o Gale Wasson, Facility Director o Dr. Brian Carlin, M.D., Medical Director o Mary Bowers, Chief Nurse Executive o Residential Director and Unit Directors: Keith Bailey, Rotley Tankersley, Glenn Heath, Kenneth Self, Todd Miller o Sherry Roark, Settlement Agreement Coordinator 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 Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o QAQI Council Meeting, 4/18/11 o PSP Meeting for Individual #569 and Individual #368 o Three psychiatry clinics o Morning medical meeting/clinical rounds
	Facility Self-Assessment: The LSSLC POI rated G1 and G2 as in being in noncompliance. The monitoring team agreed with these self-ratings. Determination of a set of activities that are required to demonstrate the provision of integrated clinical care will likely be required if the facility is to meet the requirements of G1.

	Summary of Monitor's Assessment: LSSLC was not in compliance with this important provision. The facility's sole focus regarding section G had been implementation of the new at-risk and aspiration/pneumonia policies and procedures. A focus on this area was good to see, however, much more work will be needed if integrated clinical services are to be provided. A number of specific examples were provided to, or observed by, the monitoring team that showed some ways in which LSSLC was making service provision more integrated across clinical service departments. These examples are provided below. On the other hand, there were a number of areas in which integrated services could be, but were not being, provided. Direct involvement of the facility director will likely be required if this provision is to achieve substantial compliance because, in part, it requires involvement from all of the clinical, and operational, departments at the facility, not only medical and nursing. Achieving the provision of integrated clinical services might make for a good facility wide performance improvement project. A draft of a state policy was reviewed. It addressed a combination of the requirements of both provisions G and H. The content related to section G, however, was merely a restating of the wording from the Settlement Agreement and will, most likely, be insufficient to guide the facility. As a result, the monitoring team recommends specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring.

#	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.	LSSLC was not in compliance with this important provision. The medical director was the facility's lead manager for this provision and he reported that the sole focus regarding section G had been implementation of the new at-risk and aspiration/pneumonia policies and procedures. A focus on this area was good to see. It is addressed in section I of this report. In order to achieve substantial compliance with this provision item, much more work will need to be done. The monitoring team had the opportunity to speak with the medical director and the facility director regarding the importance of integrated clinical services, viewing this as a facility-wide multi-discipline activity, and the need for facility director hands on involvement if substantial compliance is to be achieved. The facility should also consider that this provision refers to a variety of clinical services, not all of which are under the supervision of the medical department. This, therefore, may be an area for a facility performance improvement project or corrective action plan.	Noncompliance

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		Even though an overall facility plan was not in place to address this item, some activities were occurring (see below). A facility policy did not exist, however, a draft DADS statewide policy was available. It addressed both integrated clinical services (section G) and minimum common elements of clinical services (section H). The aspects of the policy that addressed section G were minimal and will not likely be helpful to the facility because the policy merely mimicked the wording of the Settlement Agreement without providing any direction to the facility, such as specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring. The medical director and the facility physicians were not conducting any self-monitoring of provision G. Implementation of self-monitoring will require the delineation of a set of activities in which the SSLCs are minimally required to engage in order to demonstrate substantial compliance with this provision item. The Monitoring Panel expects to work with DADS and DOJ on this over the next few months. This does not mean that the facility should not work towards providing integrated clinical services, only that the medical department consider further delaying its self-monitoring at this time. Examples of integration of clinical services that were observed by the monitoring team, or that were planned to occur, are listed below (in no particular order of importance). • A daily morning meeting at 8:00 am continued to occur. It was attended by the PCPs, psychiatrists, and nurses (CNE, NOO, hospital liaison, ICN, and infirmary nurse manager). • 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 dentist now attended the daily morning meeting at 8:00, too. • Progress was observed in regards to the at risk processes. • The lead psychiatrist initiated what she called a pilot project in home 523. The goal was to have broader, more integrated psychiatric care. • A psychologist attended morning rounds at the infirmary if an individual was admitted for a reason related to behavioral/psychological issues; and the dentist did the same if the admission was related to a dental issue. • Integrated progress notes were being used. • A monthly meeting between the facility director and the PCPs was occurring. This was recommended during the baseline monitoring review, was occurring during the time of the previous onsite review, and continued to be implemented and maintained. • For those individuals who were seen in neurology clinic, there was an accompanying psychiatric notation indicating collaboration and review of the	

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		information. • The OTs and PTs had conducted position and alignment assessments in conjunction with Dental to ensure proper support in the dental chair for examinations and to minimize risk of aspiration. • Habilitation Therapy and nursing had recently collaborated to ensure that nursing had the appropriate plans and equipment to implement safe presentation techniques during medication administration. Other examples indicated that more work needed to be done: • Integration of clinical services was not evident in the written annual PSP document. The narrative should document the team's discussion and illustrate (a) how integration had occurred over the previous year and (b) plans to ensure integration of clinical care was to occur during the upcoming year. In addition, there will continue to be separate plans (e.g., PNMPs, BSPs, nursing care plans), however, the PSPs should identify (in action plans) the objectives of these separate plans, identify who is responsible for implementation, identify who will review data, any modifications of plans, and integration of these plans with other disciplines as appropriate. • The medical director and the CNE noted the difficulty in having the key clinical and medical staff at all required meetings due to scheduling conflicts. For example, PCPs had morning rounds and, therefore, could not attend morning PSP meetings scheduled in the morning. o The facility was planning to begin to track attendance at PST meetings. • Although daily physician meetings included medical, psychiatry and nursing, participation by pharmacy and dental was inconsistent. Habilitation Services did not participate at all. • Psychiatrists were not always informed about behavioral incidents in a timely manner. • Dental needed to work more with psychology. • Collaboration between psychology and psychiatry was only observed at one psychiatry clinic. • The unit directors noted the difficulty many staff had in coping with the complex behavioral and psychiatric presentations of many of the individuals. Psychology and psychiatry departments may be able to help. • Psychiatrists and primary providers were reviewing the recommendations of the QDRRs, but responses were generally not appropriate. • Record reviews indicated that the nurse did not always notify the PCP of acute medical problems in a timely manner. • There was very poor collaboration among departments in the developments of SAPs.	

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		o Psychology was not involved in desensitization plans. o SLPs and language department were not involved in communication SAPs • While there was increased integration between psychiatry and nursing due to the recruitment of a psychiatric nurse, nursing preferred to contact the psychiatrist directly via either telephone or email. This was impractical given that there was only one full time psychiatrist. • With regard to dental services, while psychiatry was receiving a list of those individual's scheduled for TIVA, and reportedly collaborating regarding the use of additional medications, this had not been accomplished with regard to those individual's who were receiving oral or intramuscular medications as pretreatment sedation for dental clinic as ordered by primary care. • Nurses, usually Nurse Case Managers, needed to participating in monthly psychiatric clinic and be prepared to completely and briefly summarize data requested by the psychiatrists. • During the clinical rounds in the infirmary the nurses did not engage in or facilitate a person centered process. Individuals were not informed of the monitoring team's presence or informed of what was getting ready to occur. • OT, PT, and SLP worked in a collaborative manner, however, they did not conduct co-assessment via observation in the homes and day programs to identify potentials for skill acquisition plans and methods to enhance existing programs developed by day program staff.	
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.	As noted in the previous monitoring report, 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, and the requirement to refer relevant information to the PST. The medical director reported that each consultation form had a box to indicate agreement or disagreement and that these boxes were being used routinely. Further, he reported that consultations from the past quarter were discussed at each individual's quarterly PST meeting. Primary providers reviewed consults, initialed, and dated them. The progress notes, however, did not always contain a summary of the findings and documentation of acceptance of the recommendations. Compliance with this aspect of this provision item, however, varied across providers. The nursing department was planning to soon implement a procedure to help the facility	Noncompliance

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		address the very last part of this provision item, that is, whether to refer the recommendation (and information) to the PST. To that end, the nurse case manager was to receive a copy of each consultation note and to discuss it at the next day's sick call. The CNE said that this would put the nurse case manager directly in the information loop and that he or she could then bring any relevant information back to the PST. This new procedure was in response to a recent regulatory deficiency finding. The medical department should maintain a report log that lists all non-facility consultations and tracked them from the date received until the final report was obtained. This listing might be useful to the recordkeeping department for their conduct of quality assurance reviews of the active record (see section V3 below).	

Recommendations:

1. Develop and implement policy.
2. Add to the draft DADS policy by specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring.
3. Develop a system to assess whether or not integration of clinical services is occurring. This will require creating measurable actions and outcomes.
4. Review and consider addressing the many items above in G1 under "Other examples indicated that more work needed to be done."
5. Include a statement regarding the integration of clinical services in each individual's PSP document.
6. Implement the newly proposed procedure for nurse case manager involvement in coordinating non-facility consultations and the PST.
7. Develop and maintain a list of all non-facility consultations, per individual.
8. Consider having the facility director be the lead for this provision.
9. Consider making provision G a facility wide performance improvement project.
10. The nursing and psychiatric departments should coordinate and collaborate to ensure Nurse Care Managers actively participate in monthly psychiatric clinic, with immediate consideration for individuals with high risk ratings related to challenging behavior and/or polypharmacy.

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 DADS draft policy #005: Minimum and Integrated Clinical Services o Organizational chart, undated o LSSLC policy lists, 3/17/11 o List of typical meetings that occurred at LSSLC o LSSLC POI, 4/4/11 o LSSLC Sections G and H Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 4/18/11 o QAQI Council meeting minutes: monthly 10/10 through 4/11 (seven meetings) o Review of records listed in other sections of this report o Review of documentation regarding psychiatry attendance at PSP meetings Interviews and Meetings Held: o Gale Wasson, Facility Director o Mary Bowers, Chief Nurse Executive o Dr. Brian Carlin, M.D., Medical Director o Residential Director and Unit Directors: Keith Bailey, Rotley Tankersley, Glenn Heath, Kenneth Self, Todd Miller o Sherry Roark, Settlement Agreement Coordinator 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 Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o QAQI Council Meeting, 4/18/11 o PSP Meeting for Individual #569 and Individual #368 o Three psychiatry clinics o Morning medical meeting/clinical rounds
	Facility Self-Assessment: The LSSLC POI indicated that all seven provision items were not in compliance, and noted some comments regarding activities that were occurring towards meeting each provision item. The monitoring team concurred with these ratings as indicated below.

	Summary of Monitor's Assessment: Some progress was observed in regards to this provision item, however, over the past six months, the facility's nursing and medical departments' focus was on implementing the new at risk policies and procedures, and improving overall nursing services. As a result, little specific attention was paid to this provision. Even so, a draft state policy was disseminated. Although it was not yet completed, it provided some detailed guidance to the facility regarding provision H (but not for provision G as noted above). It will be important for the facility to include all clinical services, not only medical services, as it works towards addressing the requirements of this provision. It is recommended that the facility's QA department play a role in addressing this provision.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	An overall facility plan was not in place to address provision H of the Settlement Agreement and, therefore, a plan was also not in place to address this provision item. That is, 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 across all areas of clinical service. The CNE reported that annual medical and nursing assessments were being tracked by the facility's data processing staff and that the assessments were done on time. Psychology assessments were recently included to this system, however, psychiatry assessments were not yet part of this system. A method to ensure this provision item was being addressed across <u>all</u> clinical service areas, however, was not yet in place (e.g., also see sections J, K, M, O, P, Q, and R). For this provision item, H1, the state policy listed some details about the regulatory or statutory requirements for a nursing quarterly review, an annual dental exam, a review of behavior control drugs, an annual physical, and a review of risk status. There was nothing in the policy, however, regarding assessments and evaluations for psychiatry, psychology, pharmacy, physical therapy, speech and language therapy, dietary needs, occupational therapy, and respiratory therapy (in this policy, DADS added respiratory to the list of clinical services). Physicians conducted sick call daily. The medical staff completed infirmary rounds daily following the morning meeting. Annual medical assessments were completed but did not contain a plan of care for each diagnosis (see section L).	Noncompliance

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		The facility psychiatrists had performed 16 comprehensive assessments. They had, however, reportedly reviewed the diagnoses of 18 individuals. As stated in the discussion regarding J2 and J13 there was need for substantial improvement. For 19 of 20 individuals reviewed by the monitoring team listed in section M of this report, timely 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. Additionally acute problems were not comprehensively assessed and often provided inadequate follow-up assessments at appropriate/timely intervals. As noted in section I, the nursing assessment data base did not clearly and consistently specify clinical indicators of risk or the frequency of monitoring required for each. Psychology assessments were not consistently complete. Functional assessments were not consistently useful for understanding target behaviors (see section K). As described in Section P, there were a number of individuals who had a change in status, but had not had an OT/PT assessment in many years. A number of individuals had not had a communication assessment in many years.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	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. The CNE reported that the medical department was using ICD codes and that the records department was using the proper coding. Record reviews by the monitoring team also indicated that appropriate ICD 9 nomenclature was used. Psychiatry diagnoses were not yet up to date as required by this provision item. Further, many of the diagnostic revisions reviewed gave brief, unsatisfactory reviews of the diagnostic criteria/symptoms that an individual was experiencing such that a specific diagnosis was assigned. A review of psychology documentation for these same individuals provided greater detail regarding diagnostic criteria, medication risks/benefits, and interventions. This indicated the need for improved collaboration between the disciplines, such that a collaborative case conceptualization can be developed. Nursing assessments summarized active nursing problems, listing them using NANDA	Noncompliance

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		diagnoses, medical diagnoses, and/or descriptively. The use of NANDA diagnoses, however, may not be functional in the SSLC environment. When written plans are used to communicate primarily with other nurses and health care professionals, the use of nursing diagnoses provides valuable/understandable communication. In a setting where the plan is focused on communicating with unlicensed staff and other non-medical providers (i.e., SSLCs), health problems and risks should be provided in clear simple language (e.g., "underweight" instead of "altered nutrition, less than body requirements"). Not all NANDA diagnoses, however, are complex (e.g., "constipation" is a NANDA diagnosis).	
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 or procedure in place to ensure or monitor that treatments and interventions were implemented timely and were clinically appropriate. The facility did not, at the time of this onsite review, have a way to manage this requirement across all clinical service areas. Facility self-monitoring might include an item indicating whether there were any examples of interventions being clinically inappropriate and/or provided later than clinically appropriate. The CNE noted that nursing services had begun to use the statewide revised self-monitoring tools and that the facility had received its first external medical review (see L2 below). The draft state policy listed eight areas of treatment that were to follow various national and/or state guidelines. A ninth area referred to the federal government's guidelines website. The monitoring team, during the onsite review noted that physicians responded to reports of change in status and generally provided appropriate initial care, though follow-up of medical problems was not always adequate (see section L). Health management plans did not consistently address all of the health care needs of the individuals, but ACPs were developed in response to their emergent health care problems and risks. At the end of acute episodes, ACPs were not consistently transitioned to more appropriate long term HMPs (see section M). Increased collaboration between psychiatry, psychology, and nursing would be beneficial, specifically with increased attention to non-pharmacological interventions. Seventy-seven percent of psychological assessments were over 10 years old (see section K).	Noncompliance

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H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	According to the medical director, the facility had developed some of its own clinical protocols and these were submitted to central office. No other initiatives had been conducted related to this provision item since the last onsite review. The draft state policy included a relatively long list of data for the facility to collect and monitor in areas of medical staffing, timeliness of actions, equipment and resources, quality of care severity indices, expected death rates, morbidity, clinical indicators for a variety of conditions, diabetes care, and patient satisfaction. This looked like a good start to assist the facility in meeting this, as well as the other, items of provision H. 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.	Noncompliance
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. Recently, the way in which the facilities determined and managed risk was overhauled. The health status team system was discontinued and managing risk was incorporated into the PSP process (see section I below). Development of state policy may help guide the facility in the determination of a system to effectively monitor the overall health status of individuals, not just their levels of risk. This might include a combination of a variety of information already collected by medical, nursing, pharmacy, and other departments at LSSLC, such as the annual and quarterly medical assessments, nursing assessments, and pharmacy reviews. The activities noted in the draft state policy commented on above in section H4 also apply to this provision item. The addition of a standardized quarterly assessment would assist in the monitoring of health status. As health status had been folded into the PST process, and psychiatry was not a regular attendee, there was cause for concern that the health status with regard to specific psychiatric indicators was not appropriately monitored.	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. Functional assessments had not been modified in response to clinical indicators. PBSPs had begun to be modified based on individual behavior, but much work still needed to be done in this area (see section K).	Noncompliance

#	Provision	Assessment of Status	Compliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	Policies, procedures, and guidelines were not in place regarding Section H and, therefore, this provision item was found to be in noncompliance. State policy was in draft and incomplete format.	Noncompliance

Recommendations:

1. Develop and implement policy. Specifically indicate in the policy how it addresses each of the seven provision items of provision H.
2. Ensure that all clinical services are addressed by the facility, not only medical activities.
3. 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.
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.

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 #006.1: At Risk Individuals dated 12/29/10 o At Risk/Aspiration Pneumonia Initiative Frequently Asked Questions o DADS Risk Assessment Tools, dated 8/31/09 o DADS Integrated Risk Rating Form o DADS Quick Start for Risk Process dated 12/30/10 o DADS Risk Action Plan Form o DADS Risk Process Flow Chart o DADS Risk Guidelines date 12/20/10 o List of individuals seen in the ER or hospitalized since 1/1/10 o List of individuals with fractures since 1/1/010 o List of individuals with pneumonia incidents in the past 12 months o List of 10 individuals with the most injuries o List of all individuals residing at LSSLC and their risk rating levels o List of individuals at high risk for respiratory issues o List of individuals at high risk for choking o List of individuals at high risk for GI concerns o List of individuals at high risk for aspiration o List of individuals that have contractures o List of individuals diagnosed with pica o List of individuals who are non-ambulatory or require assistance with ambulation o List of individuals with poor oral hygiene o List of 10 individuals with the most injuries since the last review o List of 10 individuals causing the most injuries to peers 1/1/10 – 1/31/10 o List of top ten individuals causing peer injuries for the past six months. o List of Infirmary admissions 10/1/10 o List of Incidents and Injuries since 10/1/10 o List of expired individuals since 10/1/10 o List of individuals with unplanned weight loss at six months of $\geq$ 10% o LSSLC "Target" list of individuals requiring aspiration triggers data and date of at risk meeting and identification of all individuals who were enterally fed with pneumonia history, and pneumonia tracking 4/1/10-3/18/11 o List of individuals who receive nutrition enterally o List of individuals with MRSA, Hepatitis A, B, and C, HIV, Positive PPD and converters, H1N1, C diff and STDs o List of all individuals residing at LSSLC and their risk rating level in the o List of individuals at risk of aspiration, cardiac, challenging behavior, choking, constipation,

dehydration, diabetes, GI concerns, hypothermia, injury, medical concerns, osteoporosis, polypharmacy, respiratory, seizures, skin integrity, urinary tract infections, and weight, i.e., risk areas identified in previous at risk policy
- PSPs and assessments for:
  - Individual #538, Individual #498, Individual #144, Individual #504, Individual #290, Individual #470, Individual #560, Individual #45, Individual #170, and Individual #410
- Records of the following individuals including their Health Risk Assessments and HST Coordinator correspondence, data and completed reviews from 10/1/10-4/15/11:
  - Individual #010, Individual #011, Individual #096, Individual #146, Individual #102, Individual #057, Individual #267, Individual #398, Individual #258, Individual #353, Individual #535, Individual #310, Individual #345, Individual #389, Individual #245, Individual #202, Individual #141, Individual #285, Individual #569, Individual #371, Individual #310

<u>Interviews and Meetings Held</u>:
- Informal interviews with various individuals, direct support professionals, program supervisors, and QMRPs in homes and day programs;
- Lisa Currington, Employment Services Director
- Sylvia Middlebrook, PhD, Director of Psychology
- Luz Carver, QMRP Coordinator
- Stacie Cearley, Incident Management Coordinator
- Royce Garrett, Consumer and Family Relations Director

<u>Observations Conducted</u>:
- Observations at residences and day programs
- Morning Medical Meeting 4/19/11
- Castle Pines Morning Unit Meeting 4/19/11
- Daily Incident Management Review Team Meeting 4/19/11, 4/20/11, and 4/21/11
- Human Rights Committee Meeting 4/20/11
- Annual PSP meetings for Individual #593, Individual #162, Individual #569, Individual #253
- PST Integrated Risk Rating demonstrations for Individual #166 and for Individual #245

Facility Self-Assessment:

The facility POI indicated that the facility was not yet in compliance with the provisions of section I. The facility acknowledged that it was in the initial stages of implementation of the new at risk process that was designed to meet the provisions of section I. The POI indicated that teams continued to meet, discuss risks, and develop plans to reduce risk. The monitoring team was in agreement with these self-ratings.

Summary of Monitor's Assessment:

	The state had taken a number of steps to support positive results in the area of risk management. This included: • The state policy addressing risk had been revised. It was approved 12/29/10 and implementation began prior to the monitoring visit at LSSLC. The new policy included changes in evaluating and addressing risks identified for individuals. • Forms had been revised for identifying risk, and a risk action plan had been developed. • Risk Guidelines had been developed to be used by PSTs in rating risk factors. • A new initiative had been implemented to address aspiration pneumonia. A tool had been developed to identify individuals at risk for aspiration. Risk categories included Seizures, Challenging Behaviors, Fluid Imbalance, Osteopenia/Osteoporosis, Skin Integrity, Weight, Respiratory compromise, Constipation/Bowel obstruction, Falls, Fractures, Aspiration, UTIs, Polypharmacy/Side effects, GI Concerns, Cardiac Disease, Circulatory, Diabetes, Choking, Hypothermia, Infections, and Dental. The at-risk process underwent significant revision designating each individual's PST responsible for risk assessment and management, as well as ongoing risk review and addressing changes in status. Not only would the PST identify health and behavioral risks and their level of severity, but would assure appropriate plans were developed and implemented as planned in order to reduce risks and improve quality of life. The revised at-risk process identified collaboration and assistance with the BSC and PNMT in developing plans for individuals at high risk, who were not stable or for whom the team has requested assistance. Implementation of the revised process began in late January 2011. Training on the new process was provided to all PST members by 1/13/11. Training was not competency based, even for the PST leaders, the QMRPs. An onsite review of two PSP meetings was conducted by DADS state office representatives on 2/22/11 to observe the risk assessment process and offer technical assistance to the facility. The hope is that this process will more accurately describe risks for particular individuals and ensure services and supports necessary to protect each individual will be put into place. As noted throughout Section I, the monitoring team did not find that PSTs were accurately identifying risk for individuals, even with the new process. 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.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management	The new state policy, At Risk Individuals 006.1, required PSTs to meet to discuss risks for each individual at the facility. The facility was mandated to have its risk assessments/risk ratings using the new At Risk Process completed at each of the regularly scheduled next quarterly PST meeting held between 1/1/11 and 5/31/11. The at-risk process was to be incorporated into the PST meeting and the team was required to develop a plan to address risk at that time. The determination of risk was expected to	Noncompliance

#	Provision	Assessment of Status	Compliance
	system to identify individuals whose health or well-being is at risk.	be a multi-disciplinary activity that would lead to referrals to the PNMT and/or the behavior support committee. A list of indicators for each of 21 risk areas had been identified by the new state policy and each was to be rated according to how many risk indicators applied to the individual's case. The new policy had expanded the number of risk areas being addressed by this process to include choking, aspiration, respiratory compromise, weight, cardiac disease, circulatory, constipation/bowel obstruction, diabetes, gastrointestinal problems, osteoporosis, seizures, skin integrity, infections, polypharmacy, challenging behaviors, falls, fractures, fluid imbalance, hypothermia, urinary tract infections, and dental status. A risk level of high, moderate, or low was to be assigned for each category. The facility had identified a target list of individuals with a history of pneumonia and/or aspiration pneumonia and/or received enteral nutrition as priority individuals for identification of aspiration risk. There were 106 individuals (27% of all individuals at LSSLC) identified as being at risk for aspiration. Of the 106 individuals identified as being at risk, 16 (15%) were identified as being at high risk (Level 1), 25 (24%) at medium risk (Level 2), and 65 (61%) at low risk (Level 3). A list of all individuals hospitalized since 1/1/10 indicated that 19 individuals had been hospitalized due to pneumonia/aspiration pneumonia since 1/1/11. Of those 19 individuals, six appeared to have not been identified as being at the appropriate risk level for pneumonia/aspiration. • Individual #511 was discharged from the hospital on 2/4/11 with a diagnosis of aspiration pneumonia. He was not on the list of individuals identified as at risk for aspiration, though he had been discharged from the hospital on 7/20/10 with a diagnosis of pneumonia. • Individual #232 was not on the list of individuals identified as at risk for aspiration. He was discharged from the hospital on 8/19/10, 2/18/11, and 4/8/11 with diagnoses of aspiration and/or pneumonia. • Individual #172 was admitted to the hospital on 3/24/11 with a diagnosis of aspiration pneumonia. He had been discharged from the hospital on 7/1/10 with a pneumonia diagnosis. He was not identified as being at risk for aspiration. As of 3/10/11, a total of 95 individuals at the facility had risk assessments completed utilizing the new process. Fifty-two of those were on the list of individuals identified as being at risk for aspiration. It was expected that all individuals will have gone through the new risk assessment process by 5/31/11.	

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		The monitoring team met with the PSTs for Individual #166 and Individual #245 during the review week to observe and discuss how the teams assigned risk ratings. The monitoring team appreciated the PSTs' willingness to conduct this type of discussion with the monitoring team. In both meetings, the teams reviewed the list of risk areas that had been developed by the state office. Comments from the monitoring team are summarized below: • The reading of pre-determined risk ratings from previous meetings appeared to result in the lessening of active participation by attendees. • The discussion of high versus medium risk, and the availability of PNMT and BSC were new to LSSLC PSTs. • Nurses need to have a high level of participation and advocacy regarding nursing and medical issues. • Consider that important risk issues for a particular issue can be classified in the "other" category to highlight its importance, especially for challenging behaviors, such as flight/running away. Observation of annual PSP meetings scheduled the week of the review showed that PSTs had just begun this new process and were still experimenting with how to integrate the new risk identification process with the new PSP development process. This was a fairly smooth process for most of the meetings observed. QMRPs were responsible for attending meetings and facilitating the risk discussion. At meetings observed, the monitoring team observed some meaningful multidisciplinary discussion occurring during most of the PSP meetings observed. Teams were attempting to identify risk and weave that information into the discussion regarding supports needed for the individual to achieve his or her desired outcomes. Teams, however, were not accurately identifying risks for most individuals and adequate plans were not in place to minimize those risks. During the onsite review, the monitoring team had the opportunity to observe the PSP meeting regarding Individual #368. Team members including the individual's guardian (via telephone) were participating. Team members who were absent included the primary care physician and the psychiatrist. With regard to health risk status, the nursing case manager reviewed the categories, by reading out loud the risk category and the assigned rating, however, there was no discussion regarding the various categories other than when initiated by the individual's LAR. The PSP for individual #593 was observed during the monitoring visit. All relevant disciplines were represented at the meeting. The nurse case manager reviewed each risk category and waited for input by other team members before assigning a risk rating. There was some discussion around several risk areas and the team debated the risk	

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		rating in a few areas. The team discussed the efficacy of supports in place for each risk. The team expressed some concern that he may not be getting enough to drink during the day to stay properly hydrated. After some discussion and brainstorming, it was suggested that he should be given a bottle of "Crystal Light" to carry with him during the day. The team had to request an order to be written by the dietician before they could implement the plan. Policies that restrict the routine preventative activities that individuals in the community do to reduce their risks contribute to placing individuals residing at the facility at risk. Individual #569's PSP meeting, incorporating health risk identification and rating utilizing the new policy, was observed by the monitoring team. The Integrated Risk Rating Form was utilized and the health status data summaries and clinical indicators (rationale) initially provided by team members were objective and included most of the data to support the ratings. The PST did discuss factors related to her risks that went beyond the scope of the items listed in the Risk Guidelines, including her overriding issue, deterioration associated with her neurological degenerative condition, tuberous sclerosis. Individual #225's risk ratings were reviewed at his quarterly meeting during the monitoring visit. There was discussion around his challenging behavior and whether or not the team should assign a moderate or high rating in this area. The team changed his risk rating for challenging behaviors from moderate to high and increased his risk rating for injuries to moderate due to injuries that might occur during times when he exhibited challenging behavior. He was living in a locked home due to his challenging behaviors, which would indicate that he was at high risk. The team discussed his health issues and assigned appropriate risk ratings in each area. The individual contributed to the discussion regarding his needs. The meeting was a good example of integrated discussion among disciplines to identify all areas of risk and ensure plans were in place to address risks. The annual team meeting was observed for Individual #162. Risk factors were integrated into an overall discussion regarding her preferences and supports needed. It was evident that all team members knew her well and all contributed to the discussion. It was difficult to determine which discipline each team member represented because they all contributed information on each topic discussed. This was a nice example of how integrated discussion by the team can lead to integrated supports for the individual. A sample of 10 new style PSPS developed using the new person centered planning process was reviewed to determine if risks were being properly identified by PSTs. • The PSP for Individual #45 included a discussion of her health care risks and	

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		how those risks would be monitored. Although not specifically stated in her PSP, the team had determined that she was at medium risk for constipation, fluid imbalance, and UTIs. According to the facility risk list, the team had also determined that she was at low risk for aspiration, behavioral challenges, cardiac issues, dental, diabetes, falls, fractures, GI, hypothermia, infection, osteoporosis, polypharmacy, respiratory, seizures, skin integrity and weight. She had a diagnosis of chronic kidney stones and proteinuria. Her PSP noted that she would need routine follow up with a nephrologist and the dietician. The PSP did not describe symptoms that support staff should monitor, to know when follow up may be required by health care professionals. She had acne that was being monitored by the dermatologist and her PCP was monitoring her thyroid levels. She had health management plans for constipation and acne. Her plan also noted that she used a gait belt for stand and pivot transfers. Her plan did not indicate that she was at risk for aspiration, though the facility aspiration list indicated that she was at low risk for aspiration. Her PSP directed staff to cut her food in one inch bites as recommended by her OT/PT assessment. The PST referred her for an updated PNM assessment in March due to coughing during mealtime. The PST met on 3/30/11 to review recommendations from the updated assessment and revise her PNMP and dining plan. • The PSP for Individual #470 indicated that she was at medium risk for hypothermia, polypharmacy, and dental. It was determined that she was at low risk for diabetes, aspiration, choking, and GI problems. She had g-tube placement this year after a modified barium swallow study indicated that she was no longer able to swallow safely, thus indicating that she was at high risk for aspiration and choking. She was diagnosed with type II diabetes in the past year which should have elevated her risk level in that category. She also had health management plans for chronic constipation and hypertension though the team had determined that she was at low risk in both of these areas. She was taking medication for hypertension and her blood pressure was monitored regularly, but nursing assessments indicated that her blood pressure had not remained stable over the past year. She was also taking medication for constipation and had received 12 enemas over the past year for constipation, indicating that this was not a stable condition either. The team needs to reevaluate her healthcare risk and assign ratings that reflect her true level of risk. Supports necessary to reduce her risk should be clearly outlined in her PSP. Support staff should be trained on identifying symptoms and providing supports to reduce her risk. • It was not evident that a risk assessment had been completed for Individual #170. His PSP did not summarize risk levels and his name did not appear on the summary of risk ratings provided by the facility. Information in his PSP indicated that he was at high risk for challenging behaviors and polypharmacy.	

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		Additionally, he was at risk for poor oral hygiene, UTIs, elevated cholesterol, hypotension, seizures, and injury. • Individual #144 was also not identified on the facility's list of individuals at risk. There was no indication that the PST had formally reviewed his risk ratings in all areas, however, the plan did describe his current risks and supports needed in a number of areas. Protections and supports were described in his PSP for seizures, falls, injuries, skin integrity, weight gain, and high cholesterol. • The annual PSP for Individual #498 indicated that the team had determined her risk levels to be low in all areas. She was taking Depakene, Thorazine, and Trazodone. Her risk for polypharmacy was not discussed in her PSP. She had a PBSP in place to address challenging behaviors. This also was not identified as a risk by the team, but supports necessary to address her challenging behaviors was described in her PSP. • The PST had determined that Individual #560 was at high risk for aspiration, choking, respiratory, and cardiac issues. It was determined that she was at medium risk for constipation, infections, oral hygiene, osteoporosis, polypharmacy, seizures, skin integrity, and UTIs. Her PSP noted that she had health management plans in place for her G-tube, ear infections, skin integrity, hypothermia, and seizures. It further noted that these plans were monitored monthly by the RN Case Manager. Generic service objectives stating that she would be "free of symptoms related to" were developed to address many of her health care risk. Her plan did not identify signs and symptoms that direct support staff needed to monitor to reduce her health risks. • The PSP for Individual #538 did not indicate risk level ratings had been assigned, but did include a summary of areas in which he was at risk. He was not identified as being at risk in any area on the facility's risk list. Information in his PSP indicated that he was at risk for seizures, falls, injuries, challenging behavior, adrenal insufficiency, anemia, and constipation. The PSP included generic outcomes to address his dental health, seizures, and falls. He had a PBSP in place to address his challenging behaviors. The team needs to meet and assign accurate risk ratings. Plans should be developed to implement supports necessary to reduce his risks in any areas identified by the team as risk areas. • Individual #410 was also not identified on the facility's risk list for being at risk in any area. His PSP indicated that he was at risk for choking and had been placed on a modified texture diet. He was on a weight reduction plan monitored by the dietician due to his risk for weight gain. His plan noted that he was at high risk for polypharmacy. The plan stated that the psychiatrist was aware of this risk and monitored his medications. He had a PBSP and safety plan in place and was at high risk for challenging behaviors. His plan did not discuss his risks for injury though the facility's injury list indicated that he had 95 injuries	

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		documented since 1/1/10, two of which were serious injuries requiring sutures. • Individual #504 was identified on the facility's risk list as being at high risk for dental and polypharmacy. The list indicated that the team had determined he was at low risk for aspiration, challenging behaviors, cardiac issues, choking, circulation, constipation, falls, diabetes, fluid imbalance, fractures, GI concerns, hypothermia, infections, osteoporosis, seizures and respiratory issues. His PSP described supports needed to address his challenging behaviors, risk for choking, and risk for falls. His diagnoses were included in his PSP along with some basic information on plans to monitor his health. His plan did not include signs and symptoms that staff would need to be familiar with and monitor to ensure his health and safety. He had service objectives in place to address his skin integrity, dental health, and seizure activity. Other risk areas were not addressed. The team needs to meet and discuss his range of risk with input from all disciplines. They will need to develop a comprehensive individualized plan to address all areas of risks and supports necessary to ensure his safety and health. • The PSP for Individual #290 was a good attempt to integrate the discussion of risks and supports needed into one comprehensive plan. Most of his risks were identified and the plan described how he should be supported throughout his day to minimize those risks, however, not all risks were in line with information included in his assessments. Most significantly, his nursing assessment indicated that he was at medium risk for aspiration pneumonia. This was not addressed in his PSP. The facility's list of individual's risk ratings did not coincide with information in his PSP or assessments. The list indicated that he was at high risk for polypharmacy and low risk for aspiration, challenging behaviors, choking, circulation, constipation, diabetes, falls, fluid imbalance, fractures, GI concerns, hypothermia, infection, osteoporosis, respiratory issues, and seizures. The team needs to meet and reassess his risk level in each area. Plans should be implemented to address in areas identified by the team. Support staff will need to be trained on plans and made aware of any signs or symptoms that might identify areas of risk. Other inconsistencies noted in regards to risk ratings included: • Individual #419 was not identified on the facility risk list as being at risk in any category. She had been hospitalized three times since 9/5/10. Her discharge diagnosis indicated that she was discharged on 9/17/10 after treatment for constipation, on 12/22/10 after 22 days in the hospital with constipation and a UTI, and again on 3/22/11 with a UTI after four days in the hospital. She was also treated in the emergency room for constipation on 11/11/10. The facility, however, later reported that an at-risk meeting was held on 3/25/11. • Individual #52 was rated as low risk for aspiration, but had been hospitalized on	

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		6/3/10 and again on 12/16/10 for pneumonia. • Individual #288 was listed as low risk for aspiration, also. She was hospitalized on 6/19/10 and 10/24/10 with pneumonia. Numerous additional examples are listed in section M5 below. The facility was not yet in compliance with this provision of the Settlement Agreement, but it was noted that they were attempting to address this provision and put safeguards in place for individuals at the facility. It is expected that all individuals at LSSLC will have gone through the new risk identification process by the time of the next monitoring visit. The facility needs to ensure that present risk assignments are reviewed for accuracy and adequate plans are in place to address all risks.	
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 new At Risk policy required that when an individual was identified at high risk, or if referred by the PST, the PNMT or BSC was to begin an assessment within five working days if applicable to the risk category. The PNMT or BSC was required to assess, analyze results, and propose a plan for presentation to the PST within 14 working days of the completion of the plan, or sooner if indicated by risk status. As noted in section I1 above, not all risks were identified by the PST. In addition, health risk ratings were not consistently documented. 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 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. The facility was not yet in compliance with this provision item.	Noncompliance
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	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the PST. It required that the PST implement the plan within 14 working days of completion of the plan, or sooner if indicated by the risk status. 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. The new policy required that the follow-up, monitoring frequency, clinical indicators, and responsible	Noncompliance

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	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.	staff will be established by the PST in response to risk categories identified by the team. Throughout the monitoring visit, direct support professionals were asked questions by the monitoring team about risks for individuals whom they supported. Staff were generally able to accurately identify risks or identify supports needed to monitor those risks. As noted throughout this report, intervention plans were often not carried out as written, therefore, individuals remained at risk. 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. As noted in section F of this report, a sample of individual records was reviewed in various homes at the facility. Current PSPs were not available in 29% of the records. 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.	

Recommendations:

1. 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.

2. The facility should assure all PSTs are provided with training and ongoing technical assistance on implementation of the At Risk policy and its incorporation into the new PSP process. QMRPs/Team leaders should be provided with competency based training and job coaching on implementation of the At Risk policy and its incorporation into the PSP process.

3. Ensure that risk rating accurately reflect risks identified through the assessment process.

4. Update facility risk list to include ratings assigned by each PST.

5. Ensure that plans to address risks are individualized to address specific supports needed by each individual identified as at risk.

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

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 and procedures addressing the use of pretreatment sedation medication. o List of individuals who received pretreatment sedation medication for medical or dental procedures, including date , dosage, and whether a plan was in place to minimize the need. o Examples of five dental desensitization plans. o A spreadsheet of individuals prescribed psychotropic/psychiatric medication, including residence, 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 dosage and duration of use. o A list of individuals prescribed anticholinergic medications, including dosage and duration of use. o A list of individuals prescribed intra-class polypharmacy, including the medications prescribed. 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 Spreadsheet of individuals who have been evaluated with the MOSES and DISCUS scores, with dates of completion for the last six months 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, Reglan o List of new admissions since 1/1/10 and whether a Reiss scale was used. o Spreadsheet of all individuals who have had a Reiss screen completed, include date of completion of each one. o List of individuals who (in the past six months) have been referred for a psychiatric evaluation as a result of an elevated score on the Reiss screen. o A list of families/LARs who refused psychiatric treatments and/or medication recommendations. o Description of availability of genetic screening for individuals. o A list of all meetings and rounds typically attended by the psychiatrist, including any information regarding the psychiatrists' attendance at the PST, PSP, PSPA, and BSP meetings. o A list and copy of all forms used by the psychiatrists. 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 Description of administrative support offered to the psychiatrists including psychiatric assistants and psychiatric nurses that are specifically assigned to the Psychiatry Department.

	o Since the last onsite review, a list/summary of complaints about psychiatric and medical care made by any party to the facility. o CVs of all psychiatrists, including any special training such as forensics and disabilities o Overview of psychiatrists' weekly schedule. o For the last six months, a list of any individuals for whom the psychiatric diagnoses were 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 List of all individuals age 18 or younger (include DOB) who received psychotropic medication. o For the past six months, minutes from the committee that addressed 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. <u>Additional Documents Reviewed That Were Requested Onsite</u> o Copy of the presentation book for this section o Documentation of the PSP meeting regarding Individual #368 o Tracking/attendance data for psychiatry at PSP meetings for the previous six months 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 #170, Individual #57, Individual #135, Individual #370 and Individual #300 o All psychology data presented and other information provided by the psychiatry assistant and doctor's progress notes from Dr. Vyas' clinic for the following individuals: • Individual #290 and Individual #453 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 #119, Individual #300, Individual #279, Individual #166, Individual #256, Individual #51, Individual #410, Individual #301, Individual #385, Individual #538, and Individual #162 o Examples of informed consent performed by psychiatry for: • Individual #285, Individual #320, Individual #410, Individual #504, Individual #131, Individual #271, Individual #484, Individual #279, and Individual #91. o Five examples of consultation provided to the psychiatrist by the psychiatric nurse regarding: • Individual #271, Individual #529, Individual #345, Individual #490, and Individual #504 o These documents: • Demographic data sheet • Health data (most recent History and Physical) • Labs/EKG for the previous six months • Psychiatry section (for the previous six months including comprehensive psychiatric evaluation)

	• MOSES/DISCUS (last six months) • Pharmacy Drug Regimen Review (last six months) • All consults • Physicians Orders (last six months) • Integrated Progress Notes (last six months) • Last Nursing Comprehensive Assessment • Positive Support Plan (PSP) and reviews • Psychotropic Medication Consent • Behavioral Support Plan (BSP) and attached data • Restraint Checklists (last six months) o For the following individuals: • Individual #43, Individual #323, Individual #407, Individual #99, Individual #271, Individual #166, Individual #57, Individual #138, Individual #60, Individual #490, Individual #368, Individual #245, Individual #410, Individual #170, Individual #91, and Individual #131 <u>Individual Interviews and Meetings Held</u>: o Vasantha Orocofsky, M.D., Director of Psychiatry o Louis Kavetski, D.D.S., Dental Director o Judd Williamson, R.N., Psychiatric Nurse o Kacie Collins, Psychiatric Administrative Assistant o Nicole Lamb, Psychiatric Assistant o Luz Carver, Director of QMRP services o Shyam Vyas, 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 <u>Observations Conducted</u>: o Risk Meetings for Individual #245 and Individual #166 o Observation of psychiatry clinic with Dr. Buckingham for: • Individual #199, Individual #9, Individual #161 o Observation of psychiatry clinic with Dr. Orocofsky for: • Individual #170, Individual #57, Individual #135, Individual #370, Individual #300 o PSPA for Individual #57 o Observation of psychiatry clinic with Dr. Vyas regarding: • Individual #290 and Individual #453 o PSP for Individual #368 o Morning medical report

	o Polypharmacy Committee Meeting
	Facility Self-Assessment: The facility's self-assessment, its POI, for section J indicated substantial compliance in one area, J1 (having qualified psychiatric physicians). 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. With the exception of J1 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, in the intervening period since the previous monitoring visit, there was a reduction in the available full-time equivalent psychiatrists from 2.25 to 1.45. The four physicians currently accounting for 1.45 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. In an effort to provide assistance for the one full-time physician, additional staff including a psychiatric nurse, psychiatric assistant, and psychiatric administrative assistant had been hired and trained. 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. Unfortunately, psychology was not present in this discussion, so while the physicians were integrated in this area, the integration did not expand to the remainder of the team. 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 for all but newly prescribed psychotropic medications, 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). It was apparent that, in general, staff from both disciplines were unaware of how they could either provide information or extract information from the other. Positively, 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 while that staff overall were caring and invested in the treatment of the individual and had the desire to see the individual benefit from treatment, the facility was lacking a system of psychiatric care that was integrated with medical, psychology, dental, pharmacy, nursing, QMRPs, direct care staff, or with the individual. While some of these integration challenges were attributable to a lack of clinical staff resources, there were also some cultural barriers to making changes to the manner in which the various disciplines interact which will need to be addressed by facility leadership.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	LSSLC had a total of 1.45 FTE (full-time equivalent) psychiatrists. All four physicians who were responsible for providing psychiatric treatment were board certified 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, two of the part-time physicians had been providing care at the facility for an extended period of time, and one had been providing services since 2003. A third part-time physician had joined the psychiatry department approximately six weeks prior to this monitoring review. The one full-time psychiatrist had been employed by the facility since May 2010 and had been designated as the Director of Psychiatry and performed administrative psychiatric functions as well as having clinical responsibilities. It should be noted that the facility had experienced a reduction in the number of available FTE. In the previous monitoring report, the facility had two full-time psychiatrists providing services for a total of 2.25 FTE, however, in the intervening period, this had reduced to 1.45 FTE with the loss of one full-time physician and the gain of one part-time physician. With the exception of one psychiatrist who had been providing services at the facility for an extended period of time, the others were in the process of developing a working relationship with the teams in order to begin the provision of clinical services that were integrated into the team process. Given the number of part-time providers, it will likely be a challenge for the physicians to effect full team integration without the benefit of considerable time. With respect to the full-time physician, the recent implementation of a "pilot program" which incorporated an enhanced team presence and new documentation requirements for psychiatry clinic was a good start, however, both the	Substantial Compliance

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		physician and team members will need to adjust to the changes in interdisciplinary interaction made necessary by this type of clinical encounter. Practicing psychiatry in a supported living center is different than clinical practice in other settings. It may be helpful to provide the newer physicians with some mentoring from other physicians who are more experienced in the supported 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 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.	
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 (16 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 16 records of individuals at LSSLC revealed varying quality of the documentation in the quarterly medication reviews. There were rare detailed descriptions of the justification for the use of specific psychopharmacological agents located in 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. There remain concerns with regard to the facility's ability to meet the requirements of this provision, given the limited clinical consultation time available. In the period since the previous monitoring report, the facility experienced a reduction in psychiatry full time equivalents from 2.25 to 1.45. With this reduction in available staff, current providers were struggling to retain the status quo of services. The recent addition of a psychiatric nurse was helpful, however, additional staff were needed. Once the facility has an appropriate complement of clinical staff, they could consider quality assurance monitoring and/or the implementation of a peer review process for psychiatric	Noncompliance

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		documentation. For further discussion regarding diagnostic practices, see the discussion below in sections J6 and J10.	
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. 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. The review of psychiatric documentation revealed inadequate case formulations and inadequate justification for treatment with psychotropic medication. 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 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 PST meetings revealed 27 examples of psychiatry participation in the PSP process between the dates of 11/10/10 and 4/6/11. As this indicated attendance over a period of approximately five months, extrapolation of these data revealed that in a 12 months period, the psychiatrist would attend 64.8 PST meetings. Given that 208 individuals were receiving psychiatric services at the time of this monitoring review, it was apparent that the psychiatrist's attendance at PST meetings, while compromised by the lack of available clinical staff, was woefully inadequate (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 16 charts available for review, only 25% included a BSP, and the list of individuals prescribed psychotropic	Noncompliance

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		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's 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. It was notable that although the BSP documents available for review did not document psychiatry input or include a signature from the psychiatrist, information regarding the individual's diagnosis, medication regimen, medication side effects, medication changes over the previous year, and medication adjustment plan were included in the BSP. This information must be developed in consultation or collaboration with the individual's treating psychiatrist, and appropriately included in the comprehensive psychiatric assessment/quarterly psychiatric reviews. While inclusion of this information in the BSP was understandable, it must be authored in collaboration with the psychiatrist as a participant. 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 (for further discussion regarding this issue, please see the discussion regarding J13). During the onsite review, the monitoring team had the opportunity to observe the PSP meeting regarding Individual #368. Team members including the individual's guardian (via telephone) were participating. Team members who were absent included the primary care physician and the psychiatrist. With regard to health risk status, the nursing case manager reviewed the categories, by reading out loud the risk category and the assigned rating, however, there was no discussion regarding the various categories other than when initiated by the individual's LAR. In the discussion regarding the individual's behavioral challenges, reportedly, this individual had experienced increased incidents of physical aggression from 86 in the prior year to 134 in the current year. There was little discussion regarding the etiology of the increased frequency of physical aggression as the psychologist stated that she had not graphed the individual's data because this individual had only been assigned to her caseload for "a few months…and I am not familiar with what happened with him." Unfortunately, this lack of preparation	

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		for meetings was observed not only in the PST meeting, but also in psychiatry clinic (for additional information please see the discussion regarding J13). On the other hand, a second data point, pica, had reduced from 15 incidents to eight incidents. The psychology staff discussed, in detail, plans for replacement behavior training focusing on pica. A review of documentation regarding the last 10 individuals who required chemical restraint revealed six instances in the period between 9/1/10 and 2/28/10. These six instances were attributable to two individuals, who, per data, received three chemical restraints each: • Individual #410 received intramuscular injections of Ativan ordered by the primary care physician on 11/12/10 and 11/14/10. This individual was next seen by psychiatry 11/16/10. A third episode of chemical restraint dated 11/27/10, also ordered by primary care, was followed by psychiatric consultation 11/30/10. In both psychiatry consultations, the psychiatrist was aware that additional medication had been administered and made attempts to address the individual's increased behavioral challenges. • Individual #99 received Diastat per rectum three times per the order of the primary care physician. This was due to apparent agitation following a prescription of sudafed, a medication used to decrease nasal congestion that is frequently agitating to individuals. This individual was seen by psychiatry on the day of the event. Psychiatry documented consultation with psychology and attempts to address the individual's challenges both behaviorally and via medication adjustments. A review of the documentation provided revealed good documentation from psychiatry regarding the justification for the utilization of additional medication. As psychiatry was now involved in the process, the need for increased collaboration between psychiatry and psychology in the behavioral management of crisis behavior was apparent.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-	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 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 approximately equal to other incidents requiring restraint (e.g., emergency, programmatic, protective). For example, for the period of 9/1/10 to 2/28/11 there were reportedly 343 restraint incidents on campus. Of these, 161 (46.9%) were the result of pretreatment sedation for medical or dental services.	Noncompliance

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	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.	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 in the absence of input from psychology staff. 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. The dental clinic staff was, however, making other attempts with regard to dental desensitization. They had created a video, from the perspective of the individual, showing the individuals what they could expect at dental clinic. Copies of the video had been given to the individual's residence, however, dental staff were not certain if the video was shown to any of the individuals. Documentation of the coordination of the pretreatment sedation process with psychiatry specifically related to TIVA was located in some charts during the previous monitoring review. Records requested for this monitoring period included one individual who had received TIVA. Unfortunately, the copied record did not include documentation on or about the date that TIVA was ordered. 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. In addition, per an interview with the facility dental director, the anesthesiologist performing TIVA at the facility was provided with both the listing of individuals scheduled for TIVA, as well as their medication regimen for review, two weeks prior to the scheduled TIVA session. 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 period of time between 9/1/10 and 2/28/11, there were 88 individuals who received pretreatment sedation for medical or dental procedures. Of these, 58, or 65%, were	

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		concomitantly prescribed psychotropic medications. 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. It could be helpful if the facility developed a consultation system formalized in policy and procedure that required documented input from dental, primary care, psychiatry and clinic pharmacology prior to the use of pre treatment sedation. This process was being utilized successfully at other DADS facilities.	
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. One physician was providing 40 hours of service, working four days per week, 10 hours each day. This physician was a board certified adult psychiatrist, and had been designated as the facility lead psychiatrist. Given that this physician was the only full time psychiatric provider at the facility, she was overwhelmed by both administrative and clinical duties. Recently, a psychiatric nurse, psychiatric administrative assistant and psychiatric assistant had been added to the department. The added staff should be an asset to the psychiatrist, however, as discussed in the ensuing paragraphs, additional clinical staff was needed. A second psychiatrist, board certified in adult psychiatry, was providing one day of clinical services per week, eight hours per day. A third psychiatrist, board certified in both adult and child psychiatry, was providing one day of clinical services per month, eight hours per day. A fourth psychiatrist, board certified in adult psychiatry and board eligible in child psychiatry, was providing one day of clinical services per week. These four physicians accounted for a total of 1.45 full-time equivalents (FTE), a reduction from 2.25 FTE at the time of the previous monitoring review. As discussed in the remainder of this section, there were many areas where improvements were needed. Given the paucity of psychiatric staff, it was not surprising that the facility continued to experience difficulties in many areas. At the time of this monitoring review, there were 208 individuals prescribed psychotropic medication. With this volume of individuals, it was uncertain what the optimal number of FTEs would be for this facility. 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	Noncompliance

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		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 208 individuals assigned to the psychiatric clinic. As medication reviews were being performed quarterly, this equated to 34.6 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 17.3 annual psychiatric evaluations per month. Allowing for three hours per re-evaluation, this equals 51.9 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, emergency consultations, or attendance at meetings, (e.g., polypharmacy committee, behavior therapy committee, physician's meetings, behavior support planning), and/or any other clinical activity, 86.5 physician hours were consumed by clinical consultation. This indicated that 20.6 hours of physician time per week (or 0.5 FTE) are required for this activity (allowing for a total of 4.2 weeks per 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. Further, given the facility's recent designation for admissions of individuals under age 18, the need for child and adolescent psychiatry must be anticipated, such as the addition of a psychiatrist with dual board certification (or eligibility) in both adult and child psychiatry. 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 revealed a document entitled "Psychiatry Services Procedure Manual" dated 3/15/11. Per this document, which was reportedly based on the overarching DADS psychiatric services policy, "The documentation of the psychiatric evaluation must follow the format in Exhibit A." A review of Exhibit A revealed that this document was the same as Appendix B. Per the facility generated Plan of Improvement dated 4/4/11, "Implementation of Appendix B/Comprehensive Psychiatric Evaluation are being done and began as of 4/1/11. Over the past six months ten psych assessments have been completed." A listing of all individuals evaluated per Appendix B (Exhibit A) was requested. This list contained the names of 15 individuals. A review of 10 completed comprehensive evaluations revealed that the dates of evaluation were between 12/14/10 and 4/7/11. The dates of completion of the other five evaluations were not known. It should be noted	Noncompliance

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		that one of the completed examples was for an individual not listed in the total of 15 individuals evaluated per Appendix B, which brought the total number to 16. During the monitoring review, the monitoring team had the opportunity to review some completed comprehensive psychiatric assessments with the facility lead psychiatrist. Specific challenges noted with the reviewed evaluations both during the monitoring review and during off site review included the lack of a comprehensive case formulation, the lack of a justification for both the psychiatric diagnoses and the particular psychotropic medication regimen, and the lack of a behavioral-pharmacological hypothesis (for further discussion regarding these issues, please see the discussion under J11 and J13). 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). The following are examples of Appendix B documentation that illustrated the variability in documentation: Individual #199 – This individual has been diagnosed with Bipolar I Disorder, most recent episode manic in early remission, Intermittent Explosive Disorder, Profound Mental Retardation, Seizure Disorder, and a variety of other medical conditions including but not limited to Hypertension, Cataracts, and Borderline non-insulin dependant diabetes mellitus. He was prescribed Abilify 10 mg at bedtime. Per the review of the comprehensive psychiatric evaluation performed for this individual, dated 4/7/11, the psychiatrist reviewed the diagnostic criteria for mania in the history of present illness. "He has had agitated, explosive behavior…. carried diagnosis of intermittent explosive disorder…recently has had manic type behavior and the diagnosis was amended to include Bipolar I disorder…he developed symptoms of mania with hyper sexuality, excessive masturbation, more agitated hyperactive behavior, reduced sleep and much more moving about the unit...given Abilify for the agitation his manic type behavior was addressed with Depakote Extended Release…hoped it would treat his seizure disorder as well as manic behavior….he developed low platelet count and it was attributed to Depakote…it was gradually tapered…discontinued…neurology placed him on Lamictal to control the seizures….Abilify…for the mania proved not to be as effective…he was cross tapered from Abilify to Geodon…he promptly started having some falls….gait was unsteady….Geodon was discontinued…functioning continued to be…poor…lack of motivation,	

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		poor energy, lack of spontaneity…remained clumsy….some of these symptoms…could be Lamictal side effects….Lamictal level was done and was elevated…dosing reduced." This information provided detail as to the symptoms the individual was experiencing that led to a particular diagnosis; it also provided information regarding the psychopharmacological plan that the physician had developed. This information was located in the history of present illness section of the report; a review of the biopsychosocial formulation and treatment recommendation sections did not reveal detailed information. Individual #300 - This individual has been diagnosed with Schizoaffective Disorder, Severe Mental Retardation, and Allergic Rhinitis. He was prescribed psychotropic medication, including Depakote ER and Zyprexa. Per the comprehensive psychiatric evaluation dated 3/15/11, "He has a history of physical aggression, flight, noncompliance, and history of self abuse…thought process was difficult to follow as he did not say very much…did not appear to have any preoccupation delusions…auditory, tactile, visual… hallucinations absent." Per the biopsychosocial formulation, "He is preoccupied with his mother…elopes when she visits him and stays in the housing area…does get delusional that mother is in the housing area when she is not there…cry for no apparent reason…episodes of agitation, trembling and loud vocalizations have been noted…obsession with his mother is a great factor in his life…talks about her and wants to know when she will be coming. She is reluctant to take him as on his last visit he eloped…treatment recommendations: Depakote ER 750 mg twice daily, Zyprexa 15 mg at bedtime and Zyprexa 5 mg in the morning." There was no documentation of the presence or absence of symptoms required in order to meet diagnostic criteria for Schizoaffective Disorder. Additionally, this evaluation did not reveal the psychiatrist's thought processes regarding the psychotropic medication regimen, or how either the medication or specific situational stressors affected the individual's behavioral challenges. It appeared that this individual was experiencing significant stress in relation to his mother's visiting. It was impossible to tell via this evaluation how this impacted his psychiatric symptoms. It was also impossible to determine how this individual met criteria for the documented Axis I diagnosis. Individual #166 – This individual has diagnoses including Impulse Control Disorder and Moderate Mental Retardation. Per a review of the pharmacy data, she was previously prescribed psychotropic medications including Depakote and Paxil. Per the comprehensive psychiatric evaluation dated 3/17/11, this individual was only	

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		prescribed Depakote. Per a review of this individual's medical record, Paxil was tapered and ultimately discontinued in February 2011. This individual was also prescribed medications including levothyroxine, amlodipine, and simvastatin, however, as Axis III diagnoses were not included in the document, it was impossible to determine the other medical diagnoses or how these could impact her mental health and behavioral functioning. Per a review of the history of present illness, "She has shown elevations on anxiety scales…she is dependant and often seeks reassurance from others…difficulty coping with stress…physical complaints that she uses to avoid work…habit of interrupting people…arguing and blaming others…has had difficulty in conforming to rules, threatening, bullying…physical aggression toward others…victim of sexual abuse…preoccupation with a female individual in the home…did not show any depressive symptoms...denied feeling depressed." Per the included diagnostic assessment, "does show physical aggression and can be impulsive…had some sexual difficulties, which seem to arise from her previous experience of sexual abuse…gets agitated, throws things, and tries to run away…She meets criteria for Impulse Control Disorder." Despite documentation of anxiety symptoms and a history of traumatic experiences, a diagnosis of Posttraumatic Stress Disorder was not discussed or considered via this evaluation. Additionally, this individual was described as experiencing significant oppositional and defiant traits. A review of prior psychological documentation revealed a history of a diagnosis of Oppositional Defiant Disorder diagnosis, however, this was not discussed or addressed via the comprehensive psychiatric evaluation. These questions revealed that there was a need for improvement in the diagnostic formulation documentation regarding this particular individual. As evidenced by the above examples, with variability in quality and documentation, this was an area that may 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, ongoing review of these assessments will be performed during future monitoring visits.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission,	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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	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 nine individuals admitted to the facility since 1/1/10. Two of these admissions were attributed to the same individual (Individual #256) who was readmitted after a failed community placement. All of these newly admitted individuals received a Reiss Screen upon admission. A review of the dates of admission versus the dates the Reiss Screen was completed revealed a significant delay with regard to this time span. On average there was a 2.75 month delay in the performance of the Reiss Screen (with a range of zero days to seven months). As the Reiss Screen is designed to determine if an individual requires a psychiatric evaluation, this should be performed as soon as possible following the individual's admission to the facility. Per the documents reviewed, 95 of the individuals residing at the facility, not currently being treated in psychiatry clinic, were screened via this instrument. Data regarding the number of individuals who were referred for a psychiatric evaluation following this screening were not available, however, per an interview with the director of psychology, none of these Reiss Screens were positive, in that they required a psychiatric evaluation. These data points were confusing, however, as when the number of individuals screened who were not receiving psychiatric treatment (95) was added to the number of individuals currently treated in psychiatry clinic (208) the total number was 303. There were reportedly 391 individuals residing at the facility, indicating that 88 individuals had not received a baseline Reiss Screen. This baseline screening must be completed for all individuals who do not currently have a psychiatric diagnosis. The screen should also be used for those individuals who have experienced a change in status. With regard to the use of the Reiss Screen for individuals who experienced a change in status, the director of psychology reported that Individual #351 had emerging symptoms of depression, which were thought to be related to a new diagnosis of breast cancer. This individual was screened via the Reiss Screen, and because the screen was reportedly positive, there were plans to present the case to psychiatry for a comprehensive psychiatric evaluation. Please note that this individual was not included in the list of 95 individual's discussed in the previous paragraph. Additional information regarding Individual #351, including the outcome of the referral to psychiatry following a positive Reiss Screen, will be requested at the next monitoring visit. 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.	

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J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	The facility did not have any policy or procedure to guide the development and implementation of a system to integrate pharmacological treatment with behavioral and other interventions. Per interviews with psychiatrists and psychology staff, as well as observation during psychiatry clinic, the collaboration between the disciplines, while improved since the prior visit, was still limited to the psychiatric clinical encounter and sporadic psychiatry participation in the PSP process. Review of the records did not reveal any collaborative or combined case assessments or diagnostic formulations. There were, as noted above, signs of the beginnings of integration between psychiatry and psychology, specifically the attempts by psychiatry to attend some PSP meetings and attempts to change the format of psychiatry clinic. There were opportunities for interaction between psychology and psychiatry during psychiatry clinic; these were observed during three clinic observations performed during this monitoring review and were a base upon which to build integration. For additional information regarding this, please see the discussion in section J9. 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 regularly 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. The following are some examples where target symptoms for monitoring did not appear related to the specific Axis I diagnosis where medications were prescribed. • Individual #166 – This particular case review was challenging because although this individual had a diagnosis of Impulse Control Disorder, not otherwise specified, there were multiple notations regarding symptoms of both anxiety and depression. This individual was prescribed both an antidepressant and an antiepileptic medication (often used for impulse control). Recently, the antidepressant medication was discontinued, however, the target symptoms for monitoring remained verbal aggression, physical aggression and self-injurious behavior. There was no documentation regarding monitoring for mood or anxiety symptoms, which would be beneficial given the recent medication changes. • Individual #407 – this individual had a diagnosis of Bipolar Disorder, most	Noncompliance

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		recent episode depressed. Per a review of the target symptoms for monitoring and data collection, self-injurious behavior, manic symptoms and sleep disturbances were identified. There was no mention of monitoring for depression, which was, per the diagnosis, the context of the most recent episode. • Individual #43 – this individual had a diagnosis of Personality Change due to Neonatal Anoxia. She was prescribed psychotropic medication including an antidepressant, antipsychotic and an antihistamine. Per a review of psychiatric documentation, it was difficult to determine the indication for each of these medications. The target behaviors identified for monitoring included self-injurious behavior and physical aggression. 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 two of the three clinic observations performed during this onsite review, the psychiatrists made rounds in the individual's home with the assigned psychologist. 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 the previous monitoring period, individuals who would clearly be amenable to presenting in psychiatry clinic and discussing their medication and treatment were 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. While this was not directly observed during this monitoring period, the absence of the individuals in two of three psychiatry clinics indicates that it was likely still an issue. 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 two of the three clinics 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 16 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	

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		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 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.	Per interviews of both psychiatrists and psychology staff, the psychiatrists did not routinely attend meetings regarding behavioral support planning, and they were not regularly involved in the development of the plans. Therefore, this provision item was rated as being in noncompliance. To meet the requirements of this provision item, there needs to be indication that the psychiatrist was involved in the development of the PBSP as specified in the wording of this provision item J9. Psychiatrists verbalized a willingness to become more involved, but indicated that a lack of clinical contact time had made this impossible. There was concern that even if the facility was able to recruit a second full time psychiatrist that they would continue to have insufficient time available to participate as required by this provision item. Psychiatrists were aware that in some 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. It is generally accepted that the individual's psychiatric physician participate in the formulation of the behavior support plan via providing input 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 Per a review of the PBSP documentation provided in the records of 16 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.	Noncompliance

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		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. This was only one of numerous areas where psychiatry and psychology will need to develop methods to share information and collaborate regarding the treatment of the individuals at the facility. Given plans by the facility psychiatric staff to create a team concept for psychiatric clinic via increased PST presence at clinic and enhanced discussion regarding the individual's pharmacological and behavioral treatment, improved communication and collaboration may be a positive outcome. It was notable that psychology and psychiatry leadership reported good communication between the disciplines. Regardless, observation of clinic revealed that in most cases, psychiatry was not aware of how psychology can be of assistance to them in making pharmacological decisions and vice versa. Staff of both disciplines were experiencing interdisciplinary communication difficulties, which will take time to resolve. There was one notable exception to this communication deficit, and it may be beneficial for this psychiatrist/psychologist dyad to model/train others with regard to communication and coordinated interdisciplinary treatment.	
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	A review of the records of 16 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 authored by psychology included in the positive behavioral support plans, however, these did not satisfy the requirements of this provision item. The risk/benefit/alternatives to medication were being authored and presented to the individuals or their legally authorized representative by psychology staff. Discussions with psychology staff revealed that there were plans for psychiatry to assume this responsibility. More recently, psychiatric physicians had begun to perform the informed consent process for newly prescribed psychotropic medications. The individualized specific risk/benefit analysis is an important component of an appropriate informed consent, but was not yet included as part of the facility's new informed consent procedure.	Noncompliance

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	the medications.	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 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. As discussed with facility staff during the monitoring review, the success of this process of developing an organized response to an individual's psychotropic medication regimen inclusive of risk/benefit analysis, informed consent, and justification of a medication regimen will require a collaborative approach from the individual's treatment team inclusive of the psychiatrist, primary care physician, and nurse.	
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 interviews with the lead psychiatrist, clinical pharmacist and psychiatric nurse, the monthly polypharmacy review committee had been established on 3/3/11. This group had met approximately four times since that time in an attempt to "catch up…review the polypharmacy and justify the regimens." Meeting minutes dated 3/3/11, 3/15/11, and 3/30/11 revealed that the meetings were basically a review of the individual's prescribed medications. There was no documentation of discussions regarding the rationale for polypharmacy or for interventions that could be implemented in an effort to reduce polypharmacy. During this monitoring review, a monthly polypharmacy review committee meeting was observed. This meeting included the lead psychiatrist, the clinical pharmacist, the psychiatric assistant, the psychiatric nurse and the psychiatric administrative assistant. There were challenges associated with this meeting due to the number of part time psychiatric physicians providing care at the facility, and a paucity of documentation regarding the rationale for a specific medication regimen. As a result, the lead psychiatrist was attempting to justify regimens based on medical record review. In several of the cases reviewed during this meeting, determination of a rationale or justification was not possible. It was recommended that for those individuals meeting criteria for polypharmacy, the prescribing psychiatrist should provide documentation of justification for review by the committee. A review of the documentation regarding individuals meeting criteria for polypharmacy	Noncompliance

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		revealed a total of 80 individuals with 14 of these individuals prescribed intraclass polypharmacy. Of the 14 individuals prescribed intra class polypharmacy, nine individuals were prescribed two antipsychotic medications, three individuals were prescribed two antidepressant medications, and two individuals were prescribed two mood stabilizing medications. It should be noted that in the prior monitoring report, 90 individuals met criteria for polypharmacy. 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 76 individuals prescribed three or more medications. Of these, there were 49 individuals prescribed three psychotropic medications, 23 individuals prescribed four psychotropic medications, three individuals prescribed five psychotropic medications, and one individual prescribed six psychotropic medications. Given the interviews, observations, and document review noted above, the facility was in the early stages of development with regard to a facility-level review to monitor polypharmacy. The determination of polypharmacy via the review committee, pharmacy, and the physicians must be coordinated. There must be justification for polypharmacy (i.e., the rationale for the current regimen) authored by the prescribing physician included in the individual's record.	
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 16 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 as clinically indicated (e.g. for those individuals prescribed antipsychotic medication, with a recent discontinuation of antipsychotic medication, at risk for Tardive Dyskinesia, or having a diagnosis of Tardive Dyskinesia). The facility had a tracking system in place 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. Review of this tracking information for the period of 8/1/10 through 2/28/11 did not reveal any overdue scales. Per discussions with the chief nursing executive and the psychiatric nurse, the tracking document was accessible by the psychiatric nurse. The psychiatric nurse was also able to access the paper copies of both instruments in order to present them to the psychiatrist for review.	Noncompliance

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		Additionally, there were plans for the facility to pilot a program where the MOSES and DISCUS would be completed via computer and available for review electronically. Unfortunately, due to difficulties with the tabulation of the rating scales, the implementation of this process remained pending. Review of the MOSES and DISCUS rating forms for the six months prior to this monitoring visit performed for the five most recently admitted individuals and for an additional seven individuals chosen by the facility revealed a total of 47 examples. Of these, 100% were signed by a psychiatrist indicating review. Of these, the psychiatrist fully completed 46%, in that they indicated their opinion of the results of the examination via the checkboxes included on the form. A review of the quarterly psychotropic medication reviews included in the 16 records available for off site review revealed that the results of the scales were included as part of the document format. The documentation was variable with regard to the documentation of the use of this information in clinical decision-making. The majority of the available examples simply had the data included in the document. There were some rare examples where a discussion of the data was included. For example: • Individual #131 - MOSES scores for this individual were 4 on 1/4/10 and 19 on 1/31/11. The psychiatrist reported, "MOSES score is much higher this time, but then…behavior has deteriorated markedly compared to a year ago and certainly she is much more agitated in general." This individual was experiencing increased symptoms and physicians were concerned that dementia could be a contributing factor. • Individual #368 – MOSES scores for this individual were 4 on 1/16/11, with a previous score of 19 on 7/21/10. Per the psychiatric documentation dated 3/23/11 "scores discussed on 3/12/11." A review of available documentation did not include a psychiatric progress notes for 3/12/11. The MOSES form from 7/21/11 was not available for review either. Review of the quarterly psychotropic medication reviews revealed some examples noted above of 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.	

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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 participating in the PSP process as they were able. A review of the documentation regarding their participation in this activity revealed 27 examples of psychiatry participation in the PSP process between the dates of 11/10/10 and 4/6/11. Given the manner of the data request, it was not possible to determine what percentage of the total number of meetings the psychiatrist attended. Per interviews, attendance at these meetings had decreased recently due to the loss of one of the full time psychiatric physicians. The psychiatrists do have contact with PST members during psychiatry clinic. During this monitoring review, three clinic observations were conducted. These clinical observations were very different with regard to staff participation and data presentation. During these observations, multiple opportunities for discussion regarding the individual and their treatment were afforded, however, staff did not take advantage of these opportunities. For example, in one clinic observation, an excellent discussion was noted between the psychiatrist and psychologist where appropriate data was provided, however, other staff attending the meeting, while attentive to the discussion, were silent. Staff must be encouraged to discuss issues with the psychiatrist during psychiatry clinic. As psychiatry does not have the opportunity to attend PST meetings on a regular basis, the clinical encounter was where the psychiatrist had most interaction with the various team members. The second observed clinical encounter was with a new psychiatrist who had only been providing services at the facility for six weeks. This physician, while knowledgeable, energetic and pleasant, was only just becoming acquainted with facility procedures and staff. In the third observed clinical encounter, the psychiatrist and the team were attempting a "pilot program" based on psychiatric clinical services and documentation provided at another DADS facility. This model required a team approach for psychiatric clinic. While staff, with the exception of the clinical pharmacist, were present, various staff members rushed the team discussions, and discussions were truncated. During the 90 minutes of psychiatry clinic, five individual cases were discussed. This equated to 18 minutes per individual, which was insufficient for a comprehensive review of the individual's medical record and data. What was most disappointing regarding this clinical encounter was that staff, in particular psychology staff, were unprepared for the meeting. Most of the information provided to the psychiatrist was presented verbally, there was no written information provided to the physician, and no data graphs were presented. The clinical decision making was not data driven and staff discussed the individual's behavioral challenges anecdotally. Given the better interaction between psychiatry and psychology in the first observed encounter, including presentation of information regarding	Noncompliance

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		behaviors and symptoms via graphed data, allowing other psychology staff to observe and model this interaction was recommended. Interviews with both facility psychiatrists and the director of psychology revealed that the responsibility for the development of the risk/benefit analysis and the treatment planning regarding psychotropic medication was currently the responsibility of psychology. Staff interviewed noted that the behavioral-pharmacological hypothesis would be done as part of the comprehensive psychiatric assessment [Appendix B], but they were very basic, and it was just starting. Review of 10 provided examples of the comprehensive psychiatric assessments per Appendix B revealed marked variability in the documentation of the behavioral-pharmacological hypothesis. For example: • Individual #119 – "Abilify 5 mg daily…Lamictal 50 mg twice daily…more alert…poorly motivated…no longer seems to be in a stupor…In August 2008…his platelets decreased…Valproic acid…can contribute to [this]…spring of 2010, Abilify was started for his agitation and hyperactive behavior. During 2010, Depakote was tapered and…discontinued…started Lamictal in October 2010…for his seizures…it is unclear whether or not there is a family history of bipolar disorder…he now has symptoms of such a disorder…his seizure disorder and borderline diabetes…can contribute to his symptoms and also now we wonder if Lamictal toxicity may have contributed to his clumsiness, lethargy and mood blunting during this winter." This discussion provided the reader a good history indicating why specific medications or dosages were altered. It also allowed the reader to understand the psychiatrist's thought process regarding the specific behaviors that were observed and how this could have been related to medications or other physical maladies. • Individual #162- "The Abilify is for mood lability and aggression. Trazodone reportedly is for sleep and self-injurious behaviors. Buspar to decrease anxiety. These are her target symptoms reportedly…continue her…medications as prescribed…eventually the plan is to gradually try and reduce polypharmacy if possible." This example was simply a review of the specific prescribed medications and their indications. It did not include information regarding the physicians thought process or a behavioral-pharmacological hypothesis for treatment with a specific medication. • Individual #166 – "challenging behaviors of physical aggression and verbal aggression and also self-injurious behavior has been addressed with initiating appropriate social interaction…continue Depakote 500 mg twice a day." This example provided an indication for treatment with a particular medication, however, it did not elucidate a specific behavioral-pharmacological hypothesis.	

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		• Individual #484 – "as patient recently has been intrusive and has been on more supervision that a trial of SSRI to address his obsessive compulsive behavior…not allergic to any known drugs…brother was reached, and he gave verbal agreement." While this example included information regarding the contact of the LAR to obtain informed consent, and provided an indication for treatment with a specific medication, the specific behavioral-pharmacological hypothesis was not included. As evidenced by the above, the facility psychiatry staff will need to improve documentation with respect to the development of a treatment plan for psychotropic medication that identifies a clinically justifiable diagnosis, the expected timeline for the therapeutic effects of the medication to occur, and the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy. This should include the development of a psychiatric treatment planning process. What was needed was the documentation of a thoughtful, planned approach to psychopharmacological interventions. These procedures, once developed, need to be codified in policy and procedure and fully implemented across the facility.	
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 "Psychiatry Services Procedure Manual" dated 3/10/11. Per this procedure manual, "[The psychiatrist] provides education about medicaitons side effects and the reason for choice and reason to hep [sic] abbreviate [sic] symptoms. This might be readdressed when the new practice guidelines form [sic] the State for Psychiatry go into effect…must discuss characteristics of the medication, including expected benefiuts, potential adverse or side effects, dosage, standard alternative treatments, legal rights, and any questions the individual and LAR have…Psychiatrist must obtain informed consent (except in the case of an emergency) prior to administering psychotropoic medication or other restrictive procedures." Per interviews with facility staff, including the facility psychiatrists and the psychiatric nurse as well as review of facility medical records, psychiatric physicians were slowly increasing their involvement in the informed consent process. Reportedly, when a new medication was prescribed, the physicians were making attempts to contact the LAR and review information related to informed consent with them. This new process was documented via the "Psychotropic Medication Routing Form New Medication(s)." The psychiatrists had not begun the process of revising informed consent documentation for those psychotropic medications that were previously prescribed. A review of 11 examples of informed consent documentation performed via the new	Noncompliance

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		process revealed the following: • Individual #410- Per the medication order authored by the prescribing psychiatrist, "after consent is obtained, start Tegretol 100 mg po bid." An attached document entitled "Consent/Authorization for Treatment with Psychotropic Medication(s)" consisted of a list of items that were checked off. This was a basic consent form that did not include information specific to the individual nor to the specific medication. There was an attached progress note authored via the integrated progress notes, however, this notation did not include an entry for the date that consent was obtained as documented via the "Consent/Authorization for Treatment with Psychotropic Medication(s)" form. While this form was a basic checklist of the items that must be included in an informed consent, there was no individualized documentation other than the inclusion of the individual's name and the name of the proposed medication. It was concerning that specific side effects associated with a medication may or may not have been included in the consent discussion. The facility could consider basic informational handouts that could be mailed to the LAR for their review following the initial consent discussion. • Individual #410- Per a medication order authored by the prescribing psychiatrist "Zyprexa 5 mg po bid." The prescribing psychiatrist documented in the integrated progress notes an unsuccessful attempt to reach the individual's LAR. Ultimately consent was documented via the checklist entitled "Consent/Authorization for Treatment with Psychotropic Medication(s)" where verbal consent of the individual's LAR was documented following a discussion with the psychiatric nurse. There were no other signatures included on this consent document, and there was no progress note authored by the psychiatric nurse documenting the discussion. This was concerning as there were no witnesses to the consent, and no individualized documentation of the discussion where consent was obtained. • Individual #285 - Per a medication order, "Geodon 40 mg bid" was prescribed. The diagnosis noted as an indication for this medication was "Autistic Disorder." As in the examples above, a checklist regarding a review of informed consent requirements was checked off and signed by the facility director and the prescribing psychiatrist. Attached progress notes did not include documentation of any further informed consent discussion. What was concerning regarding this example, in addition to similar issues noted in the two examples noted above, was that the medication was being prescribed for an off label indication, and this was not noted in the documentation. While it was a positive step that psychiatry was more involved in the informed consent progress, the facility had also taken a step backwards in that documentation regarding	

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		informed consent was not as thorough with regard to the review of specific side effects associated with a particular medication. None of the 11 examples reviewed included a listing or documentation of specific side effects reviewed with either the LAR or the facility director. While the efforts of the psychiatry staff with regard to completion of the "Psychotropic Medication Routing Form New Medication(s)" and documentation of contact with the individuals LAR were laudable, and hopefully indicative of a transition toward appropriate practice, the informed consent policy and procedure and the informed consent practices at the facility were 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, and 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 their understanding of the information. This process must be documented in the individual's record. While psychiatry had begun to perform informed consent procedures for newly prescribed medication, informed consent processes for existing medications were delegated 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). This was inappropriate. Given the importance of informed consent, the development of an updated facility policy and procedure regarding this topic should be considered. 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, should consider a state wide policy and procedure outlining appropriate informed consent practices that comply with Texas state law and generally accepted medical practice. 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.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year,	Per an interview with the facility lead psychiatrist, neurology consultation was available at the facility once a month. While psychiatric physicians were reportedly welcome to attend the neurology clinic, the physicians reported that, "We are spread so thin so it is	Noncompliance

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	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.	hard to go…we can get our patients added to the neurology clinic schedule and they are seen quickly." Neurology clinic reportedly lasts approximately three hours. Per an interview with the facility lead psychiatrist and the facility medical director, individuals can travel to the consulting neurologists office "if need be." Per the facility lead psychiatrist, attendance at neurology clinic was a priority, and if she were unable to attend, the facility psychiatric nurse would attend in the psychiatrist's stead. Collaboration between neurology and psychiatry is imperative as evidenced by the number of individuals with concomitant psychiatric illness and seizure disorder. During the time of this review, the total population was 391 individuals. Of these, 104 individuals had a risk level of two or above per a review of the list of individuals at risk for seizures. There were a total of 208 individuals prescribed psychotropic medications via psychiatry clinic. Of these, 45 individuals were prescribed an anti-epileptic medication for a psychiatric indication in the absence of a seizure disorder, and 91 individuals prescribed psychotropic medications had a documented comorbid seizure diagnosis. This did not include those individuals with a seizure diagnosis who were not also prescribed psychotropic medication. While the above data alone would indicate the need for clinical consultation, there were other neurological disorders present in psychiatry clinic patients that would have been amenable to close clinical contact between neurology and psychiatry (e.g., headache, EPS, tremors, various syndromes, quadriplegia, Tardive Dyskinesia). Documentation of the psychiatrist's review of neurology consultation was included in the information provided via the presentation book for section J. For the four examples provided (regarding Individual #504, Individual #119, Individual #124, and Individual #385), the neurology consultation report as well as psychiatric progress notes documenting the psychiatrist's presence and participation in neurology clinic was included. Of the 16 individual's records available for off site review, seven individuals had a diagnosis of seizure disorder. While documentation of collaborative consultation was improved over the previous monitoring visit, a review of these seven records revealed some ongoing challenges in communication between psychiatry and neurology. For example: • Individual #131 – The treating psychiatrist requested a neurology consultation 1/20/11 in order to "assess for dementia…not responsive to therapy. A change from years ago. Had possible stroke in 2008 and not the same ever since." This individual was seen in neurology clinic on 2/9/11. Per the documentation from this consultation, "it may be that she is having progressive dementia…hard for me to say with no baseline mental status…MRI is unremarkable. TSH is normal.	

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		I would recommend she get a baseline RPR if not done recently and also a B12 level on her. I would treat her with Aricept 5 mg daily increasing to 10 mg daily. Follow up in clinic in six months." A review of the integrated progress notes on the date of neurology clinic did not reveal a psychiatry notation. The next psychiatry documentation noted 2/17/11 indicated, "behavior about the same. Recently say Dr. Matthews, neurologist, for dementia eval…await Dr. Matthews written consult." At this appointment, the dosage of Buspar was increased. A similar note authored by psychiatry was dated 3/3/11, and again Buspar was increased. The next psychiatry notation, dated 3/31/11 makes no mention of the neurology consultation and no medication changes were made at this visit. As of the date of the monitoring review, 4/18/11, this individual had not started a trial of Buspar, nor had the laboratory examinations as recommended by neurology clinic on 2/9/11. • Individual #99 – This individual was seen in neurology clinic 11/10/10. Per the documentation from this consultation, "He has significant behavioral issues…immediate problem seems to be the significant behavioral issues…do not have any problem increasing his Valproic acid to a maximum dosage to get a reasonably good level even up to 125, if needed, for his behavioral issues…we could try him on Tegretol or Lamictal both of which are sometimes helpful for behavior or mood issues." Integrated Progress Notes dated 11/9/10 authored by psychiatry documented plans to increase Geodon to 60 mg three times daily. A progress note per psychiatry dated 11/12/11 documented consultation with neurology and plans to increase the dosage of Valproic acid per the neurologist. Additional medication changes were made 11/16/10 (discontinue Lunesta, start Melatonin), and 11/19/10 (restart Lunesta). What was concerning was the apparent lack of a pharmacological plan. Multiple medication changes were being made quickly. The neurology advice regarding a second antiepileptic medication was not followed (documentation did not state the rationale for this). As of the date of the monitoring review, 4/18/11, this individual had not had a trial of an additional antiepileptic medication. Per interviews and observation of medical staff, there were 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 indirect contact between psychiatry and neurology. Unfortunately, the psychiatric physicians were not fully integrated into the PSP process	

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		at the facility. Given the lack of neurology resources, it would be necessary for the psychiatrist to provide information to the PST that resulted from clinical consultation. Currently, the facility had one full time psychiatrist and three part time psychiatrists for a total of 1.45 FTE, which was not sufficient to allow for regular participation in the PST process. A review of documentation requested regarding the psychiatry participation in the PSP process revealed 27 examples of psychiatry participation between the dates of 11/10/10 and 4/6/11. Given the manner of the data request, it was not possible to determine what percentage of total PST meetings the psychiatrists had attended. It can be deduced that given their attendance at 25 meetings in the course of approximately five months, this would extrapolate to attendance at 65 meetings over the course of the year, far below the total number of individuals on the psychiatric caseload, which numbers 208. Given the clinical need identified in the discussion above, it would be challenging for the neurologist to evaluate and follow these individuals with the limited amount of clinical consultation time proposed (one onsite clinic per month), much less participate in regular coordination of treatment with other professionals. 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 consultation and the recommended follow up frequency. The facility may want to consider options for increasing of 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, behavioral support planning and the development of collaborative case formulations between the disciplines.

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. 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.

5. Complete annual psychiatric evaluations following the requirements of the Settlement Agreement Appendix B. These must include detailed comprehensive case formulations, which include justification for a particular psychiatric diagnosis as well as justification for a particular psychotropic medication regimen via a treatment plan for psychotropic medication. Additional information regarding the behavioral-pharmacological hypothesis should also be included.

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

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

8. All individuals residing at the facility who are not currently attending psychiatry clinic should have a baseline Reiss Screen.

9. The Reiss screen should be completed as soon as possible following the individual's admission to the facility.

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 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. This could be included in the informed consent process.

13. Continue the facility level review of polypharmacy to include reviews of medication regimen justifications authored by the prescribing physician.

14. 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.

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

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

17. Ensure that the indications for specific medications correspond to the purported diagnosis, and that appropriate defined behavioral/symptom data points are being monitored. This should include the development of a behavioral-pharmacological hypotheses included as part of the psychiatric treatment plan.

18. Individualize the process for Informed Consent.

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

20. Explore options to increase the availability of neurology consultation in order to allow for evaluation, follow up care and collaboration with psychiatry.

The following are offered as additional suggestions to the facility:

21. 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.

22. 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.

23. 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.

24. 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.

25. Consider modeling/training of psychology/psychiatry communication and interdisciplinary treatment planning utilizing the team of Dr. Buckingham and Ms. McKnight.

26. Consider the development of a policy and procedure outlining the process for clinical consultation for those individuals prescribed psychotropic medications who also require pretreatment sedation for either medical or dental services.

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 Psychological Evaluations for: • Individual #166 (11/16/10) Individual #31 (3/17/11), Individual #392 (3/17/11), Individual #500 3/24/11), Individual #128 (4/1/11), Individual #552 (4/6/11), Individual #208 (4/14/11), Individual #170 (2/15/11), Individual #410 (2/10/11), Individual #285 (4/13/11), Individual #279 (2/10/11), Individual #340 (1/18/11), Individual #282 (no date), Individual #503 (no date), Individual #111 (10/4/10), Individual #201 (9/22/10), Individual #43 (1/20/11, Individual #555 (2/21/11), Individual #138 (2/16/11), Individual #587 (2/15/11), Individual #21 (4/7/11) o Functional Assessments for: • Individual #166 (11/16/10), Individual #31 (3/17/11), Individual #392 (3/17/11), Individual #500 (3/24/11), Individual #128 (4/1/11), Individual #552 (4/6/11), Individual #208 (4/14/11), Individual #170 2/15/11, Individual #410 (2/10/11), Individual #285 (4/13/11), Individual #43 (1/20/11), Individual #555 (2/21/11), Individual #138 (2/16/11), Individual #587(2/15/11), Individual #21 (4/7/11) o Positive Behavior Support Plans for: • Individual #166 (11/16/10), Individual #31 3/18/11), Individual #392 (3/17/11), Individual #500 (3/30/11), Individual #128 (4/4/11), Individual #552 (4/18/11), Individual #208 (4/14/11), Individual #170 (2/15/11), Individual #410 (2/18/11), Individual #285 (4/4/11), Individual #43 (2/23/11), Individual #555 (3/10/11), Individual #138 (2/16/11), Individual #587 (2/22/11), Individual #21 (3/29/11) o Positive Behavior Support Progress notes for: • Individual #245, Individual #285, Individual #60, Individual #484, Individual #91, Individual #587, Individual #271 o Peer Review minutes, dated 10/19/10, 10/26/10, 11/2/10, 11/9/10, 11/16/10, 11/23/10, 11/30/10, 12/7/10, 12/14/10, 12/28/10, 1/4/11, 1/18/11, 1/25/11, 2/11/11, 2/18/11, 2/22/11, 2/28/11 o Spreadsheet documenting each individuals dates of functional assessments, Positive Behavior Support Plans, and Psychological Evaluations, undated o Spreadsheet tracking licenses, certifications, BCBA coursework completed, and BCBA supervision for each member of the psychology department o A list of all individuals receiving counseling/psychotherapy, undated o A spreadsheet of all individuals for whom a functional assessment was completed in the last 12 months, undated

	Interviews and Meetings Held: o Sylvia Middlebrook, Ph.D., Director of Psychology o Marvin Stewart, M.A, Program Compliance Monitor o Martha Thomas, M.S., Associate Psychologist, V o Robin McKnight, M.A., Associate Psychologist V o Mike Fowler, M.A., Associate Psychologist V o Edward Hutchison, M.S., BCBA consultant o Gail Husband, Assistant Director of Programs Observations Conducted: o Psychology Peer Review Meeting • Staff Present: Sylvia Middlebrook,, Ph.D., Director of Psychology; Edward Hutchison, M.A., BCBA consultant; David Milem, M.A., Associate Psychologist V; Martha Thomas, M.S., Associate Psychologist, V; Robin McKnight, M.A., Associate Psychologist V; Marvin Stewart, QA/PCM; Julie Bradbury, M.S., Associate Psychologist III; Vernon 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., Psychology Assistant ; Schuler Ivey, M.A., Associate Psychologist III; Naomi Barlow, Psychology Assistant; Linda Nouwen, Psychology Assistant; Rosie Christian, Psychology Assistant; Pam Kayetski, Psychology Secretary o Staff Training of PBSPs for: • Individuals: Individual #21 and Individual #162 • Staff present: Mike Fowler, Associate Psychologist V; Jill Harris, Associate Psychology istIII; Troy Finch, Psychology Technician, Crystal Ly, DCP; Colleen McKnight, DCP; Leandria Thompson, DCP o Psychiatry Clinic • Individuals presented: Individual #453 and Individual #290 • Staff Present: Dr. Vyas, Psychiatrist; Hortencia Jacobo, RN; Martha Thomas, Associate Psychologist V; Judd Williamson, Psychiatric RN; Nikki Derbonne, Home Manager; William Moore, QMRP o Psychiatric Clinic • Individuals presented: Individual #161 • Staff Present: Dr. Buckingham, Psychiatrist; Danette Willey, Employment Services; Precious Scott, QMRP; Linda Thompson, DCP; Rosie Christian, Psychological Assistant; Chris Drahos, RN; Nicole Lamb, Psychiatry Assistant; Robin McKnight, Associate Psychologist V 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; 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 substantial compliance for item K2, and noncompliance for the remaining items of this provision. The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the facility's self-assessment. 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 track and evaluate 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, several improvements were noted since the last onsite review. These include: • Establishment of internal peer review (K3) • Development of a simplified data system (K4) • The use of a more flexible data system (K4) • Consistent graphing of target behaviors (K4) • Evidence that Positive Behavior Support Plans (PBSPs) are modified when data indicate a lack of progress (K5) The areas that the monitoring team suggest that LSSLC work on for the next onsite review are: • Ensuring that data are reliably collected (K4, K10) • Ensuring that PBSPs are implemented with integrity (K11) • Ensuring that all functional assessments have a clear summary of the variable or variables hypothesized to affect target behaviors (K5) • Ensuring that all Positive Behavior Support Plans (PBSPs) are based on the hypothesized function of the target behavior, and specify clear, concise antecedent and consequent interventions (K9)

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide	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).	Noncompliance

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	individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	As reported in the last 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). One psychologist at LSSLC was seeking eligibility to sit for the BCBA exam based on training and experience. Additionally, a consultant with expertise in ABA and certified as a BCBA consulted to the facility 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 continued to be in substantial compliance with this item. The director of Psychology had a Ph.D., was a licensed psychologist in Texas, and had over 10 years of experience working with individuals with intellectual disabilities. Additionally, Dr. Middlebrook enrolled to take the BCBA coursework. Supervisees interviewed indicated they had positive professional interactions with, and received professional support from, the director of psychology. Finally, under Dr. Middlebrook's leadership, several initiatives had begun toward the attainment of substantial compliance with this provision.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	This item was rated as being in noncompliance because there was no external peer review. The facility continued to make progress on this provision item of the Settlement Agreement by 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 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 the internal peer review meeting occurred weekly with regular attendance among all of the psychologists. During the peer review 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. At the time of the onsite review there was no evidence that the facility was conducting	Noncompliance

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		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 prior to achieving substantial compliance with this provision item.	
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.	There were several improvements in this provision item since the last onsite review. In order to achieve substantial compliance, however, the facility needs to expand the data system to include (and graph) replacement behaviors, add data collection reliability, interobserver agreement (IOA), and ensure that data books (or data sheets) are readily available to direct care professionals (DCPs). As recommended in the last report, the facility had simplified the data system from one that required the recording of antecedents, target behaviors, and consequences (ABC recording) to one that only requires DCPs to record target behaviors. The new data system documented target behaviors in two-hour intervals. One clear advantage of the new data system is that it was substantially easier to complete than the previous ABC system. Accordingly, all DCPs asked indicated that they found the new system easier to use than the previous ABC system. The simplified data system, however, did not include the collection of replacement behavior. It is recommended that the occurrence of replacement behaviors be collected. Additionally, it is recommended that DCPs be required to record a zero or their initials in each recording interval if a target or replacement behavior did not occur. This method would ensure that the absence of target behaviors in any given interval did not occur because staff forgot to record the data. This requirement also allows the psychologists to review data sheets and determine if DCPs were recording data at the intervals specified (i.e., data collection reliability). The facility had also increased the flexibility of its data system by using both frequency and time sampling data. Nevertheless all psychologists interviewed indicated that they did not have confidence in the reliability of the data collected at the facility. A hallmark of applied behavior analysis (ABA) is the use of data-based decisions. Meaningful data-based decisions are impossible, however, if the data are not reliable. As discussed in the last report, the addition of data collection reliability described above (which assesses whether data are recorded), along with interobserver agreement data (which assesses if multiple people agree that a target or replacement behavior occurred) represent the most direct methods for assessing and improving the integrity of collected data. It is	Noncompliance

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		recommended that the facility begin to track data collection reliability and interobserver agreement (IOA) data for all target and replacement behaviors in each home and day/vocational site. Additionally, specific data collection compliance and IOA goals should be established, and feedback and training should be provided to DCPs and their supervisors to ensure that data are reliability collected. As recommended in the last review, LSSLC had begun to graph all target behaviors. There was, however, no evidence of the graphing of replacement data. It is recommended that LSSLC begin graphing replacement behaviors. The monitoring team found some evidence that data were graphed in increments necessary to ensure sufficient data-based decision-making. For example, Individual #285's rumination was graphed in daily increments to better understand the effects of several dietary modifications on his rumination. Additionally, this graph indicated the occurrence of these potentially important environmental events with phase lines, resulting in easier interpretation of their effects on Individual #285's rumination. The monitoring team was encouraged by this example and recommends that the facility consistently graph in increments based on individual needs. Finally, there was some evidence that Positive Behavior Support Plans (PBSPs) were modified based on the absence of progress. Two of the 15 PBSPs reviewed had been revised prior to the annual review due to the absence of progress. Individual #392's PBSP was written on 2/8/11 and revised on 2/28/11, 3/10/11, and 3/17/11. Individual #31 PBSP was written on 2/28/11 and revised on 3/17/11. Nevertheless, progress of the most severe behavior problems (i.e., physical aggression and SIB) over the last six months indicated that six individuals (of the 15 reviewed) had an increase in severe behavior problems. Clearly the exacerbation of the frequency of target behaviors in all of these individuals was not likely to be solely the result of an ineffective PBSP. The monitoring team, however, will continue to monitor the progress of target behaviors as one measure of the effectiveness of PBSPs, and behavior systems in general, at the facility. On the positive side, three individual's (SIB for Individual #166, physical aggression for Individual #555, and SIB for Individual #500) data (20%) demonstrated substantial decreases in one or more severe behavior problems over the last six months of reported data. The monitoring team was encouraged by these improvements in the data system at LSSSLC, and looks forward to seeing more progress in this provision item in future reviews.	
K5	Commencing within six months of	This provision item was rated as being in noncompliance due to the lack of	Noncompliance

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	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.	comprehensiveness of some of the psychological assessments and functional assessments. <u>Psychological Assessments</u> A spreadsheet including initial psychological assessments completed, and reports from facility staff, indicated that all individuals at LSSLC had initial psychological assessments. Twenty-one initial psychological assessments were reviewed by the monitoring team. • One (Individual #279) did not include a standardized assessment of intellectual and adaptive ability. • Two (Individual #282 and Individual #503's) of the 21 initial psychological assessments reviewed did not contain a screening or review of psychiatric and behavioral status, review of personal history, or an assessment of medical status. Each individual's record should contain a psychological assessment that consists of an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, 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 210 of the 391 individuals at LSSLC had a PBSP. The monitoring team sample and reports from facility staff indicated that all individuals with a PBSP had a functional assessment. Another spreadsheet of all functional assessments completed in the last 12 months indicated that 32 functional assessments had been completed since the last review. Fifteen of those 32 functional assessments (47%) were reviewed to assess compliance with this item of the Settlement Agreement. As discussed in the last report, the facility used a 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, was insufficient for the functional assessments to be as effective as they could be. All functional assessments should include a direct assessment that consists of direct observations of the individual and documentation of antecedent events that occurred prior to the targets behavior(s), and specific consequences that were observed to follow the target behavior. The direct assessment procedures of five (Individual #170, Individual #587, Individual #555, Individual #21, and Individual #31) of the 15 functional assessments reviewed (33%) were not complete because they did not include	

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		direct observations, and instead simply reviewed target behavior frequencies. The remaining 10 functional assessments included direct assessments that described antecedent and consequent conditions, but it was not clear, in some, that the hypotheses were based on direct observations. For example Individual #166's direct assessment appeared to include consequences that were listed in her PBSP. It was not apparent if these procedures were ones observed, or consequences that were intended to be implemented. It is recommended that all direct assessments include both antecedents and consequences hypothesized to be affecting the target behavior, and clearly document that they represent direct observations of the individual. That being said, two of the 15 direct assessments reviewed (13%) appeared to be particularly useful for understanding individuals target behaviors. • Individual #392's direct assessment included many examples of observed antecedent events that had resulted in the target behavior, and several observed consequences of Individual #392's target behaviors. • Individual #285's target behavior of rumination was observed, graphed daily, and monitored as a function five dietary changes. This analysis was useful for identifying specifically how his rumination was affected by his diet. Another potentially effective way to collect direct functional assessment data is to use ABC (i.e., the systematic collection of both antecedent and consequent behavior) data. In order to be useful, however, ABC data would need to be collected for a duration long enough to observe several examples of the of the target behavior, so that patterns of antecedents and consequences could be identified. All functional assessments should contain direct measures of the target behaviors. All of the functional assessments reviewed identified potential antecedents and consequences of undesired behavior. In two the functional assessments reviewed, however, the identified functions were not operationally defined and, therefore, not useful for understanding the variables maintaining the target behavior. • Individual #170's functional assessment identified being jealous, bored, frustrated, or otherwise stressed as antecedents to Individual #170's undesired behaviors. In order for this hypothesis to be helpful in developing a PBSP to reduce his undesired behaviors these antecedent events need to be defined in objective language so that DCPs do not need to infer when Individual #170 is jealous, bored, or frustrated. • Individual #138's functional assessment concluded that there was no function or intent for these behaviors and that they were due to his psychotic disorder. Individual #138's undesired behaviors may be related to his psychiatric condition, however, a functional assessment is most useful when it focuses on	

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		the identification of the variable or variables that are affecting the target behavior (and in Individual #138's case, perhaps his psychiatric symptoms), rather than simply concluding that the undesired behavior is the function of a psychiatric condition. In other words, are there environmental variables (e.g., being tired, loud noises, being threatened by other individuals) that increase the likelihood of the psychiatric symptoms and the disruptive behavior? All hypothesized functions of the target behavior identified in a functional assessment should be operationally defined. Two (Individual #208 and Individual #21) of the 15 functional assessments reviewed (13%) did not include a summary statement. All functional assessments should include a summary statement that integrates the results of the various assessments into a comprehensive statement of the variables affecting the target behaviors. Four of the functional assessments that contained summary statements were not found to be useful. As discussed in the last report, several of the functional assessments reviewed identified multiple possible functions of undesired behavior. Typically, however, no attempt to summarize these multiple functions into a clear statement of the most important variables affecting the target behavior was apparent. The following example was typical: • Individual #500's functional assessment indicated that his SIB was a function of escaping undesired situations, getting staff to leave him alone, to gain desired objects, and to get staff's attention to alleviate his pain. 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. If, as in the example above, multiple functions are all hypothesized to be affecting the target behavior, then each function needs to be summarized into specific situations. An example of some possible interventions to be included to address Individual #500's escape motivated SIB would be: • When presenting Individual #500 with work tasks he will often engage in SIB in order to escape from work. It is important to minimize the aversiveness of the task (e.g., reduce the duration of work, or temporarily modify the job to something more acceptable to him), and/or teach him an acceptable way to escape the task. Additionally, ensure that he does <u>not</u> escape the task when he engages in SIB. Similar specific antecedents and consequences would need to be developed for each hypothesized function.	

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		In five (Individual #410, Individual #31, Individual #552, Individual #392, and Individual #587) of the 15 functional assessments reviewed, the hypothesized functions of target behaviors were not consistent with those found in the PBSP. For example: • Individual #410's functional assessment hypothesized that his physical aggression and SIB were a function of negative reinforcement and positive reinforcement. His PBSP, however, stated that his physical attention and SIB were only a function of positive reinforcement. • Individual #587's functional assessment hypothesized that her disruptive behavior was a function of negative reinforcement and attaining preferred items, however, her PBSP indicated that her disruptive behavior was only a function of negative reinforcement. • Individual #392's functional assessment did an excellent job of integrating multiple potential functions of her disruptive behavior, and concluded that their primary function was gaining staff attention. Her PBSP, however, stated "… acts out most when she is not getting her way or wants something, when she is trying to get out of doing something that she has been asked to do, and/or simply when she wants to draw attention to herself." In order for functional assessments to be useful for developing effective PBSPs, it is important that the primary functions identified in the functional assessment be accurately included in the PBSP. As reported in the last review, 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. None of the functional assessments reviewed (0%) were evaluated to be comprehensive and clear. Several functional assessments, however, contained excellent components that could be modeled for future reports. Those include: • Individual #285's direct assessment of the relationship between mealtime and undesired behavior. • Good comprehensive summary statements for Individual #392. • Good description of antecedents and consequences relevant to the undesired behavior for Individuals #43 and Individual #128.	
K6	Commencing within six months of	LSSLC's psychological assessments were not complete (see K5) and, therefore, this	Noncompliance

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	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.	provision item was rated as being in 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.	Annual psychological assessments were completed for all individuals at LSSLC. They were not, however, consistently completed (see K5). DADS and the monitoring teams have not determined how often some components of the assessment need to be updated. Therefore this provision is rated as in noncompliance. Seventeen of the 22 (77%) initial psychological assessments reviewed included intellectual assessments that were more than 10 years old. DADS and the monitoring team are determining the conditions for conducting new assessments. Future reviews will evaluate the timeliness of psychological assessments based on those guidelines. The facility had recently revised the annual psychological updates format to include each of the components discussed in K5. The purpose of the annual update is to note/screen for changes in psychopathology, behavior, and adaptive skill functioning. Thus, the annual psychological assessment update should 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. Additionally, psychological assessments should be conducted within 30 days for newly admitted individuals. A review of two recent admissions (Individuals #340 and Individual #279) to the facility indicated that this component of this provision item was in substantial compliance.	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 measured to determine the efficacy of treatment.	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, PBSPs, or PSPs reviewed did not document the need for psychological services other than PBSPs. It is recommended that needed services be documented in the psychological assessments, PBSPs, or PSPs. At the time of the onsite review, eight individuals participated in counseling/psychotherapy. As in the last report, however, there was no evidence	Noncompliance

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		provided that these services were goal directed with measureable objectives and treatment expectations. It is recommended that all psychological services other than 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 extraordinary circumstances.	This item was rated as being in noncompliance because not all PBSPs reviewed contained all of the components necessary for an effective plan, and many of the interventions were not clearly based on functional assessment results. All 15 PBSPs reviewed had the necessary consent and approvals. All of the PBSPs contained descriptions of data collection procedures, baseline data, and treatment expectations and timeframes. All PBSPs reviewed included descriptions of target behaviors, however, three (20%) of these were not operational. For example: • Individual #552's PBSP defined self-induced vomiting as "...the act of making herself vomit <u>intentionally</u>." This definition required the reader to infer if Individual #552 did indeed have an intention to vomit. An operational definition should not require DCPs to infer an individual's intentions. An operational definition should only include observable behavior (e.g., putting hand in mouth followed by vomiting). • Individual #31's PBSP included a target behavior of physical aggression that included "Any behavior <u>intended</u> to cause harm to another…." • Individual #587's PBSP defined disruptive behavior as <u>purposely</u> agitating and disrupting peers…" On the other hand, 12 of the 15 PBSPs reviewed contained operational definitions that were operational, clear, and complete. Examples included: • Individual #43's physical aggression was defined as "slapping, pushing, throwing objects, biting, and kicking." • Individual #128's SIB was defined as "slapping/hitting herself and biting or	Noncompliance

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		scratching herself." All PBSPs should include operational definitions of target behaviors. All 15 PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors, but only three (20%) were rated to be useful for decreasing the undesired behavior. A typical example of an ineffective intervention was: • Individual #21's PBSP hypothesized that her physical aggression was maintained by negative reinforcement (i.e., a way to escape unpleasant activities), but her intervention following target behaviors included "encouraging her to go to a calming environment such as her bedroom or outside." If her aggression was maintained by negative reinforcement, then this intervention would likely encourage, rather than discourage, her undesired behavior because it allowed her to escape unpleasant activities by engaging in the target behavior. Examples of PBSPs that were based on the hypothesized function of the targeted behavior and, therefore, were likely to result in the weakening of undesired behavior were: • Individual #128's PBSP hypothesized that her physical aggression and SIB functioned to gain attention and escape unpleasant activities. Antecedent interventions included interacting with her every 15 minutes to decrease the likelihood that she would engage in undesired behavior to get staff attention. Antecedent interventions also included attempting to understand what she needs and wants by encouraging her to use her communication device. This would decrease the changes that she would engage in physical aggression or SIB to get out of doing something or because she wanted staff attention. • Individual #285's PBSP indicated that his SIB was maintained by escape from work tasks and access to reinforcers. His antecedent intervention included scheduled breaks from work when he did not engage in SIB. • One hypothesized function of Individual #500's SIB was related to escaping unpleasant activities. Accordingly, one of his antecedent procedures was to give him the opportunity to go to a preferred location when he was not engaging in the target behavior. • Individual #555's disruptive behavior was hypothesized to be maintained by him getting food or money following his disruptions. Antecedent procedures included the opportunity to earn extra money by exercising, and the opportunity to spend his money to eat at a restaurant of his choice. All PBSPs should include antecedent and consequent strategies to weaken undesired	

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		behavior that are clear, precise, and related to the identified function of the target behavior. One consistent improvement in the PBSPs at LSSLC was the effective use of reinforcement. The following examples were typical: • Individual #43' functional assessment indicated that a preference assessment was conducted. Her PBSP specified that several of these preferences should be presented anytime she is not exhibiting physical aggression or SIB. • Individual #31's PBSP specified that she could request a reinforcer from her approved list when she went four days without engaging in a target behavior. • Individual #555's PBSP specified that he could earn extra money by complying with his weekly exercise criterion. Replacement behaviors were included in 14 of the 15 PBSPs reviewed. The only exception was Individual #138 for whom no function of his target behavior was identified. PBSPs should include replacement behaviors when the reinforcer for the target behavior is identified, and providing that reinforcer for alternative behavior is practical. When replacement behaviors are included they should be functional. In other words they should represent desired behaviors that serve the same function as the undesired behavior. The monitoring team found that the replacement behaviors identified in 12 of the 14 PBSPs (86%) that contained replacement behaviors were functional. An example of a functional replacement behavior was: • One of Individual #552's hypothesized functions of her physical aggression was positive reinforcement (attempting to gain desired items). Her replacement behavior included teaching her to gain access to desired objects by tapping staff on the arm, or pointing to what she wants. This was a good example of a functionally equivalent replacement behavior because it provided the same reinforcer (i.e., getting a desired item) for an acceptable alternative to physical aggression. An example of a replacement behavior that was not functional was: • Individual #170's targeted behaviors were hypothesized to be maintained by attention. His replacement behavior included appropriate interactions, being more patient, and participating in meaningful leisure activities. These may all be important and valuable behaviors for Individual #170, however, they were not functionally equivalent to the purposed function of his target behavior (i.e., attaining staff attention). An example of a functional replacement behavior for a target behavior maintained by negative reinforcement would include teaching him an appropriate way to obtain staff attention.	

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		As reported in the last review, none of the PBSPs reviewed included specific instructions for how to train replacement behaviors. It is recommended that all replacement behaviors include specific skill acquisition plans for training. Moreover, these plans should be included into the current methodology, data system (when appropriate), and schedule of implementation for other skill acquisition plans at LSSLC. 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). Overall, one (Individual #128) of the 15 PBSPs reviewed (7%) represented an example of a complete plan that contained operational definitions of target behaviors, and clear, concise antecedent and consequent interventions based on the results of the functional assessment. Several other PBSPS, however, contained components of a good plan that should be modeled in future plans. These include: • The effective use of contingent reinforcement (e.g., Individual #43, Individual #555, Individual #552, and Individual #31) • Antecedents that were based on functional assessment results (Individual #555, Individual #500, Individual #128, Individual #285) Additionally the monitoring team was encouraged by other general improvements in PBSPS at LSSLC. These include: • Improvements in the use of functionally equivalent replacement behaviors • Improved use of operationally defined target and replacement behaviors It is recommended that the facility build on these PBSPs and general improvements and, for the next review, focus on increasing the percentage of PBSPs that are representative of clear, concise plans based on the results of a functional assessment.	
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,	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. Target behavior data, but not replacement behavior data, were consistently graphed monthly at LSSLC. Replacement behavior data should also be graphed. As discussed in K4, the facility had begun to graph some individual's data 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), and some graphs were easier to understand because potentially important events (e.g., change in plans or medication) were indicated with phase lines or arrows. The facility is	Noncompliance

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	psychiatric treatment, and use and impact of psychotropic medications.	encouraged to expand these graphing practices to all individuals' data that require a more sensitive graphing increment and/or a cleaner, more readable graph. The graphs reviewed contained horizontal and vertical axes and labels, condition change lines and label, data points, and a data path.	
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, at the time of the onsite review, the facility did not demonstrate that PBSPs were reliably implemented by DCPs. The most direct way to ensure that PBSPs are implemented as written is to implement a system to systematically monitor treatment integrity. It is recommended that an effective treatment integrity system be consistently used throughout the facility, data regularly tracked and maintained, and minimal acceptable integrity scores established. In the absence of treatment integrity data, the monitoring team attempted to assess if PBSPs were understood and correctly implemented by asking DCPs how they would respond to various target behaviors, and compared their responses to those instructions written in the PBSPs. Additionally, when the monitoring team observed the occurrence of a target behavior they compared the DCPs response with that specified in the PBSP. All staff interviewed indicated that they understood each individual's PBSP. The monitoring team did not observe the occurrence of any target behaviors during the onsite review. The staff's responses to how they would respond to target behaviors were not always consistent with what was written in the PBSP. For example, a DCP working with Individual #430 was asked what he would do if Individual #430 engaged in his target behaviors. The DCP said that he stops him and simply says "no." Individual #430's PBSP, however, stated that his target behaviors were maintained by attention, and that staff should attend to him on a regular schedule when he is not engaging in the target behaviors. Additionally, the PBSP specified that if staff need to physically stop the behavior, they should do so without talking or making eye contact with Individual #430.	Noncompliance
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 psychology department maintained logs documenting staff members who had been trained on each individual's PBSP. The trainings were conducted by psychologists and psychology assistants prior to PBSP implementation, and whenever plans changed. Although some psychologists conducted paper and pencil tests to measure DCP's competency with individual's PBSPs, no direct observations of staff implementing PBSPs were included. Therefore, more work is needed to achieve substantial compliance with this provision item.	Noncompliance

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	the specific PBSPs for which they are responsible and on the implementation of those plans.	There was no system in place to ensure that all staff (including relief staff) had been trained. Additionally, there was no systematic way to identify all of the staff who required remedial training. In order to achieve substantial compliance with this provision item, the facility will require documentation that all staff assigned to work with an individual has been trained in the implementation of their PBSP prior to PBSP implementation, and at least annually thereafter. Additionally, staff training should include a direct observation of the interventions specified in the PBSP. Finally, the facility should track DCPs that require remediation, and document that they have been retrained, and subsequently demonstrated competence in the implementation of each individual's PBSP.	
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 391 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 13 psychologists with BCBAs.	Noncompliance

Recommendations:

1. It is recommended that the facility develop a plan to ensure that all psychologists attain BCBA certification, or are reassigned to duties that do not include the writing of Positive Behavior Support Plans (PBSPs).
2. The facility should add monthly external peer review meetings.
3. Operating procedures for both internal and external peer review committees are needed.
4. The facility needs to expand the data system to include (and graph) replacement behaviors. Additionally it is recommended that DCPs be required to record a zero or their initials in each recording interval of the data sheet if a target or replacement behavior does not occur.
5. Data collection reliability should be monitored and tracked
6. Interobserver agreement (IOA) should be collected
7. Specific data collection compliance and IOA goals should be established, and feedback and training should be provided to DCPs and their supervisors to ensure that data are reliability collected.

8. Data books (or data sheets) should be readily available to DCPs

9. All functional assessments should contain direct measures of the target behaviors.

10. All direct functional assessments should include both antecedents and consequences hypothesized to be affecting the target behavior.

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

12. All functional assessments should include a summary statement that integrates the results of the various assessments into a comprehensive statement of the variables affecting the target behaviors.

13. The primary functions of target behaviors identified in the functional assessment should be the same as those included in the PBSP.

14. When new information is learned concerning the variables affecting an individual's target behaviors, they should be included in a revision of the functional assessment. Additionally, functional assessments should be reviewed at least annually.

15. The need for psychological services other than PBSPs should be documented in psychological assessments, PBSPs, or PSPs.

16. 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

17. All PBSPs should include operational definitions of target behaviors.

18. All PBSPs should include antecedent and consequent strategies to weaken undesired behavior that are clear, precise, and related to the identified function of the target behavior.

19. It is recommended that all replacement behaviors include specific skill acquisition plans for training.

20. It is recommended that treatment integrity data be tracked, and minimal acceptable integrity scores established.

21. Ensure that all staff assigned to work with an individual have been trained in the implementation their PBSP prior to PBSP implementation, and at least annually thereafter. Training of PBSPs should contain a competency-based component where DCPs are observed implementing the PBSP. Additionally the facility should track DCPs that require remediation, and document that they have been retrained, and subsequently demonstrated competence in the implementation of each individual's PBSP.

The following are offered as additional suggestions to the facility:

22. 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.

23. It is suggested that ABC data collection be used to collect direct functional assessment data

24. LSSLC had begun to graph some individual's data in increments that would be sensitive to individual needs and situations. The facility is encouraged to expand these graphing practices to all individuals' data that require a more sensitive graphing increment and/or a cleaner, more readable graph.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009: Medical Care, 7/20/10 o DADS Policy#006.2: At Risk Individuals, 12/29/10 o DADS Policy#09-001: Clinical Death Review, 3/09 o DADS Policy #09-002: Administrative Death Review, 3/09 o DADS Policy #044: Medical Emergency Response, 7/21/10 o LSSLC Medical Services Policy, 3/10/11 o Mortality reviews for individuals who died between September 2010 and April 2011 o Listing, Individuals with seizure disorder o Listing, Individuals diagnosed with pneumonia o Listing, Individuals over age 50 with dates of last colonoscopy o Listing, Individuals with diabetes mellitus o Listing, Individuals diagnosed with cancer o Listing, Individuals with DNR Orders o Neurology Clinic Notes for five individuals o Listing, Individuals hospitalized and sent to emergency department o DEXA reports for individuals with osteoporosis and osteopenia o Components of the active integrated record - annual physician summary, active problem list, preventive care flow sheet, immunization record, hospital summaries, active x-ray reports, active lab reports, psychiatric assessments, MOSES/DISCUS forms, quarterly drug regimen reviews, consultation reports, physician orders, integrated progress notes, annual nursing summaries, health management plans, diabetic records, seizure records, vital sign sheets, bowel records, MARs, annual nutritional assessments, dental records, annual PSPs, and PSP addendums for the following individuals: • Individual #463, Individual #245, Individual #91, Individual #361, Individual #437, Individual #551, Individual #183, Individual #33, Individual #507, Individual #126, Individual #431 Interviews and Meetings Held: o Brian T. Carlin, MD, Medical Director o Ronald G. Corley, MD, Primary Care Physician o Nai Kwei Chang, MD, Primary Care Physician o Nelda Johnson, APRN, Family Nurse Practitioner o Vasantha Orocofsky, MD, Psychiatry Director o Mary Bowers, RN, Chief Nursing Executive

	Observations Conducted: o Presentation made to monitoring team by senior staff at LSSLC opening meeting o Daily medical staff meetings o Cottages and dorms o Day services area o Risk management meeting o Daily infirmary rounds
	Facility Self-Assessment: The facility rated itself compliant with items L1 and L2 and noncompliant with items L3 and L4. Issues related to inadequate primary care provider documentation and follow-up and a mortality review system that consistently found no areas of improvement resulted in the monitoring team finding noncompliance with these two provision items. The monitoring team agrees with the rating of noncompliance for items L3 and L4. A comprehensive medical quality review system had not been implemented and clinical guidelines had yet to be issued.
	Summary of Monitor's Assessment: Limited progress was seen in medical services since the last onsite review. Routine and preventive services were being provided, but work was needed in increasing compliance rates in areas, such as colorectal and breast cancer screenings. Follow-up of clinical issues, labs and diagnostics remained problematic. The quality of documentation in the integrated record was not adequate. An external medical review had been completed and corrective action plans developed. The process for mortality reviews made no strides as mortality reviews continued to produce no formal recommendations, even when the clinical leadership believed corrective action was warranted. The medical director began collecting data on preventive services, such as breast, colorectal, and prostate cancer screenings. It was not always clear which set of guidelines was being followed. Medical policy had been developed and implemented, but the need for clinical guidelines remained outstanding.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with	**Overview** The medical staff was comprised of three primary care physicians, a medical director, and one advanced practice registered nurse. Psychiatric services were provided by one full time and three part-time psychiatrists. The daily routine of the medical staff began each day around 8:00 am 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	Noncompliance

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	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.	events occurring since the close of business and lasted approximately 30 minutes. It was immediately followed by rounds in the infirmary. Individuals requiring acute care were transferred to local hospitals in Lufkin for evaluation and/or admission. Informal agreements with local practitioners remained in place for the purpose of providing hospital inpatient services to the individuals supported by LSSLC. These longstanding agreements with local physicians allowed for some element of continuity of care. To further increase continuity, the hospital liaison nurse conducted hospital rounds daily to obtain status updates of hospitalized individuals. Updates were provided to the PSTs by email and a verbal report was given each morning in the daily medical staff meeting. This was a valuable process and at times alerted the primary provider to issues that required intervention on the part of the facility. Neurology clinic was conducted each month. Clinic lasted for three hours, of which it appeared that two hours were devoted to direct care to individuals, based on the schedules submitted. The clinic was held onsite, which allowed participation by the psychiatrists. An onsite ENT clinic was also conducted monthly. Labs were drawn at the facility and sent to Austin Sate Hospital. Results were faxed to the facility within one day. Labs were sent to local hospitals when stat results were needed. Stat results could be received within a few hours. X-rays were done onsite and sent to Memorial Hospital for radiology interpretation. The record sample, listed above in the Steps Taken section of this report, was chosen using the following methodology: • Records were randomly selected from the various lists of individuals submitted by the facility. • Individual #245 was selected as review of a sentinel event case. Individual #183 was selected for mortality review. **General Medical Care and Documentation** Individuals received a variety of services. They received preventive services. Specialty and acute care services were also provided. The primary care providers appeared to adequately address some elements of preventive care, such as provision of pneumococcal, influenza, and hepatitis immunizations, completion of vision exams and hearing screenings, and monitoring of lipids and thyroid function. 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. Issues, such as medication errors and failure to transcribe orders for diagnostic studies, further	

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		complicated these problems. Annual Medical Assessments Annual medical assessments (AMA) were found in every chart reviewed. Eleven of 11 records (100%) contained assessments that were completed within the required timeframes. The interval medical data presented information related to sick calls, consultations, labs, and imaging studies. This format lacked chronology and made it difficult for a reader to develop a clear understanding of the individual's health status and plan of care. The required functional assessments were lacking and none of the documents reviewed provided an active problem list with a plan of care aligned for each problem. The Health Care Guidelines required a list of active problems with outcomes specific to each active problem stated as part of the plan of care. Active Problem Lists Active problem lists (APL) were found in all of the records contained in the record sample. Very few of the problem lists, however, contained accurate and updated information. The Health Care Guidelines required that the active problem list be updated as new diagnoses were made or resolved. It further required that the APL be reviewed, revised and dated at the time of the annual PSP. Integrated Progress Notes Notes were written in SOAP format. They were usually dated, timed, and signed. Documentation related to routine issues, some acute issues, and follow-up, however, was not adequate. Moreover, when notes were completed, they were very often minimal and did not contain information useful to the PST. This finding was very provider specific. The Health Care Guidelines required a standardized format to ensure communication of medical assessment results, interpretation of findings and treatment rationale to the PSTs. Quarterly Medical Summaries Quarterly medical summaries were not completed at the facility. The Health Care Guidelines required that a Quarterly Medical Summary or narrative note that addressed all active problems inclusive of chronic problems be documented in the integrated progress notes. Physician Orders Physician orders were usually timed, dated, and signed. Illegibility of orders was problematic in a few records. There was a low rate of compliance with the requirement to state the exact parameters of monitoring and changes to be brought to the attention of the PCP.	

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		Consultations Physicians were compliant with reviewing consultation reports, dating, and initialing. Less often, a summary of the consult and acceptance or non-acceptance of the recommendations was found documented in the progress notes. **Routine and Preventive Care** Overall, the provision of preventive services was adequate in some areas and inadequate in other areas. Screenings for breast cancer and colorectal cancer were being completed, but additional work in that area was needed in order to obtain adequate compliance. Influenza and pneumococcal vaccinations were consistently documented. The majority of the documents did not contain varicella vaccination documentation on the immunization records. Although Zoster was being tested in some elderly individuals, the results were not found in the immunization records. It appeared that a new immunization record had been implemented that contained Varicella, but most documents were essentially blank. The follow-up of chronic issues and acute issues raised concerns. There were numerous instances noted in progress notes, Quarterly Drug Regimen Reviews, and other documents were there was a failure to follow-up on the clinical status of an individual or a diagnostic study. There were also issues related to providing adequate information to consultants. Examples are provided later in this section of the report, under "case reviews." The Medical Services Policy stated that the US Preventive Services Task Force Guidelines screening examinations and diagnostics, with the exception of cervical cancer and breast cancer, would be used. Cervical cancer screening would be in accordance with the American College of Obstetrics and Gynecology guidelines. The criteria used for breast cancer screening were not specified in policy. Screenings Screenings (audio and visual) and immunizations were provided with high compliance rates. The rates of compliance with screening for breast, cervical and colorectal cancer were not at an acceptable level. Breast Cancer Screening • 7 of 8 females were within age range for screening mammography • 4 of 7 females had completed mammography	

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		57% of females in this sample completed mammograms A list of females over the age of 40, date of last mammogram, and reason for noncompliance was provided. The list contained 122 individuals: • 69 of 122 females had current mammograms • 37 of 122 females had outstanding mammograms • 12 of 122 females were unable to complete testing • 2 of 122 females had pending mammograms • 1 of 122 females had a bilateral mastectomy 56% of females completed mammograms based on agency data Colorectal Cancer Screening • 3 of 11 individuals were over the age of 50 • 2 of 3 individuals had completed colonoscopy 67% of persons in this sample completed colonoscopies. A list of all individuals over the age of 50 was provided. The list contained 190 individuals: • 105 of 190 individuals had completed colonoscopies • 81 of 190 individuals had no documentation of colonoscopy • 4 of 190 individuals had no documentation of colonoscopy, but an explanation 55% of persons completed colonoscopies based on agency data Prostate Cancer Screening • 0 of 3 males were within the range for routine PSA testing Cervical Cancer Screening • 8 of 8 females were within the age range for screening • 2 of 8 females had hysterectomies • 0 of 6 females completed screening for cervical cancer Immunizations • 10 of 11 individuals received influenza vaccination (1 individual had an egg allergy) • 10 of 11 individuals received the pneumococcal vaccination • 9 of 11 individuals had evidence of immunity to Hepatitis B	

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		Individual #463 and Individual #551 did not have evidence of immunity in the records provided. **Medical Management** <u>GERD</u> • 2 of 11 individuals had a diagnosis of GERD • 2 of 2 individuals received appropriate medical management <u>Osteoporosis</u> • 5 of 11 individuals had a diagnosis of osteopenia or osteoporosis • 3 of 5 individual had osteopenia • 2 of 5 individuals had osteoporosis • 5 of 5 individual received calcium and Vitamin D supplementation • 1 of 2 individuals with osteoporosis received calcitonin for treatment None of the individuals received treatment with bisphosphonates and other first line therapies. Further discussion is included in Section L3. <u>Diabetes Mellitus</u> • 2 of 11 individuals had a diagnosis of diabetes mellitus • 1 of 2 received appropriate medical management • 1 of 3 had insufficient data and history <u>Hypertension</u> • 4 of 11 individuals had a diagnosis of hypertension • 4 of 4 received appropriate medical management <u>Bowel Management/Constipation</u> • 9 of 11 individuals had a diagnosis of constipation • 9 of 9 individuals received medical management • 3 of 9 individuals received 2 medications • 5 of 9 individuals received 3 medications • 1 of 9 individuals received 4 medications	

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		Case Reviews <u>Individual #91</u> Individual #91 had diagnoses of autism, bipolar disorder, hypothyroidism, and chronic kidney disease. On 2/4/11, the primary care provider documented in the integrated progress notes: S – Boils O – R cheek/scalp A – Abscesses P - TCN/ C&S • A wound culture was done and the individual was started on tetracycline. The culture of the wound grew MRSA. • On 2/7/11, the primary care provider documented that the individual was engaging in SIB and bruising was noted. Psychiatry was consulted and a CBC and PT/PTT were obtained. Nursing documented that the primary provider was informed of lab results. • On 2/7/11, psychiatry documented SIB and recommended that the Seroquel and lithium be decreased. The physician order sheet contained an order to decrease the Seroquel. • On 2/8/11, the individual was seen again by psychiatry and an order was written to decrease the lithium to TID. • The medical provider saw the individual on 2/8/11 and discontinued the tetracycline due to drug reactions. • From 2/14/11 – 2/21/11, the individual was seen by psychiatry and the primary care providers. The rash was noted to be resolved. • On 2/28/11, the quarterly psychiatry review was completed and psychiatry noted that the lithium was never decreased to TID. • On 3/8/11, psychiatry noted that liver enzymes were increased and recommended that primary provider be consulted. The abnormalities were addressed on 3/10/11 by the primary care providers. There were several issues related to the care provided to this individual. The wound culture was positive for MRSA that was resistant to tetracycline. The individual did not receive appropriate antibiotic therapy, but the lesions resolved. None of the medical providers documented culture results or documented any precautions for transmission of MRSA. The labs obtained on 2/7/11 were markedly abnormal and included a BUN of 53, creatinine 1.8, AST 316, and ALT 139. There was some evidence that the individual was volume depleted, but this was not addressed in any provider notes. The abnormal liver enzymes were not addressed until psychiatry requested consultation with the	

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		primary providers. Nephrology indicated in October 2010 that the individual had stage 3 chronic kidney disease, but the medical provider notes did not discuss any specific interventions to slow down progression of kidney disease. The individual remained on lithium in spite of the diagnosis of CKD III. Additional Discussion • The annual medical assessment completed on 8/3/11 noted that the individual had a colonoscopy in 2007, but the negative results were questioned. The results were not found in the records. The exact reason the primary provider documented "colonoscopy?" was not clear. • Tetracycline was added to the allergy list, but the ADR report cited a probability rating of 0. Additional discussion related to the adverse drug reaction is found in section N of this report. • The failure to decrease the lithium to a TID frequency was a medication error. • The individual refused dental treatment and required TIVA for routine care. Oral hygiene was documented as poor, and several tooth extractions were required. There was no success with desensitization. • Medical provider documentation utilized the SOAP format, but it was, nonetheless, inadequate. The SOAP note example above failed to provide vital signs for an individual with an infectious process and did not document the potential risk for MRSA. While the medical provider may have considered MRSA in antibiotic selection, the SOAP note should have communicated the assessment, interpretation of findings, and a rationale for the treatment decision in order to assist the PST in understanding the individual's problem. • The nephrology consult dated 11/12/11 provided no information other than a diagnosis of CKD III and laboratory studies requested. The reason for the lack of information was not clear. <u>Individual #245</u> Individual #245 had problems including bipolar disorder, esophagitis and chronic constipation. • On 11/13/10 at 10 pm, nursing documented that the individual's last bowel movement was on 11/10/10. Enemas were given at 7:00 pm and 9:00 pm with no results. The plan was to monitor. • On 11/14/10 at 11 pm, nursing documented that the individual was screaming out as if she was in pain. Vital signs were attempted, but the individual was uncooperative. The plan was to monitor. • At 12:00 am, following administration of Tylenol, the individual had calmed down. • On 11/15/10 at 10:15 am, the individual was found with emesis on clothing.	

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		Vital signs included BP 99/65, RR 24, HR 72, and POx 86%. The primary care provider was contacted and requested transfer to the hospital. The individual was admitted with aspiration pneumonia, lithium toxicity, and dehydration. The lithium level was 3.6. The individual was discharged on 11/22/10. There were several issues related to the care provided to this individual. The individual did not have a bowel movement in three days and enemas failed to produce results. There was no notification of the primary care provider. Subsequent nursing notes did not document that a bowel movement occurred. An additional concern was the use of pseudoephedrine to increase blood pressure in an individual who became hypotensive due to the use of clonidine patches. Pseudoephedrine is not approved for this use. Although medication choices were limited for this individual, consideration should have been given to discontinuing clonidine instead of adding pseudoephedrine, which is known to cause behavioral problems. • The individual refused meals frequently and became dehydrated with a sodium of 153 on 11/29/10. A PEG was placed on 12/1/10. • On 3/2/11, nursing documented meal refusal and agitation. On 3/3/11, the individual was seen by psychiatry who noted the lethargy and documented that the individual did better on lithium. The decision was made to restart lithium and monitor lithium level in one week. On 3/4/10, the initial dose of lithium was administered. • On 3/5/11, nursing documented administration of lithium. • On 3/5/11 at 5:45 pm, nursing documented the individual had a large episode of diarrhea, was cold, clammy, and lethargic. Vital signs were BP 121/101, HR 73, RR 18, and POx 100%. It was then discovered that the individual received 150 ml (9000 mg) of lithium instead of 150 mg. She was immediately transferred to an acute care facility where she was admitted with lithium toxicity and underwent hemodialysis. She was discharged on 3/7/11. On 3/17/11, lithium was restarted. Lithium levels are monitored weekly. • This individual was also noted to have elevated glucoses. A level of 166 was noted on 3/30/11. There was no HbA1c documented in the records reviewed. Additional Discussion • The administration of 9000 mg of lithium was a life threatening medication error. This is discussed further in section N8 below. • There was no documentation of Hba1c in the labs reviewed. • The annual medical assessment did not include osteoporosis as an active diagnosis although this was listed as the indication for calcitonin. The active problem list was not updated. Iron deficiency anemia was documented as resolved, yet the individual continued to receive ferrous sulfate.	

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		• There were concerns related to the QDRRs. The report dated 3/2/11 stated that the "IAR not available for review." The primary provider indicated no action necessary. The report dated 12/1/10 also stated that the IAR was not available for review. <u>Individual #126</u> Individual #126 had diagnoses that included seizure disorder, psychotic disorder, constipation and osteopenia. • On 1/31/11, psychiatry wrote an order to increase lithium from BID to TID and obtain lithium level and TSH in one week. The order was not carried out and the error was not detected until 2/14/11. • On 2/22/11, the individual was seen by the primary care provider due to cough and nasal congestion. Physical exam reveled decreased breath sounds on the right. Vital signs included RR 20, T 98, and POx 99%. The individual was treated with Zithromax and Robitussin. An order was written to obtain a CBC and CXR. • On 2/28/11, the records documented a review of AED levels by the primary care provider. On 3/1/11, the dermatology consult was reviewed and orders written. • There was no follow-up on respiratory status, CXR, and CBC. A CXR was done on 3/15/11 that was normal. The indication was not clear in the records. Additional Discussion • This individual received phenobarbital and valproic acid for a diagnosis of seizure disorder. The last documented seizure was in 2004. The record did not include any neurology clinic notes. The individual should be reviewed by neurology and psychiatry to determine the need for continued treatment with AEDs. • In 2007, an abdominal x-ray showed a segment of apparent narrowing within the low loop of sigmoid. It was recommended that a colonoscopy or barium enema be done to rule out a lesion. In 2003, a colonoscopy was done that showed internal hemorrhoids. One of three stools tested positive for occult blood in August 2010. • The individual had multiple diagnoses that were not listed as active problems on the Active Problem List including constipation, tachycardia, and osteopenia. Mild anemia and lymphocytosis were added to the problem list. • The QDRR dated 3/24/11 indicated that the IAR was not available for review. <u>Individual #431</u> Individual #431 had diagnoses that included diabetes mellitus, conduct disorder, hypertension, and seizure disorder. General concerns related to care included: • The annual medical assessment dated 6/10/11 stated that immunizations would be determined. The individual was admitted in June 2009. Pneumovax,	

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		hepatitis, and Influenza vaccination data were recorded. • The preventive care flow sheet was not provided in the document request. • This individual was diagnosed with a brain cyst and new onset seizure disorder. The primary care provider documentation included only four brief notes over the period of one year. • The individual had a neurology evaluation 2/11. During that visit, the neurologist noted that the individual had an appointment in April 2011, but seizures had increased in January 2011. It was noted that no Keppra level was available. The recommendation was to increase Keppra to 1500 mg BID and return to clinic in three months. The order for the increase in Keppra was not written until 4/4/11. • The individual was referred for an endocrine evaluation on 7/6/10. The endocrinologist indicated that it was not known how long the individual had been diabetic and the fasting glucose log was not available. The record noted: "When all requested data available, will give further recommendations." • The active problem list was not updated to include the diagnoses of hypertension, seizure disorder, and brain cyst. • The individual was not receiving ace inhibitors or angiotensin receptor blockers for renal protection. It was not known how long the individual had been diagnosed with diabetes. **Do Not Resuscitate (DNR)** There were three individuals with active DNRs: • Individual #42 – DNR implemented on 3/00 due to anencephaly • Individual #96 - DNR implemented 7/09 due to Alzheimer's • Individual #437 - DNR implemented 1/10 due to seizures Individual #437 had a diagnosis of seizure disorder, chronic esophagitis, constipation, and aspiration. The LAR requested no medical measures that would prolong life, including cardiopulmonary resuscitation, mechanical ventilation, and enteral tubes. All invasive testing and procedures have been declined. The individual had maintained weight within the desired range. Documents provided indicated that proper procedures had been followed prior to implementation of the DNR orders. The PSTs should review the appropriateness of continuing the DNR status given that no terminal illness had been identified. These orders will likely be modified given the upcoming changes in the DNR policy and procedures for the SSLCs.	

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		Seizure Management The facility conducted onsite neurology clinics. The neurologist and psychiatrist saw individuals with seizure disorder and a psychiatric diagnosis simultaneously. Documentation of seizure management during the past six months was submitted for five individuals. Documents provided included clinic notes and lab results. Reports of labs contained identifying data only on the first page and, therefore, were not used. Neurology clinic notes were very brief and included information on seizure frequency, drug dosages, drug levels, and labs. Recommendations for drug adjustments were given when appropriate, but the recommendations were not specific. The medical director reported that no one had experienced status epilepticus during the past six months. There were no individuals identified with refractory seizure disorder. Individual #437, who was on four seizure medications, was noted to have five to six seizures in just three months, and approximately 16 seizures in 2010. The medical director should re-evaluate seizure data in order to ensure that no individual with refractory seizure disorder have been missed. A list of all individuals with a diagnosis of seizure disorder was provided. The facility reported that 199 individuals had a seizure disorder. Of those on the list, 189 received treatment with AEDs. With regards to medication management, the facility reported percentages of individuals on multiple AEDS: 2 AEDs (14.7%), 3 (9.6%), 4 (1.855) and 5 (.25 %). These percentages were calculated using the facility census total which resulted in inaccurate values. The AED data based on the number of individuals receiving medications were: • 73 of 189 individuals received one AED • 66 of 189 individuals received two AEDs • 40 of 189 individuals received three AEDs • 8 of 189 individuals received four AEDs • 1 of 189 individuals received five AEDs Quality of life measures, such as an individual's cognitive ability, ability for self-care, communication use, social skills, and motor skills were not documented in the neurology notes provided. There was no discussion of medication side effects and MOSES and DISCUS data were not utilized in assessments and decision-making. The facility needs to reassess its seizure management program and related data. AED polypharmacy data were actually double the reported numbers, and one individual in the	

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		record sample had refractory seizures by definition, but was not identified. The identification of individuals with refractory seizure disorder is necessary so that they may be referred to a qualified epileptologist for evaluation. The facility should assess its need for additional neurological services, either onsite or off site. Clinic records indicated that one neurology clinic was conducted each month for about two hours. It also appeared that some individuals were seen off campus. A facility with 189 individuals receiving AEDs is clearly in need of a substantial amount of neurology services hours.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	<u>Medical Reviews</u> An external reviewer completed a medical quality review from 2/1/11 – 3/31/11. The audit assessed compliance with 32 requirements of the Health Care Guidelines. DADS state office staff discussed the process and data from the facility's first review with the monitoring team during the onsite review. While the process and tools had not been finalized, the audits provided valuable data on compliance with the Health Care Guidelines. Action plans were generated by the facility's QA Department based on audit data. The QA department was in the early stages of following up on corrective actions. The review was focused entirely on processes. There were no outcome indicators among the 32 items. As outcomes of individuals are the primary focus, a quality review must include these. These can be determined at the individual level and aggregate data determined for the facility and statewide. If a particular disease process is evaluated, a mix of process indicators and outcome indicators would be reviewed. For example, process indicators, such as appropriate monitoring of HbA1c and creatinine/protein ratios, would be easy to document by record audit. Outcomes would be based on achieving the therapeutic targets. Establishing a list of specific diseases for monitoring would be necessary. Starting with those covered by the clinical guidelines may be appropriate. <u>Mortality Reviews</u> Mortality Reviews were another type of case review completed by the facility. 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.	Noncompliance

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		There were five deaths recorded from September 2010 to April 2011. The average age at death was 49 years. The causes of death were listed as: • Severe coronary artery disease • Myocardial hypertrophy • Respiratory failure • Cardiopulmonary arrest secondary to metabolic acidosis The mortality documents for four deaths were reviewed. The Clinical Death Review Committee and Administrative Death Review Committee meetings were conducted per state policy. The Clinical Death Review Committee meetings were conducted via scan call. The LSSLC medical director and attending physician participated in all meetings. Other participants included the state medical services coordinator, a community physician, the QA nurse, and chief nurse executive. <u>Mortality Review Management at LSSLC</u> Autopsies were completed on three of the individuals. The administrative and clinical death reviews were completed for the first four deaths (the last death occurred one week prior to the onsite review). The clinical death reviews rarely generated any formal recommendations. When recommendations were generated, the administrative death reviews did not include them. The mortality review process was discussed with the medical director, chief nurse executive, and QA nurse. The monitoring team inquired about the process for accepting and implementing recommendations. This was of particular interest since the four deaths reviewed during the last onsite review also resulted in zero recommendations by the Clinical and Administrative Death Review Committees. This would seem to indicate that the facility determined there were no opportunities for improvement in processes related to the provision of care involved in these cases. Opportunities for improvement do not necessarily indicate fault or causation and should be considered opportunities to improve systems for the benefit of those supported by the facility. The QA nurse reported that the medical director completed chart reviews for each death in addition to the review completed by the QA nurse. Concerns and recommendations were documented in the QA nurse reviews and surfaced in the Clinical Death Reviews. The Clinical Death Review Committee made recommendations to the Administrative Death Review Committee. The recommendations from the Administrative Death Review Committee were the formal recommendations. The monitoring team requested further	

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		explanation regarding the observation that none of the concerns and recommendations from the QA Nurse reviews submitted were included in the clinical death reviews. The CNE and QA nurse both responded that they had no explanation for this pattern. The medical director chaired the Clinical Death Review Committee, but did not provide any response to the questions related to generation and acceptance of recommendations. Recommendations from the QA Nurse reviews provided onsite included: 1. Educating RN Case Managers on policy and procedure 2. Prioritization by psychiatry in updating assessments 3. Developing parameters to contact physicians 4. Establishing methods for prompting staff to review hospital discharge notes 5. Revising the methods by which consultations are scheduled and followed up to see that appointments are kept These recommendations were based on findings in the record reviews and represented opportunities to improve systems. Minimally, there should have been discussion during the clinical death reviews and documentation to support the decision to not include these as valid concerns. The CNE explained that she had opted to take corrective action by discussing with the facility director implementation of nursing related changes as informal recommendations. Furthermore, the mortality review process did not benefit from a thorough review of all records by a physician reviewer. There was no physician assigned to complete a through review of all records, inclusive of the integrated record to determine if there was compliance with the standards of care of medical practice.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	The facility had not implemented a formal medical quality improvement program. The medical director had taken some steps to move towards compliance with this provision item by tracking some quality data, including compliance with screening for breast cancer, prostate cancer, and colorectal cancer. Data were also collected related to detection and treatment of osteoporosis and compliance with treatment standards for diabetes mellitus. While these data provided some useful information, there were concerns related to the use of the data for the purpose of assessing the quality of medical care. Many of the graphs and tables provided did not contain titles or timeframes and, therefore, will not be discussed.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>The following information was presented as part of the medical department's osteoporosis care practice improvement.

<table>
<tr><th>Type of Osteoporosis Care</th><th>Compliance (%)
n=69</th></tr>
<tr><td>Measurement of Vitamin D</td><td>90</td></tr>
<tr><td>Adequacy of calcium and Vitamin D supplementation</td><td>91</td></tr>
<tr><td>Treatment</td><td>93</td></tr>
<tr><td>Occurrence of Fractures</td><td>81</td></tr>
<tr><td>History of gastritis</td><td>16</td></tr>
<tr><td>History of constipation</td><td>46</td></tr>
<tr><td>History of gastritis and constipation</td><td>86</td></tr>
</table>

The quality improvement plan:
1. Annual Vitamin D, calcium, and phosphorus levels drawn.
2. MBD tests scheduled for at risk patients.
3. Attempts will be made to optimize control of falls

<u>Additional Discussion</u>
The data above represent one of the initiatives taken by medical services to improve the quality of care provided. High rates of compliance with measurement of Vitamin D and supplementation were noted in the record audits. Improvement in this process as a measure of quality should include information on treatment regimens. The records request made by the monitoring team specifically asked for all drug therapy, but that was not provided. Additionally, the ability to participate in exercise should be assessed and compliance documented

It was good to see that this process was completed. Measurement of quality requires that the standards be outlined, but that had not occurred. Clinical guidelines for treatment must ensure that a thorough risk assessment is completed. The risk indicators on the preventive care flow sheet are not comprehensive and should be expanded and formalized in the clinical guidelines.</td><td></td></tr>
<tr><td>L4</td><td>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</td><td>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. Also, DADS Policy #009: Medical Care was issued in July 2010.

The medical department had issued a revised Medical Services Policy based on state issued policy, but clinical guidelines had yet to be issued. According to the medical director, the clinical guidelines/protocols developed by the various medical directors were in the final stages of approval in state office.</td><td>Noncompliance</td></tr>
</table>

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	care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.		

Recommendations:

1. The medical director should work with the medical staff to ensure that the requirements of the Health Care Guidelines are clear.

2. Physicians should conduct follow-up on individuals with acute problems until the problem is resolved or stabilized. The intervals may vary, and depend on the problem. The medical director should draft specific guidelines on requirements for follow-up. Some acute problems may require daily follow-up until stable.

3. The medical director should address the following issues related to requirements for documentation:
    a. The Active Problem Lists should be updated as problems arise or resolve.
    b. A template for quarterly medical summaries should be developed.
    c. SOAP noted should comply with requirement of the Health Care Guidelines.

4. State office should provide guidance on which set of screening guidelines should be used. The Health Care Guidelines did not provide autonomy to the individual centers on this issue.

5. The medical director must review data related to seizure disorders to ensure that anyone with refractory seizure disorder is identified. Individuals with refractory seizure disorder should be referred to a qualified epileptologist for evaluation.

6. The facility must assess it current needs related to services for persons with seizure disorder to ensure that the needs of the individuals are being met.

7. All individuals with DNR orders should be reassessed to determine the appropriateness of the order and ensure compliance with state guidelines.

8. The facility must resolve the recurrent problem of failure to transcribe physician orders as this contributes to medication errors and other delays in care.

9. Mortality Reviews should include a detailed review of medical care completed by a physician. If an external physician cannot perform this task, the medical director should complete the review. Furthermore, the process should be used as an opportunity to improve in areas where problems were identified.

10. The medical director should ensure that immunization records document each individual's varicella status.

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: Care Plan Development (July 2010) o DADS State Supported Living Center Policy: Physical Nutritional Management (3/11/11) o DADS State Supported Living Center Policy 006: At Risk Individuals including the accompanying Risk Guidelines, Risk Action Plan, Risk Process Flowchart, Risk Rating Documentation form (11/2/10) o DADS State Supported Living Center Draft State-wide Nursing Training on Physical Health Assessment including plan, outline and competency checklist o LSSLC Nursing Policy and Procedure Manual, 182 Day Orders, 4/1/11 o LSSLC Nursing Policy and Procedure Manual, Medication Administration procedure .0310, revised 4/11 o LSSLC Nursing Policy and Procedure Manual, Seizure Management procedure .0810, revised 4/11 o LSSLC Nursing Policy and Procedure Manual, policy on Dental/Medical Sedation and Restraint, dated 7/16/10 o LSSLC Nursing Policy and Procedure Manual, Documentation procedure .0910, revised 9/10 and currently in draft o LSSLC Nursing Policy and Procedure Manual, Gastrostomy or Jejunostomy Tube-Nutrition/Hydration/Medication .0709, rev. 4/11 o LSSLC Nursing Policy and Procedure Manual, Acute Illness/Injury Management and Communication.0708, rev. 4/11 o LSSLC Nursing Policy and Procedure Manual, Sedation-Pretreatment and Post Sedation Monitoring. 10/09, rev. 4/11 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 Alphabetical list of individuals with current PSP, annual nursing assessment, and quarterly nursing assessment (due) dates o List of admissions since 10/1/10 o List of Infirmary admissions 10/1/10 o List of Emergency Room Visits 10/1/10

	o List of Incidents and Injuries since 10/1/10 o List of Hospitalizations 10/1/10 o List of expired individuals since 10/1/10 o List of Pneumonia Diagnoses since 10/1/10 o List of individuals with unplanned weight loss at six months of ≥ 10% o List of 10 individuals with the most injuries since 10/10 o LSSLC "Target" list of individuals requiring aspiration triggers data and date of at risk meeting and identification of all individuals who were enterally fed with pneumonia history, and pneumonia tracking 4/1/10-3/18/11 o List of individuals who receive nutrition enterally o The last six months, minutes from Weekly Nursing Management Meetings 9/7/10-3/1/11 o The last six months Nursing Quality Enhancement reports, 9/22/10-1/5/11 o Quality Enhancement/Quality Improvement Council minutes 1/19/11-3/16/11 including medical emergency response o LSSLC Trend Analysis for Emergency Response Drills, quarter 1, 2011 o LSSLC Training outline and power point presentation on Responding to Hazards and Emergencies dated 10/09 o Nursing training dates for each specific policy and percentage of nurses trained in each policy o LSSLC completed Section M and previous Health Monitoring checklists completed 9/30/10 through 2/25/11, raw data without summary o Licensed Nurse Competency/Skill Assessment, LSSLC o Infection Control Committee Meeting minutes 8/12/10 through 3/10/11 o Infection incidence list and 2011 analysis to date o Section M: Medication Administration and Documentation observation checklists from 1/4/11 and 1/20/11 o Sample completed Comprehensive Nursing Assessments, before and after critique by nursing CNE and NOO dated 2/28/11 o Sample completed IPN on seizure episode and follow-up o Adult Preventive Care flow sheet form o Model Health Management Plan to address risk of aspiration o LSSLC Nursing Education Curriculum and written test on Signs and symptoms requiring nurse notification for DCS o Aspiration pneumonia trigger Teaching Outline and written test o Aspiration trigger data sheet o LSSLC Priority list for who is in need of a new wheelchair dated 4/12/11 o LSSLC Nurse Compliance Coordinator Pneumonia Investigation results o LSSLC The Nurse's Responsibility in Vital Sign Monitoring power point presentation, 4/17/11 and written test o LSSLC Skin Integrity Committee Meeting minutes 8/12/10-3/10/11 o LSSLC Bi-weekly Medication Errors Meeting minutes 9/1/10 through 3/9/11 o LSSLC Pharmacy and Therapeutics Committee meeting minutes and attachments from 11/16/10 and 2/8/11

	o Nutritional Management Team Reports for last six months, 9/10-3/11 o Mortality and death review summaries and nursing service summaries since 10/10 o LSSLC POI 4/4/11 o LSSLC Meeting Schedule for 4/18/11-4/22/11, updates o Records including at least physician's orders, IPNs, nursing assessments and health data, HMPs and progress reports on HMPs, At Risk Ratings and At Risk reviews, hospital discharge summaries, and MARs of: • Individual #10, Individual #11, Individual #96, Individual #146, Individual #102, Individual #57, Individual #267, Individual #398, Individual #258, Individual #353, Individual #535, Individual #310, Individual #345, Individual #389, Individual #245, Individual #202, Individual #141, Individual #285, Individual #569, Individual #371 o Selected portions of records for: • Individual #310: IPNs and seizure records <u>Interviews and Meetings Held</u>: o Chief Nurse Executive, Mary Bowers o Nursing Operations Officer, Laura Flowers o Quality Enhancement Nurse, Gena Hanner o Nurse Managers: Jackie Lindsay, Sheryl Fuller, and Richard James o Infirmary Nurse Manager, Clinton Hook o Infection Control Nurse, Bobby Duke o Nurse Educator, Zalinda Colston o Nursing Compliance Coordinator, Gerald Davis o Nurse Case Managers: Joyce Adams (549A), Melissa Huggins (549A), Peggy Ivey (549D), Debra Peterson (524), Margie Taylor (549A), and Carmen MacDonald (561 B) o Workshop RTTIV, Jennifer Rawls o Respiratory Therapist, Leah Jarvis o QMRPs: Mallory Thompson and Leigh Ann Hall o Direct Care RN, Brooke Draper o LVNs: Hope Hamilton and Michael Lovett o Home Managers: Pamela Derbonne (561A), Beulah Williams (506), Rhonda Williams (549A), and Theresa Spencer (561B), o Direct Support Professionals: Janet Doyle, MRAIII (549A), Katasha Davis, MRAI (549B), Lucious Wade, MRAI (561A), Martha Barthold, MRA (561A), Brandy Blackshire, MRAII (563A), Anella Biggs, MRAIII (557B), Branda Jefferson, MRAI (549), Linda Thompson, MRAIV (557A) o DADS Nursing Education Roll Out, Connie Horton, APRN, Nursing Consultant <u>Observations Conducted</u>: o Weekly Nurse Administrative and Safety Meeting 4/19/11 o Weekly Nurse Manager Meeting 4/19/11 o Daily Medical Meeting 4/19/11 o Annual PSP for Individual #569, chaired by Shanta Scott, QMRP, 4/19/11

	o Medication pass on 4/20/11 at 1700H in home 549A and on 4/21/11 at 0700H in home 563A o Nebulizing treatment (549A) o Enteral nutrition (549A)
	Facility Self-Assessment: At the time of the review, the facility provided a POI updated on 4/4/11 that provided a description of the steps the facility was taking to assess compliance with regard to the specific sections of the Settlement Agreement related to Section M: Nursing Care. The POI indicated that there was not compliance with each provision in Section M and the monitoring team concurs. The updated POI described numerous system and process changes in progress to address each of the provisions including several that were implemented within the last quarter. They have initiated audits targeting nursing care and treatment related to urgent care/emergency care/hospitalizations, infection control, acute illness/injury, GERD, quarterly and annual nursing assessments, documentation, and seizures. Improvement in the timeliness and completion of assessment items on the comprehensive nursing assessment form was noted, but there continued to be a lack of data quality and summarization and analysis of the data. The POI involved nursing staff at all levels and the Quality Enhancement Nurse.
	Summary of Monitor's Assessment: During the conduct of this review, at least 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; 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 administration of medications without knowledge of potential side effects, pre-pouring medications, appropriate administration and follow-up for response to treatment with PRN medications, and consistent vital sign monitoring related to administration of antihypertensive and other medications with potentially negative effects on blood pressure. The administration of medication and the management of the medication administration system at LSSLC continued to undergo numerous changes since the previous review including changes initiated on 10/20/10 to utilize monthly MARs and medication delivery. The effectiveness of these initial and recent changes will continue to require further review and evaluation. Nurses continued to hand write in orders for monitoring vital signs and other treatments. 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 was 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 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 being reviewed and revised in order to promote progress toward the achievement of this provision of the Settlement Agreement. Model plans were developed for the priority area of aspiration. 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. Completion of investigations of pneumonia episodes had been performed and collaboration with the Quality Assurance department for ongoing reliable monitoring was in progress. The nursing department had targeted seven areas addressed in the Texas Health Monitoring Tools for quality improvement. Internally designated nurses were starting to monitor urgent care/emergency care/hospitalizations, infection control, acute illness/injury, GERD, quarterly and annual nursing assessments, documentation, and seizures. There were yet to be implemented plans for summary and analysis of results and validation of monitoring results in these areas by the Quality Enhancement Nurse. Training initiatives included the nurses training DCS on the Aspiration Triggers and completion of the accompanying data sheet as well as on seizure documentation. 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. Designation as one of two SSLCs to serve children would also require re-evaluation of population needs and resources particularly associated with the acuity of the children's population to be served. Additionally, there was the issue of maintaining an adequate level of appropriately trained staff, particularly on the 2-10 shift. Training nurses to meet the new requirements was addressed through planned revisions to new nurse orientation and an extended preceptorship to better assure carry over into actual nursing practice.

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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.	The Nursing Operations Officer (NOO) continued to supervise and/or participate in most facility processes that impacted on functioning of the individual units, including individualized health care management to address the areas of focused nursing audits. 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 individuals 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. Nursing staffing and adequate training of staff were identified as the number one challenge for the NOO. • The Master Tracking list was maintained to continue 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 continued to be used to track 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 was continuing to shift to the quality and individuality of plan interventions. Documentation that plans were implemented as planned, with supporting data adequately summarized and analyzed, continued to require improvement. • 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 previous review. 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 designation of LSSLC as a facility for children, some shift in the age of the population will be expected, but not necessarily those with low acuity levels. With the initial and continued 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. Several revisions to state-wide policies and procedures, such as the At Risk policy and Section M-Nursing Monitoring Guidelines required revisions or delays to implementation of strategies in progress. There was an improvement in the pattern of frequent and regular identification of health care problems and risks, but implementation of appropriate and individualized interventions, and appropriate follow-up to resolution remained inconsistently documented across the entire sample of 20 individuals.	Noncompliance

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		During the onsite monitoring review, 19 of 20 individuals were visited, and their records were reviewed. Individual #398 had transitioned to a community residential program and only his record was reviewed. Records were organized, and nurses' notes were usually in the DAP (Data, Analysis, Plan) format. The revisions to the nursing documentation policy that were in draft at the time of the review will change in the IPN format to a SOAP format with accompanying training for nursing staff. The DAP notes did not provide 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 written in the plan section was that they will continue to monitor, however, there was frequently 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 or improperly signed and dated. Several late entries in the IPNs were not entered correctly by identifying the date and time the entry was made as well as what date and time the late entry coincided with, (e.g., Individual #202 IPNs on 3/31/11). 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, and other abnormal vital signs). Exceptions are described in sections M2, M3, and M6 for Individual #96, Individual #10, Individual #535, Individual #245, Individual #285, and Individual #57. 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 of the nursing process from assessment to evaluation of plan effectiveness. Examples 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	

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		procedures during the last quarter.	
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 #146. Her assessments dated 4/15/10, 2/2/10, and 7/27/10 were provided to the monitoring team for review. 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. An improvement in the completion of all the items specified on the assessment, and appropriate to the individual, was noted when compared to the 10/10 monitoring review. 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. Nineteen of the 20 individuals reviewed had annual and quarterly nursing assessments completed and filed in their records. All 19 had completed Braden Scales to rate skin integrity risk. The assessments were conducted by RN case managers. Nursing assessments completed since October 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 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 nursing assessment. Notwithstanding the positive findings, performance of nursing assessments failed to provide a complete and accurate review of each individual's health status, particularly summaries and analyses of health status data including data documenting interventions were implemented as planned.	Noncompliance

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		Annual and quarterly nursing assessments completed since October 2010 were more complete than found during the previous review. Less assessment items were left blank, however, they continued to lack the comprehensive health care data needed for analysis to identify changes, patterns and/or trends and provide a foundation for appropriate diagnosis and planning. Examples are presented below. • Frequently a complete list of the individual's routine as well as PRN medications including dose, frequency, and reason for and response to treatment were not documented. This was the case for Individual #10's 1/10/11 quarterly nursing assessment, Individual #258's 2/23/11 annual assessment, Individual #535's 3/31/11 quarterly assessment, Individual #310's 1/19/11 annual assessment, Individual #202's 2/15/11 quarterly assessment, Individual #141's 3/24/11 quarterly assessment, and Individual #285's 3/14/11 quarterly assessment. For some individuals routine medications and their effectiveness were reported in the comments section of the assessment. Changes in medications and use of PRN medications were frequently listed. • The scoring key to the Braden Scale ratings of skin integrity and/or the meaning of individual ratings were to be placed on the Comprehensive Nursing Assessment. It was not present for nine of 19 assessments reviewed. • Individual #10: An analysis of her weight and diet data was not included (i.e., weight gain from 140 pounds to 146.6 despite a change from a 1500 calorie to a 1200 calorie diet). Her desired weight range was 90-118 pounds. Her bowel management plan was noted to be effective because she had received no enemas despite dependence on Docusate sodium 100 mg orally three times daily, Polyethelene glycol 17 gm twice daily and Bisacodyl suppositories 10 mg rectally at bedtime on Monday, Wednesday, and Friday. Her previous diagnosis of osteoporosis was not in the history section. Although she had spastic quadriplegia with multiple flexion contractures there were "no abnormal findings" of upper and lower extremities in the musculoskeletal sections, and no sensation or temperature assessments of extremities completed. • Individual #102: The weight at her last 1/5/11 assessment was not included and compared to her current weight. There was no evidence of analysis of weight changes. Self injurious behavior was checked on the assessment, but there was no brief description of the behavior or reference to the existence of, or the nurse following, her behavior management plan. • Individual #57 was on an 1800 calorie regular diet. His weight was 200 pounds, up 26 pounds from his weight of 174 pounds last year (EBWR was 122-177). The 1/7/11 assessment had no documentation that the unplanned weight gain was recognized with no summary of weight changes/trends over the past year and changes in strategies tried. There was no comparison of his weight gain trend with medication changes known to have possible metabolic side effects.	

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		• Individual #258's 2/23/11 annual assessment included the frequency of vomiting episodes, but no analysis of patterns and trends. There was no assessment of oral hygiene by the nurse. There was no notation of the additional risk associated with Dilantin therapy. • Individual #353's 4/1/11 nursing assessment noted she did not allow a dental evaluation on four consecutive occasions. There was no identification of the need for a desensitization plan. • In Individual #310's 1/19/11 annual assessment oral hygiene was an identified nursing problem, but the assessment items addressing oral hygiene from the dentist including the dentist's oral hygiene rating and assessment of oral hygiene/oral cavity by nursing were both blank. His assessment summary noted he was uncooperative for tooth brushing and dental cleaning, but to continue to attempt to clean after meals and monitor monthly without any direction for the DCS implementing the program. He refused the pulse oximeter at the time of the annual assessment, which did not have to be done in one sitting. There was no indication of retrying to obtain his oxygen level noted in the summary or strategies used to obtain cooperation. His assessment had no tympanic membrane assessment or indication of refusal. There was no indication of a specified bowel management plan or frequency/pattern of bowel elimination. • Individual #202's 2/15/11 assessment left physical assessment of the eyes incomplete. His bowel management plan was reported in place, but not specified, and he was non-ambulatory and on a positioning schedule, but no musculoskeletal abnormalities were noted. Edema of his lower extremities (i.e., his lower left foot) was noted but not the severity. • Individual #285's assessment did not list self-induced vomiting/rumination as a diagnosis. 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 M3. Several examples of other nursing assessments did not meet the nursing care needs of individuals. The assessments did not meet the criteria established in the state's Health Care Guidelines, particularly for: (1) Vomiting to include assessment every shift until no vomiting for 24 hours and daily to include abdominal assessment, respiratory assessment, vital signs and analysis of intake and output, if at risk for constipation a rectal exam is performed, NPO and clear liquid diet as appropriate; (2) Temperature to include assessment of complete vital signs every four hours for greater than 101degrees until afebrile for 48 hours, then nurse evaluation each shift until afebrile for 48 hours, assure nursing interventions to prevent dehydration; and, (3) Respiratory distress to	

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		include prompt notification of the physician of oxygen saturation less than 95% unless otherwise indicated, administer oxygen for panic level of 90% or less. Examples include the following: • Individual #10: On 3/12/11 this individual was sent to the ER with a high temperature and low BP. She was discharged to the infirmary on 3/15/11 with a 3/16/11 clarification of her orders. She was admitted to the infirmary with diagnoses of UTI and dehydration and discharged to her dorm on 3/17/11. Nursing assessment, communication and actions were not consistently appropriate. On 3/12/11 at 0135H she had an episode of vomiting one and one half cups of yellow liquid with "some thick clumps and mucus." She was assessed by the LVN with vital signs, O2Sat levels, and noting two soft bowel movements reported on the 10-6 shift. On 3/12/11 at an unknown time, an RN follow-up assessment stated her vital signs were stable, but vital signs were not recorded, O2Sat was not recorded, respirations were reported to be even and unlabored, and lungs were clear to auscultation, abdomen was soft and bowel sounds present. The documented plan was for DCS to monitor for further emesis and/or respiratory difficulty and notify nursing. Approximately four hours after her first vomiting episode on 3/12/11 at 0520H, she vomited approx four cups of yellow chunks mixed with mucus. The episode was observed by the LVN and DCS. The LVN assessment included BP 90/60, P 98, R 22, and O2Sat 95%. She was reported alert and in no acute distress and the episode was reported to the infirmary RN. No other actions or plans were noted including positioning. It was unclear how these episodes were documented on this individual's aspiration trigger sheet. The RN evaluation occurred at 0700H, where she received a report the individual had vomited at 0520H today with no documented report of the 0135H episode. There was appropriate assessment documented, but her O2Sat on room air was 94-95%, which was lower than usual for her. There was no plan for replacement fluids, clear diet, and no assessment of intake and output other than she had bowel movements the day before. The plan was for 24 hour post vomiting follow-up. She then had a seizure at 0715H with orders for the DCS not to feed her while she was lethargic after the seizure. At the 0830H she ate poorly, but drank eight ounces of skim milk. It was reported she was "more alert" and "to bed for quiet time and rest." At 1300H, nursing was notified the individual needed to be assessed. Her vital signs were BP 100/56, P 79, T 98.5, R 20, and a low O2Sat of 93%. The nurse administered Albuterol via nebulizer during which the individual had a one-minute seizure. It was noted by the monitoring team that no one mentioned the significant vomiting episodes that occurred before her two seizures on 3/12/11. After the breathing treatment, she was reported to have had "audible congestion than can be cleared with coughing." It was unknown if these assessment results were obtained before or	

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		after the breathing treatment. It was noted that her O2Sat was up to 95% after the treatment. She was assisted to bed and placed on her left side. Six hours later at the 1900H there was a documented follow-up assessment related to vomiting and refusal of supper and fluids. There were no vital signs other than her O2Sat at 95% and abdomen soft and tender. At 2045H, her IPN reported there had been no oral intake on the 2-10 shift and she was not taking her oral medications. She was wheezing and the "HOB slightly elevated. Coughing." No vomiting or seizures were reported on the 2-10 shift. Her vital signs were T101.4, P 109, R 22, all elevated, BP 84/54, that was low, and a dropping O2Sat of 94%, which were reported to the RN. At the 2125H the RN assessment results included wet sounding non-productive cough, T101.4, P114-120, R20-22, BP 83/58 and 85/60, and O2Sats 94-96%. She had not eaten or taken in fluids all day as noted by the RN, but other records indicated she did have eight ounces skim milk in the morning. She had diminished lung sounds. She was sent to the ER and admitted with a diagnoses of UTI and rule out sepsis and found to be dehydrated. Aspiration was ruled out. She was discharged to the infirmary on 3/15/11 at 1705H and arrived at 2150H. Part of her plan was to encourage oral fluids with no specific plan in place, no specific plan to implement and monitor the results of her fluid intake. On 3/17/11 she was discharged to home. Although "extra fluids", eight ounces per shift was checked and then crossed out on the Client Care Flow Sheet for March 2011 and there were repeated indications extra fluids were needed, there was no documentation to support the extra fluids were given. Both before and after she was discharged to her dorm, vital signs were not assessed as indicated. She had no IPN or vitals from IPNs from 2/25/11-3/10/11. There were vital signs post seizure on 3/11/11, and then vital sign assessment started on 3/12/11 post vomiting episode, as described above. On 3/26/11 at the 1400H and 2200H, vital signs were assessed related the individual coughing up phlegm and receiving a breathing treatment. She was administered a PRN nebulizer treatment with Albuterol-Ipratropium 3 ml inhalation for "chest congestion/wheezing" per nebulizer. Two IPNs, one at 1645H and one at 2200H, documented coughing clots of greenish yellow phlegm and adventitious lung sounds upon auscultation in upper right lobe. There was no follow-up assessment documented and the plan was directing DCS to report further coughing or phlegm. Vital signs were assessed again on 3/27/11 at the 0700H on sick call for coughing up yellow phlegm and at the 0845H her vital signs were stable at T97.8, P71, R18, O2Sat 96%, and BP 110/68. There were then no vital signs recorded from 3/28/11 through 3/31/11. On 3/18/11, she was administered pseudoephedrine at 1420H for a low BP of 83/60 after the MD was notified. Follow-up assessment at 1520H reported a	

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		BP of 80/53, P88, and O2Sat 94%. The MD was contacted and the individual was sent to the ER at 1550H, evaluated and returned at the 2200H with a diagnosis of transient hypotensive episode. On 3/19/11, she had a seizure with lethargy at 0900H with the neurological assessment checklist initiated and completed at 900H, 1000H, and 1400H. Nowhere in any note for this ongoing episode was fluid intake addressed adequately to prevent further complications such at UTI, dehydration, and/or hypotension. Her 3/19/11 seizure record reported an elevated BP of 156/97 with no follow-up assessment and the plan was to monitor for increased seizure activity. o After these recurrent episodes of multiple types there were no revisions to health management plans and no new nursing orders for vital signs, particularly blood pressure. • Individual #11: On 1/13/11 at 0100H, a promethazine HCl rectal suppository, 25 mg, every four to six hours for vomiting was administered. The evening before, on 1/12/11 at 2235H, the IPN documented a vomiting episode of one cup of "orangish colored emesis." Vitals signs were assessed and abdominal and respiratory assessments were completed, including auscultation and notation of her last bowel movement. There was no further analysis of intake and output, particularly fluid intake. The plan was to continue to monitor, reposition and assure the HOB was up. On 1/13/11 at 0100H, she vomited one-fourth cup of emesis with the same plan plus administration of the promethazine HCl suppository given for her second emesis with timely follow-up. No further vomiting or distress was noted, but there were no assessment data or measures recorded at 0200H and no notation of a plan for replacement fluids provided. Nursing assessment every shift for 24 hours after the vomiting episodes was documented at 1230H, with the exception of analysis of intake and output. The next IPN was a medication review on 1/15/11 at the 1400H. • Individual #102: On 4/2/11, this individual was admitted to the infirmary for hypothermia and discharged to her dorm on 4/3/11. On 4/2/11 at 1705H, a 93.9 degree tympanic temperature was reported by DCS and verified by the nurse with a 94 degree rectal temperature. The MD was notified, and "warming procedures started." Unless the nursing and direct care staff were checking off the warming procedures they implemented somewhere in the record that was not made available to the monitoring team, warming procedures implemented were not consistently documented. The MD ordered her sent to the infirmary for treatment with the Bair Hugger (warming blankets), and she was admitted to the infirmary at 1800H with a 92.4 body temperature. Her temperature was monitored every hour and her temperature increased to 94.5 degrees at 2125H, 97.8 on 4/3/11 at 0830H, and she was discharged to home at 1120H with a temperature of 97.8. The next assessment by nursing on 4/4/11 in an IPN timed	

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		at 1010H and 4/5/11 "post infirmary assessment, day two stated no action was needed. Then on 4/6/11 at 1428H, a body temperature of 95.8 was reported by DCS with warming procedures implemented. The plan was to recheck in one hour, and at 1520H her temperature was 91.2 rectally, BP 145/56, P 50, R 18, and O2Sat 95%. She was admitted to the infirmary at 1550H with a rectal temperature of 91.4. She was transferred to the ER for treatment and hospital admission. She was discharged back to the infirmary on 4/13/11 with hypothermia and bradycardia diagnoses, the same as on admission. She was discharged back home on 4/18/11 with documentation of nursing assessment of vital signs that did continue every four hours for two days after her return. Her post infirmary nursing assessments were completed 4/18/11 and 4/19/11 without further action needed or changes to monitoring and intervention procedures. • Individual #398: On 1/12/11, an IPN of the same date reported that medical treatment was prescribed for diagnoses of an upper respiratory infection and cough, including Zithromax, an antibiotic, normal saline nasal spray, Allegra 60 mg twice daily for rhinitis and Robitussin cough syrup two teaspoons four times daily for three days and then four times daily PRN for seven days. The subsequent IPNs did not document appropriate follow-up assessment. The IPNs primarily noted "no signs of cough" and "no signs of nasal drainage." There were no vital signs or lung/respiratory assessments. The IPNs for 1/13/11, 1/15/11, 1/16, 1/17/11, and 1/18/11 reported nasal drainage, but no cough. Then on 1/19/11 at 1340H, the individual was reported to be coughing, vomiting, and shaking with complaints of abdominal pain, and vital signs were within normal limits. He was sent to the ER for evaluation, was hospitalized and returned 1/30/11 with resultant diagnoses of bilateral lower lobe pneumonia, acute sinusitis/chronic sinusitis, anemia, and pancreatitis improving. • Individual #258: This individual was prescribed PRN promethazine rectal suppositories for vomiting. Despite recurrent problems with vomiting, there was inconsistent documentation of a complete analysis of intake and output when episodes occurred, particularly fluid intake and output. On 3/7/11 at 0930H, he vomited a large amount of "pink emesis." The episode was assessed well by the LVN, including timely notification of the RN. There was no time documented for the RN follow-up assessment, and no documentation every shift for 24 hours after the vomiting episode. On 2/7/11 at 2000H, 2/8/11 at 0105H, and again on 2/9/11 at 1045H, vomiting episodes were treated with promethazine. Another episode of vomiting at on 2/10/11 at 0850H was not treated with promethazine. The associated nursing assessment did not include the abdomen or respiratory system. There was no change in diet to clear liquids since this occurred after eating breakfast and there was no plan for replacement	

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		fluids. He was reported to make frequent independent trips to access and consume fluids, up to and exceeding 24 ounces at one meal. The next IPN after this episode was on 2/11/11 at 0900H. • Individual #389 was prescribed guaifenesin 100 mg/5 ml for a cough, PRN, 15 ml, four times daily. On 1/16/11 at 1300H it was administered for a "cough," and documented as effective on the MAR. A complete nursing assessment was documented in the IPN. The next IPN was 1/17/11 at 1315H related to aspiration risk assessments completed by nursing staff with coughing seven times reported for the day, wet rattling nonproductive cough and regardless of position (positions tried not noted), in no respiratory distress. There were no vital signs or lung assessment completed. The next nursing IPN was on 1/19/11 at 1310H for aspiration risk factors, including five coughing episodes and "no signs of aspiration" with the plan to continue to monitor. He continued with the non-productive cough and there were no vital signs or lung assessment completed. The next IPN was at 1440H including a complete assessment and vital signs. Other, more recent, weekly risk factor assessments began including vital signs, lung assessments, and other assessments as appropriate based on presenting risk indicators such as a chronic recurrent coughing, and positioning and alignment at 30 degrees or more against gravity, including wheelchair support. • Individual #202: On 3/19/11 at 1810H he vomited undigested food with the plan to continue to monitor. The IPN reported his vital signs were stable, but did not specify the results of measures taken. The next IPN on 3/20/11 at 0410H was a follow-up assessment for vomiting. The next two IPNs were on 3/20/11 at 1705H and 3/22/11. On 3/29/11, a tympanic temperature of 86.7 was reported. Follow-up assessment by the nurse reported a body temperature of 91.4 degrees rectally at 0635H. Warming blankets and a knit cap were applied and his temperature was 95.6 at 0650H. At 0715H, his rectal temperature remained low at 91.3. His groin and maxillary areas were warmed with warm linens as well. At 0800H, his temperature was 96.8 and his O2Sat dropped to 95%. At 0810H, his temperature was 92.2 rectally, BP 105/58, and O2Sat 95% and at 0820H, T 92.9, low BP 88/53, and lower O2Sat at 93%. The plan was to continue monitoring body temperature although there were the accompanying drops in blood pressure and oxygen levels. The 0905H IPN contained no body temperature, BP 90/54, P 61, and O2Sat at 94%, and assessments at 0930H, 1000H, and 1030H continued to document low oxygen levels and body temperature, but improving blood pressure. The plan at 1030H was to follow up in one hour, with the next assessment documented one and one half hours later at 1200H with vital signs of BP 116/78, P 89, T 97.8 rectally, and O2Sat 95%. At 1300H, his temperature had continued to rise to 98.1, but his blood pressure	

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		was low at 88/54 with no action taken and the next note at 2130H with the plan to monitor twice per shift until his temperature was maintained at or above 97 degrees for 24 hours. On 3/30/11 at 0130H his temperature was 94.7 and warmed blankets were applied, at 0525H his temperature was 98.4, BP 98/67, P 88, and O2Sat at 95%, at 1000H, his temperature was 100.7, and at 1300H, it was 97.4. The next IPN was over 24 hours later on 3/31/11 at 1330H, with a reported body temperature of 95.0 tympanic and 94.0 rectal with HOB at 30 degrees, warming procedures in place, but not specified, no other vital signs recorded and a plan to monitor his temperature within 30 minutes. The next rectal temperature at 1430H, one hour later, was 93.8, BP 91/58, and oxygen level at 94% with warming blankets and warm clothes continued. It was unknown if he was continuing to wear the stocking cap. The plan was to monitor in one hour, though he had worsened over the last hour. The IPN at 1530H documented a temperature of 93.8 rectally, BP 97/66, P 63, R 18, and O2Sat 95%. The plan was to monitor temperature and continue warming procedures though there was no improvement. A late entry for 1630H documented BP 101/60, P 65, R 18, T 95.5 rectal, O2Sat 96%, lungs clear to auscultation, abdomen soft, and continue warming procedures with "hat on" and temperature monitoring. At 1745H the nurse was positioning the individual to monitor his rectal temperature and removed his pad to find the individual had a "large amount of clots and bright red bleeding from rectum." His vital signs were BP 113/78, P 78, R 10, O2Sat 95%, and T 97.8 temporal. He was ordered to transfer to the ER. The RN follow-up assessment at 1810H documented BP 110/70, P 70, R 10, O2Sat 98%, T 97.8 temporal, rectal bleeding of one to two cups of bright red blood with multiple clots the size of quarters. He was transferred at 1815H with rectal bleeding and hypothermia. He was discharged back to the infirmary on 4/5/11 with a diagnosis of GI bleeding. There was no documentation of what his body temperature was or how he was dressed for transport home. He was discharged to his dorm at 0900H on 4/7/11. At 1440H, his body temperature was 95.5 tympanic and 95.4 rectally and warming blankets were applied with the plan to recheck in one hour. At 1535H, a body temperature of 96.3 rectally was recorded, but no other vital signs. The plan was to continue to monitor temperature every hour until 97 degrees was maintained. At 1645H, his temperature was 96.0 rectally, with no other vital signs recorded, the MD was notified and the hypothermia protocol continued. At 1830H, his temperature had risen to 98.7 rectally with no other vital signs recorded. His 1910H post infirmary nursing follow-up assessment included vital signs of BP 98/71, P 82, T 98.7 rectally, O2Sat 96% and reported no action was needed although nursing staff were only mid-way in monitoring for consistent body temperatures above	

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		97.0 degrees for 24 hours. The IPNs at 2000H and 2050H documented assessing his body temperature at 99.5 with no other vital signs. On 4/8/11 at 0105H a post infirmary nursing follow-up assessment was completed, including all vital signs within normal limits with O2Sat borderline at 95%. Again, there was no notation 10 hours remained of the 24 hour monitoring for body temperatures above 97 degrees (i.e., twice per shift). The IPNs through 4/9/11 continued to frequently assess temperature in isolation, but did monitor twice per shift until over 97.0 for 24 hours. The IPNs did not consistently identify the route of temperature, which was an important factor with his recent rectal bleeding episode. • Weights as ordered and/or planned were not consistently recorded, particularly when individuals required more than once monthly weight measures. Weight monitoring results were found on the Growth Record for each individual's monthly weights, the minimum required for all individuals at LSSLC. For those requiring more frequent monitoring, weights were recorded on the MARs. Weight data spread across multiple months of MARs in various locations on the MARs made both concurrent and retrospective analysis of weight data for patterns and trends difficult. o Individual #96: There were no weekly weights on her MARs since 2/12/11 when she weighed 96 pounds with an unplanned weight loss from the previous year of 12 pounds. Weekly weights were planned, but not initiated when identified as a need in her risk evaluation on 3/15/11. Weekly weights were also not indicated for DCS to take and record on the Client Care Flow Sheet. o Individual #146: Every two week weights were not consistently recorded from 2/15/11-3/19/11. Prior to this date, weights were to be recorded weekly, which were also not recorded consistently, although clearly indicated on the MAR. o Individual #353: Weekly weight data were missing one weight in 3/11. Significant changes in body weight were not addressed in IPNs or other available documentation, including 89 pounds to 106.4 pounds in one week recorded on 2/12/11. o Individual #202: Weekly weights were inconsistently recorded over the last quarter, although he had remained within his estimated weight range. o Individual #141: Weekly weights were discontinued in 2/11, but only a monthly weight was recorded for 1/11. o Individual #285: Weekly weights were changed to twice weekly on 2/15/11. He had experienced significant weight loss over the past year (i.e., 129 pounds in 3/10 to 100 pounds on 3/4/11).	

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		• Vital signs were not consistently documented assessed as ordered and/or planned for both those measures taken routinely and those that were for short term monitoring of acute conditions. Also see Section M3 and M6. Routine vital signs were often recorded in IPNs resulting in data that were difficult to analyze for patterns and trends. o Individual #10 had orders for PRN administration of pseudoephedrine every four hours for systolic blood pressure less than 90 starting on 3/18/11 when she had two episodes of hypotension. No change in the frequency of her routine blood pressure monitoring was made. Routine blood pressures were taken only monthly and she had no monthly blood pressure recorded for January 2011. o Individual #96 had daily blood pressures noted on the MAR from 12/15/11-1/15/11 with one day missing, from 1/16/11-2/15/11 data were not recorded for five days while she was residing at the facility and not hospitalized, and from 2/16/11-3/15/11 vital sign data were recorded for only nine days with no follow-through to daily recording from 3/16/11-4/15/11. o Individual #102: A review of current temperature measures taken by DCS was completed by the monitoring team through MRA interview and review of the current, 4/11, records as well as last quarter's temperature documentation on Client Care Flow Sheets for 1/11-3/11. Routine temperature monitoring by DCS was not implemented as planned for three times daily with below and above normal ranges or other signs and symptoms of hypothermia to be reported to nursing staff. Only one to two temperature measures of the three planned daily were recorded on 3/6/11, 3/12/11, 3/15/11, 3/16/11, 3/19/11, 3/20/11, 3/24/11, 3/25/11, 3/29/11, 3/31/11, and 4/5/11. The IPNs were to be reviewed for routine temperature measures every day but were recorded for only eight shifts in March 2011. o Individual #57 had weekly blood pressure and pulse measures ordered as well as twice daily pulse monitoring before propanolol administration for hypertension. Propanolol was to be held if his pulse was below 60 or above 100. Weekly blood pressures were not consistently recorded as ordered. He had no pulse taken before propanolol administration on 3/5/11 at 1200 and 2/16/11 at 1700H. On 1/10/11 at 1700 his pulse was 57 and the medication was held per MD order at 1730H. The nursing plan was to continue to monitor, which was completed at 2000H with a pulse of 54 with "no action required, no f/u needed." The next IPN was on 1/11/11 at 0400H without documentation of vital signs. On the same day at 1700H, his	

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		pulse was 58 and the propanolol was not held per physician's order and there was no accompanying IPN. o It was reported that Individual #267 had blood pressure and pulse measures ordered weekly that were documented as planned over the last quarter. He received no pulse measures before administration of Atenolol for hypertension with physician's orders to take his pulse prior to administration and hold if less than 60 or greater than 100. The Atenolol was documented administered, but there were no pulse measures recorded on 2/20/11 at 0700H and 3/26/11 at 0700H. He had physician orders from 2/28/11 to 3/2/11 to monitor his vital signs and right facial swelling every four hours for 48 hours. Vital sign recording started 2/28/11 at 1000H and ended on 3/1/11 at 1000H after 24 hours. His vital signs were stable and the right side jaw swelling continued to be noted. o Individual #258 had blood pressure monitoring ordered by the physician twice daily and PRN for six weeks starting on 3/21/11. The data provided to the monitoring team ended 3/31/11 with three measures missing through 3/31/11. Prior to 3/21/11 blood pressure monitoring was ordered for every other week on Tuesdays, which was not consistently recorded over the last quarter. o Individual #353 was to have body temperature monitoring three times daily to four times daily by the DCS and recorded on the Client Care Flow Sheet due to risks associated with hypothermia. Temperatures were not recorded or not recorded at the planned frequency on 2/5/11, 2/6/11, 2/7/11, 3/15/11, and 3/24/11. She also had her blood pressure assessed twice daily by nursing to monitor for PRN pseudoephedrine, 30 mg, administration for blood pressures less than 80/50. Over the last quarter, 1/11-3/11, 15 measures were missing. On 1/7/11 at 1300H she was given pseudoephedrine, 30 mg, for a low BP of 79/45. Follow-up blood pressure monitoring and reassessment occurred at 1315H with a blood pressure of 92/64. On 1/13/11 at 1415H, she had a low blood pressure of 84/54 with next nursing IPN and untimely follow-up on 1/22/11. She was given pseudoephedrine on 1/30/11 at 1000H for low blood pressure at 82/44 with the next IPN and follow-up assessment nine hours later at 1950H, without blood pressure monitoring. An IPN on 1/31/11 at 1550H reported a low blood pressure of 89/54 with a repeated measure of 82/56. The plan was to "keep monitoring BP above parameter for Sudafed PRN" with the next at 1800H with a BP of 101/59, an IPN at 2115H with a BP of 94/52. There were additional Infirmary Nurse Assessments at 1400H with a	

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		low BP of 82/84, at 2300H with normal BP of 106/60 and at 0300H on 1/31/11 with a normal BP of 105/63. o Individual #535 had physician's orders for blood pressures four times daily for PRN pseudoephedrine, 30 mg, for blood pressures less than 90/50. The pseudoephedrine was given on 2/18/11 for a blood pressure of 81/51 at 0325A, on 2/18/11 at 1500H, on 2/19/11 at 0430H, and on 2/19 at 0845H. A 1/29/11 administration of pseudoephedrine at 0030H and 1215H had no blood pressure measures documented on the MAR. The accompanying IPN at 0030H reported a BP of 85/55 with a follow-up assessment at 0145H of 92/50. The next assessment was at 0315H with no vital signs and an infirmary follow-up sheet that was not provided to the monitoring team followed by an IPN at 0630H with a BP of 93/68. During an earlier episode of hypotension on 1/29/11 at 1100A, his blood pressure was low at 78/50. He was repositioned and his blood pressure rechecked an hour later, which was untimely reassessment. At reassessment, his blood pressure continued to be low at 88/55 at 1215H, at 1250H a BP of 77/52, at 1355H a BP of 131/86, then at 1920H a BP of 128/72. • For each individual receiving nursing administration of nebulizer treatments, pre and post treatment respiratory assessments were generally not present, including lung sounds and respiratory rate. For examples, see Individual #10, Individual #11, Individual #96, and Individual #141. • Baselines established regarding individuals' bowel elimination pattern and needs did not include prescribed routine laxatives and the specified schedule of use for each including PRN laxatives and enemas, and nutritional interventions necessary to maintain an adequate elimination pattern to eliminate or reduce acute constipation episodes (i.e., the bowel management plan). PRN laxatives and enemas were not administered using consistent criteria with planned interventions (e.g., Milk of Magnesia on day two without a bowel movement, Docusate sodium rectal suppository for day three without a bowel movement and Fleet enema for day four without a bowel movement). Individuals without consistent bowel management plan and PRN laxative administration included Individual #10, Individual #11, Individual #96, Individual #102, Individual #267, Individual #535, Individual #141, and Individual #202.	
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	Health management plans (HMP) and acute care plans (ACP) were prepared at LSSLC. Nursing staff at LSSLC had continued to implement the July 2010 state policy on care plan development over the last six months. The plans continued to need a great deal of improvement as detailed below in order to meet the requirements of this provision item.	Noncompliance

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	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.	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 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, including documentation of implementation, and continuously evaluated and modified as needed. All 20 individuals reviewed had their health needs and risks reported to be referenced in a Health Management Plan (HMP) or Acute Health Care Plan (ACP). Records provided for Individual #202 and Individual #535, however, did not include HMPs. These plans were developed by each individual's RN Case Manager 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 this review continued to be problematic and in need of review and revision in order to promote progress toward the achievement of this provision item of the Settlement Agreement. • One issue with the HMPs and ACPs was due to identification of health problems that were not "active nursing problems" in need of a HMP per the DADS Care Plan Development policy. • Another issue was due to the application of generic/standard care plans or protocols to health problems that instead required individualized approaches and interventions particularly for those required to address significant risks that were identified in the revised integrated risk rating process. There were several plans that had been individualized, such as for Individual #146 for her persistent chronic skin conditions with associated skin integrity problems and self-injurious skin picking. Her HMP reflected the changes in interventions to address her changing needs. General comments regarding care planning and implementation of planned interventions are presented below. • Across all individuals reviewed, HMPs and ACPs were consistent in format, completed in a timely way, signed, and dated. • Across all individuals reviewed, HMPs and ACPs were in place to address most of the identified health care problems and risks, but were generally of poor quality. There was a shift toward individualization, but interventions continued to lack specificity, including the frequency of implementation and documentation requirements. There were new plans for separating the actions to be provided	

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		by DCS that were designated on HMPs to aid in easy identification and implementation. • The interventions in the HMPs were there for many of the individuals even though the individuals, as well as the precursors, nature, scope, and intensity of their problems, were very different. The HMPs were standard health care protocols generally more suitable for use in an acute care situation, such as management of a prolonged seizure, the healing of a fracture, or as a guide for training direct support staff on specific conditions than for individualized long term management of a health risk or problem. The protocols or generic plans provided the nurse a reference for 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, most plans were essentially generic health care protocols that did not provide specific person-centered interventions as a foundation for positive outcomes. 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 (see examples below). • Although there were dates and signatures indicating timely reviews and HMP "updates," despite changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes or their changes in risk status, their HMPs and ACPs were not consistently revised. • There was documentation that, at least quarterly, individuals' nurse case managers conducted a review of the individuals' HMPs and ACPs. They did not consistently ensure that 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, objective health status data. It was noted by the monitoring team that this nursing task was the primary nursing action identified in the new risk action plans to address the significant risks of individuals, but was still not being effectively implemented. • 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. The recent shift to the PST's identification of the health and behavioral risks of the individuals they support as well as action plans to address the risks should improve this area in the future. • Individuals' records often contained many copies of various overlapping HMPs with various dates and inconsistent documentation of the discontinuation dates of the old plans. This made it difficult to readily identify what was current and	

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		what were the interventions nursing and direct support staff should have attended to and assured were implemented. The monitoring team noted that each of the individual's HMPs required revision and individualization as described above in this section. Detailed examples from HMPs and ACPs of some individuals are presented below. • Individual #10 had a HMP for: (1) overweight that was generic and had not changed to reflect changes in strategies such as providing flavored water for juice. How this change with juice (not prune juice) affected bowel elimination was not addressed or monitored. In reviews of the plan there were "no problem with current diet" and comments to continue weighing monthly though her weight was increasing 10/28/10, 11/22/10, and 12/26/10 despite a 1200 calorie diet. Her plan still did not address portion control. (2) Her HMP for constipation was generic with basic inservice actions for DCS to observe for signs and symptoms and assure she received her diet and her bowel elimination was recorded on the Client Care Flow Sheet. The plan did not include a specific bowel management regimen or the action that nursing monitor bowel elimination records daily. There was no inclusion of daily prune juice and the amount and time it was provided prior to it being discontinued. (3) Her seizure HMP was also generic with no changes 7/29/10-3/30/11 after nine reviews of the plan. The reviews did not always include the number of seizures experienced year to date as well as the number of seizures for the month by type and inconsistently compared the number for the current month with the number that occurred the previous month. After seizures when lethargy occurred, there were orders to hold diazepam reported but not included in her health risk review data or action plan. (4) An unnecessary HMP for a routine physician ordered preventative measure, use of elbow and heel protectors to prevent skin breakdown was in place. The order could have been documented on the Client Care Flow Sheet and monitored by nursing on the same form with complete evaluations at least at the time of quarterly assessments and as needed. A plan would have been appropriate to have been reviewed and updated for the acute episode of right heel blister after her hospitalization in 3/11, but was not. The same was true for a HMP for acne; this condition and treatment could also have been reported on in the quarterly assessments. (5) At the time of the review, she had dehydration and UTI issues after discharge from the hospital and an ongoing need for monitoring and assuring adequate fluid with limited calorie intake without a specified plan. There was no documentation in her IPNs or infirmary nurse assessments of increasing fluid intake or monitoring of fluid intake, no urine output such as number of voids per shift or changes of soiled/wet briefs, and no analysis of fluid intake and output.	

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		• Individual #11 had several HMP and ACPs: (1) Her HMP for her seizure disorder was originally written on 9/17/10. The plan stated nursing assessment of vital signs only be completed after more serious episodes, such as prolonged cyanosis or respiratory difficulty after a seizure, prolonged or repeated seizures, etc., when an assessment and vital signs are taken for all seizures reported to nursing staff at LSSLC per protocol and policy and procedure. Although attempts to individualize the plan included addressing the need for consistent adequate fluid intake, strategies to achieve that or establishment of daily fluid intake minimums were not specified in her plan. She received 24 ounces daily (eight ounces per meal) of milkshake consistency fluid and her remaining fluids were received via gastrostomy tube. Enteral intake records indicated an additional 24 to 30 ounces per day via g-tube, including medication flushes and auto flushes. Enteral intake records did not include twenty-four hour fluid intake totals, oral fluid intake totals, and formula totals were included for 10-6 shift, but no orders for formula overnight were provided for review. (2) The chronic constipation HMP attempted individualization, such as more clearly identifying direct care responsibilities, but nursing interventions remained the routine procedural practices such as checking the bowel movement record daily. Providing the total amount of prescribed fluid was an intervention listed for both DCS and nurses and across multiple HMPs but nowhere was the minimum total daily fluid amount required specified. Her nursing assessments and enteral flow records identified water/fluids administered enterally: 65 cc every one hour from 9pm-4am, 60 cc with each med pass and 60 cc cranberry juice twice daily. She was also to receive eight ounces (240 cc) of milkshake consistency fluids with each meal (i.e., 240 x 3 = 720 + 60 x 6 = 360 + 65 x 7=455 which totals 1535 cc/day). Separate documentation of her fluid intake at meals was not documented. At times when she was noted to have poor oral intake at meals, there were no clarifying IPNs or documented follow-up by the nurse to identify what percentage of fluids were consumed orally (i.e., was her fluid intake also fair or poor?). There was no nursing documentation following up on recorded low fluid intake via gastrostomy tube on the 10-6 shift. Given her continued need for hydration via gastrostomy tube and the continued oral eating transition, daily oral fluid intake at meals should have been documented and daily fluid intake totals for both enteral and oral and enteral intake combined should have been maintained by nursing. The constipation HMP specified the nurse would complete an assessment including a rectal exam for three days without a bowel movement but documentation of such examinations as planned were not present in the IPNs. (3) The ACP for post anesthesia care dated 3/24/11 included assessment of vital signs, O2, breath sounds, and skin color every hour for first two hours back on the unit then every shift for 72 hours. Assessments were	

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		timely, but all the assessment components were not included in each assessment, and there was inconsistent documentation of assessment of lung sounds and skin color. • Individual #96 was at high risk for aspiration, respiratory compromise and UTI. Her HMP to address aspiration pneumonia was updated to include use of the aspiration triggers data and monitoring process. The other HMPs for constipation, gastrostomy, prolonged seizures, and oral hygiene deficit were generic although reviewed and updated in 3/11. Her HMP to address potential respiratory distress related to apnea spells had a goal she would not have respiratory distress related to apnea spells. It was written 3/11/11 and updated 3/21/11, and included monitoring for correct body alignment to avoid hyperextension and hyperflexion of her neck to protect the airway. It also included monitoring her weight weekly, which was not implemented, and vital signs per shift, which did not include monitoring O2Sat or monitoring O2Sat continuously when not directly supervised. Her risk of aspiration pneumonia was increased to high on 3/16/11 and included action plans to implement aspiration trigger monitoring and data analysis, and change to a suction toothbrush. Her HMP to prevent aspiration was not updated to include use of the suction toothbrush. • Although Individual #146 was at risk of falls with use of a gait belt specified for all ambulation, she was observed on 4/18/11 at 1330H at her home being prompted to stand and go to the bathroom after a toileting accident without staff support with the gait belt and she fell to the floor, fortunately without injury. • Individual #102: (1) Her HMP for seizures dated 4/20/11 was generic with no mention of the PRN Diastat administration parameters. (2) The Hypothermia HMP had individualized interventions, such as documentation of temperatures before bathing and routine temperature monitoring three times daily. It was last reviewed on 4/19/11. She last went to the ER on 1/23/11 with hypothermia but the episode was not included in review data. The review had no analysis of the time episodes occurred, activities during events, number of episodes year to date as well as accurate information for episodes over the last month. The protocol for acute episodes specified in the HMP stated interventions were to take her temperature every hour until her temperature was 97.0 degrees or greater. Once reached temperatures would be taken hourly for two more hours. If she maintained a body temperature of 97.0 or higher temperatures were to be taken at least twice per shift until her body temperature had been maintained at 97.0 or higher for 24 hours. This wasn't followed consistently for any episode and no changes in body temperature monitoring or recording (i.e., recording at the same time each shift and before and after baths, organized to review across time, identifying usual temperature ranges at each time of day), was needed for data	

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		to be conducive to analysis for patterns and trends. There was generally no reporting of individual's activities at the time of hypothermia. The information that was usually reported were temperature, implementation of warming procedures and calling the MD. (3) Her oral hygiene HMP had several individual instructions to DCS regarding positioning for the individual and staff during tooth brushing. She has remained with fair oral hygiene for over a year with no changes to her plan. After nursing HMP reviews for progress 3/9/11 and 4/19/11 reported rating her oral hygiene poor and describing her as resistive to oral hygiene with staff as well as reports of mild halitosis, there were again no changes in plans. (4) Her HMPs for constipation remained generic and did not address fluid intake issues specific to meet her needs or specify her bowel management plan. It also did not address the polypharmacy risks associated with concurrent use of Senna, Mirilax, Docusate sodium, and Fleet enemas PRN for constipation. • Individual #57: (1) The two HMPs reported necessary in his annual nursing assessment were tachycardia and oral hygiene. Reviews of these plans reported no episodes of tachycardia. There were several episodes of bradycardia that were not included in the review summary, nor was it noted that his propanolol was held. His oral hygiene-review reported continued good oral hygiene with several individualized interventions. (2) He also had a HMP to address overweight status that was generic and included the intervention to weigh weekly. He was weighed monthly. After his weight risk was increased to high on 4/14/11, one place on the plan the intervention stated to weigh weekly and in another place to weigh every other week per ISP team at risk plan 4/14/11. The direct care staff inservice/interventions were more individualized, but remained unspecific (i.e., walk and/or attend gym exercise class (for how long) at least three times per week). (3) On 3/16/11, he had a HMP to address skeletal fractures and potential re-injury of a clavicle fracture with his left arm after treatment with an arm sling. The plan had several individualized instructions/ inservice for DCS, but did not include changes to the plan based on revised restraint parameters and the potential for re-injury with physical restraint. There was no frequency specified of checking for signs and symptoms of pain, and no specified frequency of observation or physical assessment of the left clavicle and left upper extremity. The action plan established after the 4/14/11 at risk meeting, did not specify how often nursing staff were to monitor his sling to validate DCS checking it twice per shift and to assure it was fitted properly, clean and dry. • Individual #258 had multiple seizures monthly and was administered frequent doses of PRN Diastat generally for frequent seizures, clusters of very short seizures. The HMP focused on injury prevention and was partially individualized	

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		with instructions to offer him the soft helmet to wear at meals and removal of his helmet every two hours for 10 minutes while seated and closely supervised. The plan included nothing about monitoring for patterns and trends of his seizures, consistent adequate fluid intake, or indications for PRN Diastat requests. Plans contained conflicting information regarding allowing him to sleep and observing him after a seizure as well as allowing him to resume routine activities. There had not been any evidence or assessment data to support any post ictal problems with drowsiness or sleepiness or any change in quick recovery to alertness • Individual #285 self induced vomiting and/or ruminated. Care plans to address weight loss and vomiting dated 1/20/11 were continued, but not implemented as planned and did not identify a consistent protocol for use of PRN phenergen for vomiting episodes. The plan included review of intake and output by nursing daily, and nurse assessment of skin turgor and mucous membranes every shift that were rarely documented. Characteristics of vomitus were rarely recorded. Despite recurrent fluid intake issues, related hospitalizations and diagnoses, urination and vomiting data were not collected and recorded consistently on a new data sheet as planned. In addition, his client care flow sheets were not complete with many shifts of food and fluid intake and bowel elimination not recorded. There was also inconsistent documentation of review and analysis of the data on a daily basis as planned, but only 11 days were signed by nursing in 1/11. The new data sheet did identify how many times he vomited but did not include the amount and there was inconsistent documentation of providing replacement fluids. The interventions of planning for specific levels of intake, monitoring fluid intake, and output and providing adequate fluids as planned were not consistently implemented for those individuals with risks/health conditions that worsen with inadequate fluid intake such as pneumonia, urinary tract infections, dehydration, etc. For most of the individuals their data was complete for 2/11 and 3/11, but 1/11 food, fluid and bowel elimination data were inconsistently reported and monitored by nursing (i.e., blanks on the forms). • Individual #267 had inconsistent food intake and bowel elimination data recorded as well as inconsistent monitoring by nursing throughout the first quarter of the year. • Individual #101 had "extra fluids," eight ounces per shift checked off as needed and then crossed out on her Client Care Flow Sheet for March 2011, although there were repeated indications extra fluids were needed. There was no documentation to support the extra fluids were given. • Individual #146 had dehydration and UTI issues with physician orders from 11/18/10-2/10/11 for water three times daily with medications and meals to	

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		ensure adequate hydration. When the plan was reviewed, the order stopped and documentation of extra fluid intake daily stopped on 2/11/11. She had an acute UTI 3/7/11-3/22/11 with the primary preventative strategy of continued extra fluids. • Individual #353's 1/11 and 2/11 Enteral Feeding Records did not consistently document daily fluid intake totals or total water provided. Totals that were recorded varied from 723 cc-1412 cc daily without clear explanation or assessment of the variance. There was no explanation or documentation of replacement fluids provided after vomiting episodes. • Individual #389's Enteral Feeding Record included no daily totals of water intake, no formula totals and no daily fluid intake totals for 2/11 and 3/11. His 1/11 record had no daily/24 hour totals. • On 1/31/11, Individual #245 had orders for 250 ml of water per tube five times daily spread out evenly over 24 hours for four days for hypernatremia. Administration was not consistently documented implemented as ordered on the MAR. On 2/4/11 a decrease in the amount of water ordered to 200 ml three times per day was documented through 3/14/11. • For Individual #285, despite recurrent fluid intake issues and related hospitalizations and diagnoses, urination and vomiting data were not collected and recorded consistently on an individualized data sheet as planned. The new individualized data sheet included recording how many times he vomited, but did not include the amount. There was inconsistent documentation of replacement fluids. Comprehensive assessment of skin conditions did not consistently provide a complete and thorough initial assessment including location, size, and other characteristics, such as, presence or absence of drainage, description of drainage if present including color, color, depth, shape, texture, border, and surface characteristics appropriate to the presenting problem. For example: • Individual #11 had a topical cream prescribed for a skin rash on 3/20/11. The initial assessment by the RN reported "rash to L side R groin and R inner leg. Lotrisone cream tid ordered last night for treatment." The follow-up assessment from the LVN was a more complete and thorough initial assessment including location, size, characteristics, and no presence of drainage. The status of the rash was charted on again on 3/21/11 reporting improvement, but documentation did not continue to resolution. • On 3/17/11, Individual #96 had Lotrimin cream prescribed to both feet twice daily and as needed until healed or review in 14 days. Although reddened and excoriated buttocks was reported in the infirmary nurse assessments and in IPNs starting 3/16/11 and treated with PRN Lotrimin, documentation did not	

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		include any other description and did not consistently follow the condition to resolution. The same was true of redness to both feet with prescribed treatment on 3/17/11 and the first description reported in infirmary nurse assessments on 3/19/11. She also had skin integrity issues at her stoma gastrostomy tube stoma site with Sucralfate paste to stoma site ordered on 4/8/11. The condition of the stoma site was not consistently reported for PRN administrations. Leakage at the g-tube stoma site resulting in redness and excoriation was noted in IPNs starting 4/8/11 with no description of size, and inconsistent documentation of color, presence of drainage or odor, presence or absence of excoriation, or open skin areas. The condition of site was not consistently documented at times of treatment and dressing changes as well as not followed and consistently assessed on per shift infirmary nurse assessments. • Individual #146 had recurrent skin lesions associated with lichen simplex chronicus with chronic excoriations exacerbated by scratching and picking at her skin. She had previously had both medical restraints in the form of mittens and one to one staffing to prevent further injury. Her skin was observed by the monitoring team to be dry. It was reported this was usual. A reduction in skin lesions and skin abscesses were reported after initiating bleach baths, one ounce per five gallons of water every night, rinse well, and apply Remedy cream. Although it may relieve itching, this type of treatment should have had every three days or twice per week administration to prevent over drying of the skin. • Individual #57 had a shoulder splint/shoulder immobilizer for a fractured left clavicle, described as a "claviclular figure-8" in the record, required daily checks by nursing to assure a snug fit and monitor skin integrity, as well as check circulation, movement and sensation (CMS). The condition of the site and CMS checks were not consistently documented. Nursing assessment of seizures and seizure documentation had improved but continued to be incomplete or lack documented follow-up assessments as indicated. Analysis of data related to seizures most often included total numbers of seizures per month or per year and associated injuries to the exclusion of other variables. • Individual #310 received three antiepileptic drugs and had a VNS (vagal nerve stimulator) for seizure control. Despite treatment, he experienced multiple seizures that had increased this year over last. He had 35 seizures to date in 4/11, most (i.e., 21 seizures) were occurring between midnight and 0600H with no analysis of seizure data for patterns and trends. There was no report of discussion with the physician and pharmacist regarding use of Depakote sprinkles to maintain more constant blood levels, monitoring to assure blood levels were drawn at trough level, consideration of changing timing of the	

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		medications/time between medications (i.e., 2100 until 0700, and/or hydration related data and laboratory studies. On 4/13/11, his VNS wand was not available to DCS for use as documented in an IPN. The plan specified in the IPN was to "monitor and record all seizures," but there was no information on whether the VNS wand had been found or the DCS directed on where and how to store it for quick and easy access to this individual during a seizure. There was no notation on his 4/19/11 at 0100H seizure record that this was his second seizure in short period of time. If a VNS wand was reported used on the seizure record, there was rarely specific information regarding its use or follow-up assessment by the nurse to determine if the individual's VNS protocol was followed as written including when and how often swipes were repeated. • Individual #258 had a diagnosis of Lennox-Gastaut syndrome, a difficult to control seizure disorder/syndrome with a constellation of symptoms, including difficult to control multiple seizure types and usually other developmental disorders. The frequency of his seizures has increased significantly over last year with 3-12 seizures per month last year and 15-43 per month in the current support plan year. Most seizures were short, seconds rather than minutes, and all were under three minutes. He received frequent rectal Diastat from 10 mg to 20 mg for three seizures changed to five seizures on 3/28/11. There was inconsistent documentation of assessing precipitating events and analyzing them for indications for HMP strategies that may need to be changed. There was no summary of the usual duration of seizures and characteristics, analysis of the time of day seizures were occurring or a comparison to medication administration times. He received four medications for seizure control including Lamotrigine, Valproic acid, and Dilantin. After frequent PRN Diastat use, Diazepam 5 mg four times daily by mouth was prescribed for seizures starting on 3/1/11, and changed on 3/8/11 to three times daily. There was no indication of discussion or questions by nursing related to this order. Nurses were inconsistently completing all sections of the nursing portion of seizure records, and indicating if more information or a continuation of documentation would be found in the IPN. The nurse must complete the date and time of follow-up, vital signs, other assessment data/results, medication given/time or indicate n/a, and nurses signature and title. Frequently the nurses documented the individual "resumed activity," but there was no reference to what activity. Seizure records rarely documented what activity he was involved in at the time the seizure was observed and was not obtained by the nurse in follow-up assessment. There was no follow-up interview of the DCS or others who observed the seizure. Many of his seizure reports documented "he fell," which was the reason for the protective helmet he wore. Most seizures were usually three to 10 seconds in duration, only five seizures in excess of 30 seconds, one at 45 seconds, and on 4/18/11	

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		one of 47 seconds and then one at 10 seconds, with full recovery between all seizures reported. There was no nursing documentation on the seizure record of assessment 2/5/11 at 1550H and 1600H, seizures 10-30 seconds. Descriptions of seizure characteristics were inconsistent, see 2/25/11, 2/5/11, 2/22, and 2/1/11 records. On 3/28/11 at 1930, Diastat 20 mg rectally one dose now for five short seizures occurring from 0835H-1830H for 3-15 seconds each with recovery between each with the 1830H seizure not documented by nursing on the seizure record including medication follow-up administered. Baths on an elevated concrete slab were reported to occur for individuals residing on 549 and 557. There were also other elevated bathing systems in each living area. Multiple DCS interviewed were able to describe the appropriate bathing process, including following infection control procedures, as well as following PNMPs regarding the incline of the trunk and head of individuals at either 30 or 45 degrees. Wedges to provide appropriate incline at both 30 and 45 degrees were available. The slab bathing equipment and wedges were clean. The DCS as well as the monitoring team recognized that, although the facility's bathing and individualized procedures were followed, the slab baths remained hard and cold, particularly cold in the winter. This type of bath would be contraindicated for individuals with hypothermia and those with significant osteoporosis risks. It was noted by the monitoring team that this contraindication/instruction was not identified in hypothermia HMPs. The facility was beginning to address the risk management issues and integration of the process that would impact on reducing health risk for identified individuals, and implementing the revised At-Risk Individuals policy. See Section I for further discussion. The following are continued examples of risk management issues: • From 10/15/10 until 3/15/11, there were 67 hospitalizations, and 73 ER visits. Respiratory issues were the major cause of hospitalization, many of which were suspected to be aspiration. Implementation of the aspiration trigger sheets and identification of those at greatest risk for aspiration had occurred facility-wide in accordance with the new state-wide policies and procedures. • There were 11 hospital discharge diagnoses of Urinary Tract Infections (UTI) and/or sepsis and required acute care, but individuals were not consistently rated at medium to high risk in this area. Many of these had diagnoses for both pneumonia and UTI without follow-up to address adequate and consistent fluid intake. • As in the previous monitoring team reviews, 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.	

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M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	At LSSLC, the Chief Nurse Executive, Nursing Operations Officer, Nurse Educator, Hospital Liaison, Infection Control Nurse, Quality Enhancement Nurse, Nurse Compliance Coordinator, 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 facility's 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. As noted, there were numerous issues, described above in sections M1, M2, and M3 and below in section M6. Thus, the anticipated positive outcomes for individuals due to the implementation of assessment and reporting protocols were not yet evident in the records reviewed. Informal meetings were held between the monitoring team and various nursing management staff including the Chief Nurse Executive, three Nurse Managers, Quality Enhancement Nurse, Nursing Operations Officer, Nurse Educator, Nurse Compliance Coordinator, Infirmary Nurse Manager and Infection Control Nurse. Changes in the nursing management that had occurred since the last review included a new Nurse Educator, Infirmary Nurse Manager and Infection Control Nurse. All were hired from within LSSLC. The CNE reported several nursing initiatives in progress including the new employee orientation that started in March 2011, including training by nurses in the new skills lab on the following topics: aspiration pneumonia and aspiration trigger sheets, signs and symptoms to report to the nurse, bowel management, seizures, skin integrity and infection control. In January 2011, the preceptor program pairing new nurse employees with quality experienced nurses was lengthened and the nursing staff in collaboration with the Nurse Educator were revising the preceptor program outline and objectives. Nurses on all four units had been trained on vital sign assessment, follow-up, and documentation. Nursing staff provided competency-based training to DCS on Aspiration Triggers and documenting on the trigger data sheets as well as on seizure documentation. The facility's Nursing Documentation Policy and Procedure was under revision. The draft policy had received input from all levels of nursing staff and included a change from DAP to SOAP charting in progress notes. The CNE reported plans for competency-based training of the new documentation policy for all nurses in the near future. The CNE and NOO had organized nursing management staff and involved them in implementing the Revised Monitoring Tools focusing on urgent care/emergency room/hospitalizations, infection control, annual and quarterly nursing assessments, documentation and seizures. Monitoring of acute illness, injury, and GERD were also planned to compare and contrast with monitoring data related to urgent care/emergency	Noncompliance

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		room/hospitalizations. Summarizing and presenting results and establishing valid and reliable results were in progress and being coordinated with the QA department. The CNE has initiated investigations for all individuals with pneumonia diagnoses that were performed by the Nurse Compliance Coordinator. It was reported that vomiting episodes were a recurring significant factor in the pneumonia episodes reviewed. Future needs identified included the nurses role in management of psychiatric conditions, including functional participation and preparation for psychiatric clinic, management of acute psychiatric episodes, monitoring for medication response and side effects, and coordination and collaboration with the psychiatrist and psychologist. The CNE also reported changes in the Infirmary Nurse Manager who made a change to 12 hour shifts in the infirmary that have improved coverage for the 2-10 hours. The Infirmary Nurse Manager assured emergency kits were complete and at the ready, held mock drills to assure infirmary staff worked together as a team in a smooth and fluid fashion. He reported currently addressing storage and ordering of frequently needed supplies and documentation by DCS. Several of the initiatives described by the CNE were implemented with the collaboration, coordination, and assistance of the new Nurse Educator, as of 3/1/11. She had previously been the Assistant Nurse Educator. She described that most of her job duties had related to revisions and implementation of health related topics and skills training in new employee orientation and assuring all training rosters were maintained for all staff training related to policies and procedures. She reported a new Assistant Nurse Educator was hired and would be joining her on 5/1/11. She developed and provided the vital sign training to nurses. 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, Program Compliance Coordinator and Nurse Managers. The monitoring team attended the weekly Nurse Management meeting. A priority discussed was staffing. There were a total of 144 nursing services positions including one administrative clerk. Positions that were vacant included three direct care RNs, one infirmary RN shift supervisor, four LVN positions, four LVNIII positions and one RN III Shift Supervisor position for a total of 13 positions vacant. Top priorities for the nursing department were described as continuing to assure the LSSLC nurses were knowledgeable regarding the Texas Health Monitoring Instruments, including the revisions and guidelines for their use from DADS. In an effort to move toward full implementation, they had targeted seven areas of nursing care: urgent care/emergency care/hospitalizations, infection control, acute illness/injury, GERD,	

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		quarterly and annual nursing assessments, documentation and seizures. They agreed they were in the early stages of implementation with the revised Monitoring Tools. An additional priority was to fully implement nursing assessment and health care planning policies and procedures and complete quality assessments and plans in a timely fashion. Activities related to these priorities included involving the nursing staff at all levels in the process. Continued training and support for nurses was needed targeting their role and responsibilities in health risk rating determination as part of the PSP process as well as problem solving in the PNMT process. Internally designated nurses were starting to monitor using the new checklists. Completion of all targeted monitoring was in progress with data summary and analysis to follow. There were yet to be implemented plans for validation of monitoring results in these areas by the Quality Enhancement Nurse. Collaboration and coordination between the CNE and the Quality Enhancement Director had recently been initiated to address validity of quality data collected as well as summary and analysis. Currently the Quality Enhancement Nurse presents findings of individual monitoring checklists at the weekly Nurse Management meeting. The LSSLC presentation on progress toward meeting the Settlement Agreement provisions provided to the monitoring team on 4/18/11 included progress in the nursing care provision presented by the Chief Nurse Executive, Mary Bowers. Numerous initiatives and nursing team efforts were highlighted as well as progress toward each nursing provision. Several of these initiatives were (1) Initiating use of the revised Monitoring Tools for identified target areas of urgent care/emergency care/hospitalizations, infection control, acute illness/injury, GERD, quarterly and annual nursing assessments, documentation, and seizures; (2) providing DCS training on seizure documentation and aspiration triggers and revising new employee orientation to include more competency-based training provided by the nurse educator; (3) completion of audits of care plans for GERD and aspiration and development of a care plan template; (4) providing educational in-services to all nurses on vital sign assessment, follow-up and monitoring; and (5) lengthening and expanding the new nurse orientation and preceptor program. Below are additional comments regarding the activities, progress, and status of a number of areas of nursing assessment and reporting practices and protocols. A meeting was held regarding DADS Nursing Education Roll Out with Connie Horton, APRN, DADS Nursing Consultant, Mary Bowers, RN, CNE and the monitoring team. The plan for state-wide competency based training on physical assessment for registered nurses was described and the opportunity for questions and feedback given. Draft program materials were presented as well.	

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		Emergency equipment competency training was completed for all the nursing staff with mock CPR drills. Emergency CPR Drills were documented held for each residence each month. Competency-based training for skills, such as tracheostomy care and straight urinary catheterization were provided and completed in new employee orientation (NEO) and the annual nursing skills fair, but there was no competency-based training for assessment and care planning. One nurse case manager on Home 524 was asked by the monitoring team to locate and set up emergency equipment. She was unable to set up the suctioning and oxygen equipment without assistance. The monitoring team also noted the emergency equipment was dirty and stored in a dirty area with large amounts of visible dust. The monitoring team noted that the equipment and area had been cleaned by the next day and the case manager in question had developed her own plan or corrective action and taken it to her supervisor on the same day. The monitoring team met with the new Infection Control Nurse during the onsite review to discuss current infection control data and reports. She had been on the job for three months and was awaiting training by an Infection Control Nurse from another SSLC, including a review of the updated state-wide infection control manual. Discussion focused on her plans for the short and long term, including implementation of the infection control monitoring tool, auditing charts and investigating infection episodes, and collecting and analyzing variance data associated with aspiration pneumonia. Analysis of data and attempts to reduce urinary tract infections (UTIs) were discussed, including the number of individuals with pneumonia who also had UTIs. Comparisons across residences, male/female, device/non-device, and type of device had been made. As is common, individuals with devices had higher rates of UTIs than individuals without devices. There had not been consideration of comparing the factor of ambulatory versus non-ambulatory and evaluating the effects of positioning or other PNMP interventions to aid in kidney and bladder emptying. The Infection Control Nurse with the assistance of nursing management staff had maintained data on instances of various infection types as well as graphs by month with an emphasis on tracking the frequency and type of pneumonias, reviewed the infection control related documents, and interviewed nursing staff regarding infection control issues and procedures. She was reported to be directly involved in the daily process of nursing assessment and reporting. The Infection Control Nurse also received information from the facility's medical director and pharmacist related to antibiotic prescriptions and practices across the facility, as well as collaborating with them regarding the needs, monitoring, and treatment of specific individuals. 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	

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		with re-education and training in standard precautions and follow-up on individuals who were diagnosed with infections. The Infection Control Nurse also provided 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 in written reports that were sent to the individuals' nurse case managers, physician, and DCS Supervisor, and were also filed in the individuals' records. She continued to collaborate and coordinate with facility staff including physicians, Nurse Case Managers, and direct support staff in order to assure a safe and complete transition of the individual upon readmission. She participated in the daily Medical Meeting to present information on the status of individuals who were in the hospital and/or ready for discharge back to LSSLC. The Quality Assurance (QA) Nurse was not a member of the Nursing Department, but a member of the Quality Assurance Department and reported to the Director of Quality Assurance. The QA nurse was involved in all aspects of quality oversight of the delivery of health care services to individuals at LSSLC. Further, she was a member of many of the facility's committees (e.g., Medication Error, Infection Control). A quality improvement approach focused on areas targeted by analyzing data from the revised monitoring system was identified as the focus of discussion for this review. She was waiting on access to the upcoming state-wide data tracking system. The data as yet were not summarized and analyzed to identify improvement or to address the quality and comprehensiveness of some nursing process components, such as nursing assessment summaries and health management plans. Findings from individual tools completed were presented at the weekly nursing management meeting. The QA Nurse had several other self-described responsibilities, including tracking and monitoring unusual incidents involving abuse allegations and high profile incidents, as well as completing mortality reviews. Plans for the process of validating the nursing department's implementation of the Health Monitoring Tools was being discussed by the CNE and QA Director. Nursing assessment and reporting protocols and processes at LSSLC would not be complete without the role and responsibilities of the RN Case Managers, Campus Nurse Supervisors, and Nurse Managers. These were the nurses who were responsible for data gathering and direct observations of individuals, documentation, collection, aggregation,	

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		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). Three of the Nurse Managers met with the monitoring team to audit vital sign data together for individuals living in their units who were reviewed by the monitoring team. 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, body temperature, fluid intake and output, bowel elimination, and respiratory assessment data as reported in section M2 and M3.	
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.	The recently revised process (i.e., 11/2/10 DADS At Risk Individuals Policy #006) was currently being implemented with a shift to initial identification and rating of health risks by the PST. The monitoring team observed the new process for Individual #569 during her annual PST meeting on 4/19/11 and during two mock meetings set up for observation by the monitoring team. The QMRPs were implementing this new health risk identification process and the newly revised PSP. The nurse on the PST was prepared and presented the Aspiration Triggers Data Sheet and contributed to the health risk rating discussion of the team. The monitoring team supports the role and responsibility of each individual's PST in fully implementing the new risk identification and tracking process. Integrated discussion of risks and related factors as well as discussion of all associated data and influencing factors, however, was not yet apparent. Discussion often started with the recommended risk rating instead of a discussion of the risk and associated risk indicators and influencing factors first. It was too early to evaluate the effectiveness of the new process (see similar discussion in other sections of this report). What was evident was the need for staff with the expertise to be available to collaborate and provide technical assistance to the PSTs, as well as continuing to facilitate the process throughout the facility. All 20 individuals reviewed had a completed Health Risk Assessment Rating Tool that was timely. Individuals' Health Risk Assessment Rating Tools completed more recently and those with the Integrated Risk Rating Form completed provided improved data summaries and rationales related to the health risk rating areas with the inclusion of less subjective data and criteria. All 20 individuals whose records were reviewed were also	Noncompliance

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		reviewed by the HST and had multiple risks identified that were related to their health and/or behavior. At the time of the previous reviews, health risk ratings were not consistently revised when significant changes in individuals' health status and needs occurred. At the time of this review, risk ratings were more often being changed in a timely way in response to acute events and communicated to appropriate PST members, but changes or revisions to health management plans other than physician's orders were grossly lacking. Please also see section I and sections M1, M3, and M4 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 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.	The administration of medication and the management of the medication administration system at LSSLC had undergone numerous changes since the baseline and 10/10 reviews, including a new 30-day distribution system initiated in 10/10, moving of the pharmacy to a larger location and the implementation of a monthly MAR in 9/10. Pharmacy staff had received additional training regarding the WORx system and improvements to the WORx system had been made. Also see section N Pharmacy below in this report. Continued changes to the MARs to assure administration instructions and vital sign instructions required collaboration and coordination with pharmacy services. The following comments from the previous 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 system. • Nurses continued to check each individual order against the supply provided by the pharmacy and handwrite any variance onto the physician's order on the MAR. • 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 tablets 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	Noncompliance

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		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. • Thousands of 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 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 individual, 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. 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. 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 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 at least January 2011 through March 2011 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	

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		omissions without a documented code or reason for not administering the medication, however, were found during this review: • Individual #96: Sucralfate to use as paste at stoma site on 3/21/11 at 0730H, on 2/24/11 at 2100H and on 3/3/11 at 2100H; Cholecalciferol for vitamin D on 2/24/11 at 2100H; Levetiracetam for seizures on 2/24/11 at 2100H; Metoclopramide for decreased GI motility on 2/24/11 at 1700H and 2100H and on 3/12/11 at 1200H and 1700H; Sucrulfate suspension for GERD on 2/24/11 at 1700H and 2100H and on 3/13/11 at 1700H and 2100H; Mycolog cream to abdomen for yeast rash on 2/8/11 at 2100H; and, Albulterol-Ipratropium 3 ml ampule nebulizing treatment on 1/15/11 at 0730 and 1700H, 1/16/11 at 0730H, 3/26/11 at 0730H and 1700H and 3/17/11 at 1200H. • Individual #102: Sennoside for constipation on 2/8/11 at 1200H, and clonazepam for insomnia on 2/22/11 at 1200H and 2/28/11 at 1200H. • Individual #267: Gentamycin eye drops for conjunctivitis on 3/31/11 at 1200H; Lactulose for constipation on 2/20/11 at 0730H; and Ferrous sulfate on 2/16/11 at 0700H. • Individual #398: Vibramycin, an antibiotic, on 2/11/11 at 2100H and on 2/23/11 at 0700H; and Flonase nasal spray on 2/11/11 at 2100 H. • Individual #398: He should have been administered one more dose of Vibramycin and Flonase nasal spray at 0700H on 2/23/11 (ordered 2/9/11 twice daily for 14 days started at 2100H on 2/9/11). • Individual #258: Amoxicillin for sinusitis on 3/28/11 at 0730H and 1200H; Dilantin for seizures on 2/18/11 at 1200H; and Cholecalciferol/Vitamin D on 1/30/11 at 0730H. • Individual #535: Flagyl for infection on 1/7/11 at 1200H. • Individual #310: Carbamazepine for seizures on 2/9/11 at 1200H and 1700H and on 2/15/11 at 1200H; Docusate sodium for constipation on 2/15/11 at 1200H; and Valproic acid for seizures on 2/15/11 at 1200H; Provigil for bipolar disorder on 1/15/11 and 1/16/11 at 0700H; Dextran eye drops/ natural tears for dry eyes, refused day after day with no plan for tolerance or cooperation building procedures and refusals, "O" on MAR, inconsistently documented; and, Robitussin for cough ordered for seven days on 2/26/11 was administered five not seven days . • Individual #345: Metoprolol for hypertension on 4/5/11 at 2100H and 4/14/11 at 2100H; Sennoside for constipation on 3/19/11 at 2100H; Clonidine for hypertension on 4/14/11 at 1700H; Cholecalciferol/Vitamin D on 3/13/11 at 0730H; Hydroxyzine HCl for pruritis on 3/13/11 at 0700H and 1600H; Sodium chloride nasal spray for sinusitis on 3/13/11 at 1200H and 1700H; Gentamycin topical antibiotic on 3/13/11 at 1200H and 1700H and on 3/14/11 at 1200H; Megace on 2/16/11 at 2100H, and 3/12/11 and 3/13/11 at 2100H; Ranitidine	

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		on 2/9/11, 2/12/11 and 2/13/11 at 2100H. • Individual #389: Levofloxcin for pneumonia on 2/16/11 at 0730H; Metoprolol tartate for hypertension on 2/17/11 at 2100H and 1/23/11 at 2100H; and Duonebs inhalation treatment on 1/12/11 at 1700H. • Individual #245: Magnesium Hydrox/ Al Hyd oral suspension for severe ulcerative esophagitis on 3/29/11 at 1200H and 1/28/11 at 1200H ; Psudoephedrine 30 mg for hypotension on 3/18/11 at 0730H; Quetiapine for bipolar disorder on 2/19/11 at 0730H, 3/13/11 at 1700H and 3/23/11, 3/29/11 and 4/1/11 at 0730H; Calcitonin 200U nasal spray for osteoporosis on 2/2/11, 2/11/11, and 4/12/11 at 0730H; Lithium carbonate for bilpolar disorder on 4/12/11 at 0700H and 4/14/11 at 1700H; and Temazepam for sleep at 2100H on 3/14/11. • Individual #141: Normal saline nasal spray on 1/18/11 at 1700H and 2100H and 1/19/11 at 2100H; Metoclopramide on 1/26/11 at 1700H, most probably hospitalized but no code on MAR; Cranberry juice on 1/26/11 at 1200H and 1700H; Polyethelene glycol on 3/25/11 at 0730H; Sulcralfate paste to g-tube stoma on 3/20/11 at 0000H and 0400H and on 3/25/11 at 0400H; and Duoneb three times daily nebulizer treatments on 3/7/11 at 0730H and 1200H, 3/10/11 at 1200H, 3/24/11 at 0730H and 1200H and no codes for respiratory therapy administration. • Individual #285: Docusate sodium for constipation on 2/27/11 at 2100H; Lorazepam for autism on 2/27/11 at 2100H; Hydrocortisone 1% cream to back and knees on 2/1/11 at 2100H, 2/6/11 at 2100H, 1/14/11 and 1/23/11 at 0700H and 1/10/11 at 2100H; Sertraline for autism disorder 1/10/11 and 1/11/11 at 2100H (it was noted by the monitoring team he was in hospital on 1/10/11, but not 1/11/11 at 2100H); Trazadone for autistic disorder on 1/13/11 at 2100H and 1/14/11 at 2100H; Clindamycin 1% gel topical for acne on 1/10/11 at 2100H; Ativan for autism on 1/21/11 at 0700H and 1/14/11 at 2100H; and Topamax for autism on 1/23/11 at 0700H. • Individual #569: Septra DS for proteinuria on 3/16/11 at 2100H, and Oxcarbamazepine for seizure disorder on 1/22/11 at 2100H. • Individual #371: Fosamax weekly for 6 weeks for osteoporosis starting 2/2/11 had four doses/weeks documented, no documentation of the last two administrations was on the MAR. There were several examples of PRN medications being administered without a clear notation of the individual's complaint or condition that led to administration and/or did not provide a clear notation of the individual's response to treatment, including the date and time of follow-up assessment for effectiveness. There was very little use of the MAR PRN Medication and Treatment Record on the back of each MAR page. When	

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		documentation was present on these forms, it was generally a restatement of having given the medication (e.g., "Fleet enema given"). Examples included: • Individual #11 had an order for PRN Fleet enema administration for the third day without bowel movement, but the order was not implemented when she did not have a bowel movement from 2/16/11-2/19/11 or from 3/16/11-3/19/11. • Individual #96: On 1/17/11 at 0630H, a Fleet enema was administered the morning after two days without a bowel movement as documented on her Client Care Flow Sheet with no accompanying IPN or narrative on PRN administration documented on the MAR. On 3/4/11 at 1415H, a Fleet enema was administered for three days without a bowel movement and administration was reported to the next (2-10) shift. "V+S" was noted on 2-10 shift bowel movement record on the Client Care Flow Sheet. No response for this PRN administration and no follow-up were noted by the next shift on the next note dated 3/5/11 at 2125H in respiratory distress and ordered to the ER. She had orders for pseudoephedrine for low BP/hypotension, 60 mg four times daily PRN for systolic BP below 90 that began 12/10/09. The pseudoephedrine was documented given on 3/13/11 with no accompanying IPN. On 3/14/11, it was given for a BP of 84/53 with an accompanying IPN documenting a BP of 84/58 by the RN, but with no other vital signs or further assessment data. It was given at 1510H with a plan to retake her BP in one hour but the next IPN was at 1540H related to a g-tube pulled out by the individual. The next infirmary nursing assessment with vital signs was at 2200H. On 2/7/11, pseudoephedrine was administered twice for low blood pressure: once at 0700H for a BP of 85/50 and again at 1350H for a BP of 70/40. There was no IPN or PRN documentation on the MAR for the 0700 administration. The follow-up assessment for response to the 1350H administration was three hours later at 1700H documented on the Infirmary Nurse Assessment form. • Individual #267: A Fleet enema administered on 3/30/11 at 1320H had no follow-up on results documented. It was documented given at 1330H and reported to the next shift. There were no results documented in an IPN or narrative on PRN administration documented on the MAR. Acetaminophen 650 mg every four hours for pain or fever over 101 was administered on 2/23/11 at 1330H for pain associated with jaw swelling post multiple teeth extractions. There was no documentation of follow-up assessment and response in an IPN or narrative on PRN administration documented on the MAR. An administration on 2/28/11 at 0845H included documentation the nurse directed DCS to follow-up, but there was no assessment by the nurse for signs pain associated with persistent jaw swelling post extractions (on 2/28/11 it was noted that on 2/16/11, he had the roots of teeth #28, 30 and 31 and teeth #23, 24 and 25 extracted, and on 2/28/11 was experiencing swelling associated with	

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		extractions 28-31). • Individual #398: Acetaminophen 650 mg every four hours for pain or fever >101 degrees was ordered. On 2/18/11, it was documented administered on the MAR, but there was no documentation of follow-up assessment and response in an IPN or narrative on PRN administration documented on the MAR. The time of administration was not documented and it was noted by the monitoring team that the administration was during an episode of sinusitis. • Individual #258: Promethazine rectal suppositories were prescribed PRN for vomiting and administered on 2/7/11 at 2000H and on 2/8/11 at 0105H with no accompanying IPN regarding administration. On 4/9/11 at 1500H, Diastat 20 mg was administered rectally for three seizures of three to 10 seconds each that occurred at 1145H, 1400H, and 1445H with full recovery between seizures. The parameters in physician orders at the time were for administration after five seizures. • Individual #535 was administered acetaminophen on 2/17/11 at 2030H for a fever of 101.7. Follow-up assessment at 2210H included body temperature of 98.6, but with no other vital signs taken. On 2/18/11 at 0230H, his BP was low at 88/47 and PRN pseudoephedrine was administered. An IPN without the time of entry on 2/18/11 after a 1500H and before a 1600H IPN, documented low blood pressure again at 81/51. The 1600H IPN documented he was home from the infirmary and at 1430H had a low BP of 84/57 and low oxygen levels at O2Sat 96%. His Tylenol #3 was held and pseudoephedrine given at 1500 with the plan to continue to monitor. The next IPN was on 2/19/11 at 0430H with a low BP of 82/52. PRN pseudoephedrine was administered with follow-up at 0530H, 0620H, and 0830H with continued low blood pressures. Pseudoephedrine was administered at 0845H per physician's order with a BP of 84/69. Follow up assessment was not complete and timely to resolution of the low blood pressure episode. Follow-up assessment at 0930H documented a BP of 84/59 then 84/69, at 0945H of 94/56, and six hours later at 1530H of 94/55. The next IPN was at 1730H related to a medication review and including no vital signs. On 2/20/11 at 0000H, BP remained border line at 92/60. On 1/29/11 at 1100 BP was documented at 88/55 without administration of PRN pseudoephedrine as prescribed for low BP. • Individual #245: A promethazine HCl rectal suppository was administered PRN on 1/23/11 at 1940H for vomiting that had occurred two hours earlier. She had an accompanying elevated body temperature of 101.5 for which she had received PRN acetaminophen. • Individual #141: On 4/17/11, pseudoephedrine 60 mg now was ordered for a low blood pressure of 74/44 at 1515H and his Ibuprofen. An IPN noted a positive effect with a BP of 90/57, pulse of 75, respirations of 18, and a low	

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		O2Sat of 95%. The time of the follow-up assessment did not include the time it was completed and next IPN was at 2135H. • Individual #285: On 1/25/11 at 1540H, he was administered a PRN Fleet enema with no reason or response documented on the MAR or in an IPN. He was reported to engage in self-induced vomiting. He also had multiple gastrointestinal disorders including GERD, hiatal hernia, and Barrett's esophagus. Promethazine HCl rectal suppositories for self-induced vomiting were not consistently administered and reason and response data were lacking in detail for 11 of the 15 administrations documented. Generally, the reason for administration was "vomited x2" or "vomited x3". Other examples of medication management and administration from the same 20 records that did not meet generally accepted professional standards of care included: • Individual #245 was administered a potentially lethal dose of Lithium. She was prescribed 150mg/2.5 ml but 150 ml containing thousands of milligrams was administered on 3/4/11 at 1920H. Also see Pharmacy Section N for additional comments from the monitoring team. On 3/5/11at 1745H the individual had diarrhea, was lethargic, cold, and had clammy skin. Her diastolic BP was high at 121/101, body temperature low at 95.0 degrees, and she was vomiting. She was sent to the ER with renal dialysis initiated at 2300H at hospital with the CNE and NOO at the individual's side. She had a lithium level of 3.8 mEq/L before she received three dialysis treatments administered at the hospital. (The monitoring team noted the usual therapeutic range for maintenance therapy would be 0.6 to 1.2 mEq/L). She returned to the facility infirmary on 3/7/11 at 1430H with orders to hold her lithium until the orders were reviewed. She returned to her home on 3/8/11. On 3/24/11, her order for lithium carbonate was not clarified until 4/14/11; the order was for 150 mg crushed tablets or sprinkles from open capsules, but the order indicated milliliters of liquid medication to be administered; the order read "lithium carbonate tab (crushed) or capsule (sprinkled) 150 mg (2.5 ml) every 0700H, 300 mg (5 ml) every 1200H and 150 mg (2.5 ml) every 1700H x 182 days" with lithium level in six days. This medication was administered by a graduate nurse who did not recognize the drug's dose and safe dosage range before administration. • Lack of instruction for administration of "do not crush" lansoprazole tablets to individuals receiving medications via gastrostomy tube, including for example, Individual #11, Individual #96, Individual #535, and Individual #141. There was no indication that capsules which could be opened and the granules administered were available. • Individual #10 had physician's orders for acetaminophen every four hours PRN without an identified reason for administration/purpose in the order or on the	

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		MAR. She was prescribed PRN pseudoephedrine for systolic BP less than 90 on 3/18/11 and renewed on 4/11/11. Routine daily or multiple time daily blood pressure monitoring was not implemented. Blood pressure measures were recorded monthly with the 1/11 measure missing. On 3/26/11, she received breathing PRN treatments with Albuterol-Ipratropium 3 ml four times daily for "chest congestion/wheezing" per nebulizer. The accompanying IPNs at 1645H and 2200H documented the individual coughing clots of greenish yellow phlegm and adventitious lung sounds upon auscultation in the upper right lobe. The individual was administered the PRN nebulizing treatment with no follow-up assessment documented and the specified plan of directing DCS to report further coughing or phlegm. • Individual #102 had inconsistent and incomplete documentation of respiratory assessment before and after breathing treatments 12/29/10-1/2/11 post hospitalization and infirmary stay 12/20/10 to 12/27/10 for pneumonia and UTI. • Individual #57 had physician's orders for acetaminophen every four hours PRN for fever, but it was administered on 3/8/11 for complaints of a headache and on 3/24/11 for complaints of shoulder pain. • Individual #267 had no pulse measures recorded before administration of Atenolol for hypertension per the physician's order to take his pulse prior to administration and hold if <60 or >100 on 2/20/11 at 0700H and 3/26/11 at 0700H. 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 continued to be 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 that was initiated in September 2010 continued to be inconsistently and inappropriately completed. The forms were generally inadequately completed to meet the standard of documentation required for each administration, 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	

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		time of follow-up assessments for response to as needed treatment. The observations of medication administration were conducted on Homes 549A and 563A, including medications administered via the enteral route. During the observations, medications were administered in the individual's room at bedside or with the individual, nurse, and medication cart surrounded by new more stable portable screens set up in common living areas of the homes. One nebulizer treatment was observed at Home 549A that was administered by the respiratory therapist. Nebulizing treatments provided by nursing staff, usually evenings and weekends, and associated documentation did not include appropriate pre and post treatment assessments, including vital signs, breath sounds, and O2Sats (oxygen levels) when indicated. During all observations, nurses properly washed and disinfected their hands prior to medication administration and between individuals, identified the individuals receiving medications, 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. For enteral administration of medications on 549A the nurse checked their stoma sites and abdomens for signs of distension, pain, and skin breakdown, and appropriately flushed and clamped their feeding tubes. The nurse did not check the positions of the individuals and their feeding tubes, and did not properly administered all the individuals' medications in accordance with their physician's orders and facility policy. As was noted by the monitoring team during the previous review, medications administered via gastrostomy tube were not administered with a 10 cc flush between medications, per the Texas Health Monitoring Instrument and appropriate nursing practice. • The 1700H medication pass on 549A included administration of medications to individuals via gastrostomy and oral routes. The LVN observed reported he had been on the job for several weeks. He was not able to identify common and/or life-threatening side effects of medications he was administering, including carbamazepine, quetiapine, risperidone and baclofen. He did not consistently check for and adjust individuals positioning before administration, including requesting assistance from DCS. Individual #22 had orders for nectar consistency fluids and he could have his crushed medications mixed in applesauce or pudding or in juice. The administering nurse had to be stopped and prompted several times by the monitoring team to assure that, if fluids were used as the medium, the fluid was of nectar consistency. Crushed medications were mixed into a small cup of thickened cranberry juice, but medication remained in the cup when the nurse was prompted not to hyperextend the neck	

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		(i.e., this individual needed a nosy cup to transfer the fluids safely to his mouth). • The LVN administering medications at 0700H on 563A had pre-poured stock medications, such as multivitamins and had to waste them prior to initiation of each person's medication pass. The medication cart was in need of cleaning. This LVN was implementing self-administration of medication programs during her medication pass. For one individual who tended to keep his hands in his pockets, it was suggested by the monitoring team that the nurse may wish to ask him to remove his hands from his pockets before asking him to point to medications. During the medication passes observed, 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 "open so I can check your mouth," while directing the individual to finish swallowing solid or liquid medications. It was generally not a person-centered process. Many oral medications (tablets and/or capsules) were presented by the nurses together in a medicine cup and swallowed together in a single mouthful, presenting a choking risk to individuals. This would be a consideration for those individuals with risks associated with aspiration who receive multiple medications orally. Medication administration monitoring and observation by the nursing department included the recent implementation of the Section M-Medication Administration and Documentation checklist revised in 12/10 and initially implemented in 1/11. Nurse Managers and the Nurse Compliance Coordinator will be involved in nursing department self assessment. RNs had been assigned to periodically and directly observe and monitor medication administration. Observation of a complete medication pass was planned for each observation. Two of these monitoring checklists completed since the new form was implemented were completed by the QA Nurse and were presented to the monitoring team. Further evaluation and analysis would be necessary after adequate data on the new checklists is collected and summarized. Identified medication errors were complicated by problematic pharmacy systems and inconsistent transcription methods. Medication Error Committee meeting minutes from 9/1/10 through 3/9/10 were reviewed. Error data for the previous month presented on 3/9/11 included 51 errors, 39% related to pharmacy, 0% to physician and 61% to nursing. Extra doses and wrong doses administered by nursing continued to occur. Administering to the wrong individual last occurred in 1/11.	

Recommendations:

1. The facility should continue to refine the electronic MARs with all individualized instructions and orders for weights and vital sign monitoring 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).

3. The facility should continue to 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 continue with plans to develop and implement clinically sound competency-based training for nursing assessment, health management planning, and documenting implementation in concert with state-wide competency based physical assessment training. 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, the facility should continue to provide competency based training and job coaching to PST members and leaders on the integration of the PSP and Risk Rating processes and facilitation of the team to produce truly integrated risk ratings and action plans that support appropriate and ongoing health care management. Additionally, the facility should continue to provide training and ongoing support for nursing staff on the appropriate preparation, facilitation and participation in collaborating with PSTs in determining health risk ratings and aspiration triggers and PNMTs to problem solve physical and nutritional management problems and/or track progress. Once the new system is fully implemented and individuals' risks are appropriately identified by PSTs, teams need to conduct integrated team reviews, and develop appropriate proactive treatment plans to address identified areas of risk

7. Documentation training, particularly on the upcoming transition from the DAP to the SOAP format of charting as specified in the Health Care Guidelines, should be developed and all nurses trained and monitored until nurses are implementing this process more systematically. The facility should assure that monitoring of documentation using the revised tool provides nursing management and individual nurses with the feedback and follow-up necessary to improve the quality of that documentation, including appropriate documentation of the "A," analysis, of the data, instead of actions taken.. The training should include proficiency-based practice and ongoing monitoring on the appropriate and consistent documentation and tracking of specific health problems or issues from initial assessment to resolution using the appropriate form and/or format.

8. The facility should re-evaluate the roles and responsibilities of nurses throughout the campus to assure a process for inclusion of more person-centered approaches, for example the nurse's role in medical rounds, medication administration.

9. The facility should 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 as planned during implementation of the Medication Administration Competency Checklists and/or revised monitoring tool. The data should be aggregated and analyzed to facilitate corrective action.

10. The facility should assure appropriate implementation of 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 consistently 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 to establish reliability between auditors and in order to effectively aggregate and analyze the data to facilitate optimal corrective action.

13. Consider replacing the slab baths with adjustable height bathing systems with built-in/adjunct lifts for safety. The facility should assure that individuals with hypothermia and those with significant risks related to osteoporosis are provided with alternatives to a slab bath and contraindications are noted in their HMPs.

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 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 LSSLC Operational Procedures Manual, Medical 15 Adverse Drug Reaction Reporting, 12/16/10 o Pharmacy and Therapeutics Committee Meeting Minutes, dated, 11/16/10, 2/8/11 o Medication Error Reduction Committee Meeting Minutes, dated 9/1/10, 9/22/10, 10/16/10, 10/27/10, 11/11/10, 12/8/10, 1/26/10, 2/9/10, 2/23/10 o Variances Per Month Based on Discovery Date o Adverse Drug Reaction report o Quarterly Drug Regimen Reviews for the following individuals: • Individual #545 Individual #476, Individual #597, Individual #382, Individual #158 Individual #218Individual #44, Individual #586, Individual #450, Individual #306 Individual #405, Individual #179, Individual #167 Individual #132, Individual #352, Individual #590 Individual #292, Individual #383, Individual #184, Individual #380, Individual #139, Individual #104, Individual #502, Individual #302, Individual #361, Individual #67, Individual #424, Individual #51, Individual #265, Individual #256, Individual #176 Individual #431 o MOSES and DISCUS forms for the following individuals: • Individual #339, Individual #382, Individual #424, Individual #363, Individual #23, Individual #116, Individual #382, Individual #492, Individual #160, Individual #169, Individual #166, Individual #221, Individual #135, Individual #352, Individual #413, Individual #469, Individual #300, Individual #177, Individual #176, Individual #92, Individual #569, o Drug Utilization Evaluation Summaries: • Calcium carbonate • Carbamazepine 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 Informal observations of medication administration
	Facility Self-Assessment: The facility rated itself noncompliant with Provision items N1, N2, N3, N4, and N8. The monitoring team agrees with the facility's self-assessment. The facility found itself compliant with items N5, N6, and N7. The MOSES and DISCUS forms were completed in a timely manner, but the substantial number of documents that lacked a physician response prohibits the monitoring team from finding substantial compliance. The facility reported one adverse drug reaction in spite of the fact that records provide evidence of many medication associated adverse drug reactions. The facility completed two Drug Use Evaluations over six months. Data alluded to deficiencies in facility practices. The DUE reports as submitted require a plan of corrective actions. Thus, the monitoring team found noncompliance in all three provision items.
	Summary of Monitor's Assessment: The facility had made little progress in the provision of pharmacy services and safe medication practices. The pharmacy director and medical director both appeared to have little involvement in many of these systems based on responses during interviews. That lack of clinical leadership may have contributed to the limited progress noted during the review. The facility had revised only one policy since the last onsite review: Adverse Drug Reactions. The facility's policy and procedure manual contained several policies that were not congruent with the Health Care Guidelines and many policies and procedures had not been reviewed or revised in 8 to 10 years. A state issued policy on safe medication practices was included in the manual, but was watermarked "DRAFT." Physician orders were being reviewed as part of the entry into the WORx software. There was very little documentation of interactions between the pharmacists and the medical practitioners independent of notations made on the physician orders. Drug regimen reviews were completed, but very often these lacked any substantive review of the necessary information due to the integrated record not being available for review. When the record was not available for review on the scheduled day, there was usually no documentation attempts to repeat the review. Formatting of the drug regimen reviews made it difficult to recognize recommendations and this may have contributed to physicians consistently indicating that no change was necessary. The MOSES and DISCUS rating instruments were completed, but the medical staff did not appear to use this information in therapeutic decision-making. Moreover, the medical staff's response to QDRR recommendations and data derived from the MOSES and DISCUS tools was frequently inadequate. Two Drug Utilization Evaluations were completed, but concerns related to data accuracy and generation of

	corrective actions were noted. One ADR was reported since the last onsite review. Medication variance data were being collected and reviewed. The pharmacy accounted for a significant percentage of errors. There were recurrent wrong patient, wrong drug, wrong dose errors, yet there was no evidence that any substantial process analysis had occurred to determine contributory and causal factors. Corrective actions were most often labeled as teaching and coaching.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	A prospective review was completed for all new orders through the WORx software program. The program checked a number of parameters, such as therapeutic duplication, drug interactions, allergies, and other issues. The POI documented that the facility was "able to input and print Single Patient Intervention Reports on any individuals. Each day reports are generated for new and refill orders." In response to the request for all Single Patient Intervention (SPI) Reports and notes extracts since the last monitoring visit, 39 SPI documents and 11 notes extracts were provided. The SPI documents were generated from April 2010 to February 2011. Documents were provided onsite as well as in the electronic format. The documents for the provision item differed. Specifically, for several interactions, the dates differed by several months. Prospective and retrospective interventions could not be differentiated. Many of the interventions appeared related to QDDR because they included comments, such as "most recent ocular exam is not documented under Consult tab of IAR." Several of the reports simply stated patient intervention and had no comments. Eleven Notes extracts dating back to 2006 were provided. The comments appeared to be more prospective in nature and included: • All meds by tube • All medications are to be given by tube and crushed • Simvastatin discontinued for 20 days while giving Clarithromycin The Health Care Guidelines required that "all discussions between the pharmacist and prescribing practitioner shall be documented for retrieval and review as needed by the pharmacist." Clarification of drug orders was documented on the order form by the pharmacists, however, there was no consistent documentation of discussions. The monitoring team reviewed the requirements for documentation with the pharmacy director. During discussion with the medical director, pharmacy director, and clinical pharmacist, the monitoring team inquired about any other processes used for	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>documentation of interactions and the “Single Patient Intervention Reports. The medical director was not familiar with this report and there was no additional documentation to support the prospective reviews and documentation of interactions. Information from the SPI should be collected and submitted to the medical director for review and corrective action when necessary. Potential issues include therapeutic duplication, failure to note allergies, and incomplete physician orders. This process serves not only as a mechanism of clarification and prevention of errors, but also as an assessment of physician performance that provides opportunity for improvement.</td><td></td></tr>
<tr><td>N2</td><td>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.</td><td>The clinical pharmacist completed Quarterly Drug Regimen Reviews. The QDRRs included reviews of allergies, the appropriateness of medications, rationale for therapy, proper utilization, duplication of therapy, polypharmacy, drug– drug/food/disease interactions, and adverse reaction potential.

The facility implemented a revised QDRR template that included several notable changes. A checkbox was added for the medical staff to indicate that no action was required or no changes were necessary in response to the recommendations of the pharmacist. The form also indicated that the psychiatrist was to sign if the individual received psychoactive medications. The template also provided guidance on the types of information to be included in the pharmacist’s discussion, such as pertinent drug levels, lab results, antibiotic treatment, clinic visits, dose adjustments, drug interactions, and any other applicable comments about the individual overall health status. Moreover, the facility implemented a revised and expanded lab matrix that established the criteria for the monitoring of drug use through the QDRR.

A sample of 32 QDRRs was reviewed for timelines, pharmacy assessment, and physician response. The table below captures the key dates, drugs with monitoring parameters, pharmacy comments/recommendations, and physician responses. The “discussion” represents comments from the monitoring team.

<table>
<tr><th>Individual #</th><th>Key Completion Dates
Pharmacy
PCP
Psychiatry</th><th>Drugs, Monitoring, Comments/Recommendations</th></tr>
<tr><td>256</td><td>2/1/11
?
2/8/11</td><td>• Chlorpromazine
• Clonidine
• Tolterodine
• Paroxetine
• Iloperidone
• Docusate
Pharmacy Comments/Recommendations:</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status			Compliance
				• Per Psych clinic, baseline DISCUS was completed, but not filed in record. • The 12/10 and 8/10 Vitamin D levels were sub-therapeutic; recommend providing supplementation. Medical Comments: No action required Discussion: The recommendation for a Vitamin D level was repeated from previous review.	
		380	2/1/11 2/2/11 2/1/11	• Certa-vite, ferrous sulfate • Aripiprazole • PEG • Oxcarbazepine • Fexofenadine Pharmacy Comments/Recommendations: • 2/1/11 – IAR was not delivered today for review • 7/29/10 – Recommend assessing whether eye exam is up to date • 5/4/10 – lipids wnl; TSH 5.13; increasing weights documented. Medical Comments: No action required Psychiatry Comments: No action required Discussion: The record review for the most recent quarter was not completed. There was no normal value reported for TSH nor was any recommendation made. A 9.5 pound weight gain was documented, but no f/u comments were made related to the use of the new generation antipsychotics. In spite of these findings, the PCP and psychiatrist both noted no action required.	
		590	2/1/11 2/2/11 NA	• Certa-vite, Vitamin D • Fexofenadine Pharmacy Comments/Recommendations: • CMP, lipids, CBC and Vitamin D are up to date. Slightly low platelet and WBC counts. Recommend close monitoring. Medical Comments: No action required Psychiatry Comments: NA	
		51	2/1/11 No Date 2/2/11	• Docusate • Vitamin D • Levothyroxine • Atorvastatin • Carbamazepine • Propranolol Pharmacy Comments/Recommendations: • CMP, lipids and hepatic function - WNL Medical Comments: No action required Psychiatry Comments: No action required Discussion: Previous QDRR recommendation made to monitor CBC every six months (last 6/10). The CBC was not documented. There was no BP or HR monitoring noted.	
		431	2/1/11 2/1/11 NA	• Atorvastatin • Levetiracetam • Metformin	

#	Provision	Assessment of Status			Compliance
				• Metoprolol Pharmacy Comments/Recommendations: • CMP – the same; lipids and microalbumin - WNL; HbA1c 6.2 sl elevated Medical Comments: No action required Discussion: Liver enzymes for Atorvastatin and Metformin monitoring were not documented. Monitoring of BP and HR for metoprolol was not documented.	
		383	2/7/11 2/8/11 2/14/11	• Docusate, Cal/Vit D, simethicone • Ferrous sulfate • Atorvastatin • Cetirizine • Levothyroxine • Certagen • Azelastine, flunisoloide • Sertraline, exemestane • Miconazole powder Pharmacy Comments/Recommendations: • "IAR was not delivered for review today." Medical Comments: No action required Psychiatry Comments: -- Discussion: This individual had no review of records or lab parameters completed by the clinical pharmacist. In spite of this, the PCP noted no action required. The psychiatrist signed, but did not check any boxes.	
		132	1/24/11 1/24/11 NA	• Propranolol • Docusate • Calcium antacid • Vitamin D • ASA 325 • Simvastatin • Ferrous sulfate • Omeprazole • Levothyroxine • Raloxifene Pharmacy Comments/Recommendations: • Recommend getting updated Vitamin D, 7/20/10 level subtherapeutic at 18. Also recommend lipid panel, as abnormalities were identified 8/10. Increase in Simvastatin may be necessary. CMP - WNL Medical Comments: No action required Psychiatry Comments: NA Discussion: There was no documentation of TSH, BP, and HR monitoring. QDRR (1/10) noted a TSH of 7.31 (high). The medical practitioner documented no action required in spite of the recommendations.	

#	Provision	Assessment of Status			Compliance
		158	2/7/11 2/8/11 NA	• Azelastine • Celecoxib • Vitamin D • Atorvastatin • Brimonidine • Timolol • Lisinopril Pharmacy Comments/Recommendations: • Vitamin D subtherapeutic at 27 and individual is not on supplementation. Recommend supplementation. CMP and lipids – WNL; AST 46 ALK 68 Medical Comments: No action required Psychiatry Comments: NA Discussion: The pharmacist indicated that the individual was not on Vitamin D. Vitamin D was listed as a medication.	
		139	2/7/11 2/8/11 NA	• Certa-Vite • Amlodipine Pharmacy Comments/Recommendations: • Weekly BP and HR checks performed; CMP with sl increased albumin of 4.8 Medical Comments: No action required	
		292	2/7/11 2/8/11 NA	• MetoprololVitamin DHCTZ Pharmacy Comments/Recommendations: • CMP glucose 158, repeat 85; total bilirubin consistently elevated, noted to be Hep B carrier; weekly HR and BP monitoring done Medical Comments: No action required Discussion: There was no BP and HR monitoring noted. The Vitamin D level was not documented.	
		218	2/1/11 2/2/11 No signature	• Lactulose, Sennosides, docusate • Esomeprazole, sucralfate • Ferrous sulfate • Tolterodine • Certa-vite • Latanoprost • Flunisolide • Fluphenazine • Paroxetine • Fexofenadine Psychiatry Comments/Recommendations: • Last ocular exam 6/10 recommended three month eye exam, but there was no documentation in IAR. Medical Comments: No action required Psychiatry Comments: -- Discussion: PCP did not address the recommendations; there was no documentation of monitoring of anemia related to iron use.	
		502	2/2/11 No date 2/14/11	• Certa-vite • Risedronate • Vitamin D, ferrous gluconate	

#	Provision	Assessment of Status			Compliance
				• Metoclopramide • Levothyroxine • Lactulose, docusate sodium • Lansoprazole • Mirtazapine • Topiramate • Loratadine • Nystatin cream Pharmacy Comments/Recommendations: • AlkPhos elevated 64; TSH, iron panel, Vitamin D – WNL, LDL 31 (low) Medical Comments: No action required Psychiatry Comments: No action required	
			104	2/2/11 2/4/11 NA • Sennosides, PEG • Clotrimazole • Vitamin D • Estradiol Pharmacy Comments/Recommendations: • No new interaction identified Medical Comments: No action required	
			179	2/2/11 2/1/11 NA • Risedronate • Calcium/Vitamin D • Atorvastatin • Docusate, bisacodyl • Pantoprazole, metoclopramide Pharmacy Comments/Recommendations: • "Chart unavailable for review. Review of drug regimen shows no new interactions, no significant lab values to report for MISYS review." Medical Comments: No action required Discussion: Monitoring for Atovastatin not documented – lipids and liver enzymes. Last BMD for use of Risedronate should be documented.	
			302	2/2/11 2/4/11 NA • Bisacodyl, docusate, lactulose • Calcium/Vitamin D, Vitamin D, ferrous sulfate • Ascorbic acid • Certa-vite • Oxcarbazepine, gabapentin • Lansoprazole • Terbinbafine Pharmacy Comments/Recommendations: • Most recent lipids shows abnormalities (Tchol 223, LDL 137). Previous lipids 2/2009 were WNL. Recommend dietary modification for 3-6 months, then reassess. Medical Comments: No action required Discussion: Monitoring was needed for the continued use of ferrous sulfate – Hb/Hct	
			67	2/2/11 2/4/11 • Divalproex, lamotrigine, gabapentin • Calcium/Vitamin D, Certa-vite, Vitamin D	

#	Provision	Assessment of Status				Compliance
				No Sig	• Levothyroxine Pantoprazole • Docusate • Sertraline • Coenzyme Q • Medroxyprogesterone • Atorvastatin • Cilostazol • ASA 81 Pharmacy Comments/Recommendations: • "IAR not available for review. DRR/MYSIS review present no new concern." Medical Comments: No action required Psychiatry Comments: NA Discussion: There was no review by psychiatry for this individual who received psychotropics for SIB.	
			545	2/8/11 2/10/11 NA	• Certa-vite Calcium/vitamin D • Lacosamide • PEG, bisacodyl docusate • Pantoprazole • Lamotrigine • ASA • Atorvastatin • Oxcarbazepine, phenobarbital • Topical metronidazole • Desonide Pharmacy Comments/Recommendations: • IAR was once again not delivered for quarterly review. Medical Comments: No action required Discussion: There was no record and therefore no review of labs such as lipids and liver enzymes.	
			586	2/8/11 2/8/11 NA	• Levetiracetam • Olopatadine • Digoxin • Florastor • Furosemide, KCL, metoprolol • Levothyroxine • Tamsulosin • Docusate sodium, Sennosides • Cerovite liquid, Vitamin D Pharmacy Comments/Recommendations: • IAR not delivered for review today. Medical Comments: No action required Discussion: There was no record and therefore no review of digoxin level, TSH, and BP/HR monitoring.	
			450	2/8/11 No Date NA	• Atorvastatin • Vitamin D, Calcium/Vitamin D • Enalapril • Certagen	

#	Provision	Assessment of Status			Compliance
				• Topiramate • Terbinbafine • PEG Pharmacy Comments/Recommendations: • IAR not delivered. Recommended changing administration time for atorvastatin from daily to HS. Medical Comments: No action required Discussion: There was no record review and therefore no comments related to lipids, liver enzymes and monitoring for antihypertensives.	
		405	2/8/11 2/8/11 NA	• Vitamin D • Certavite • Phenobarbital • Lactulose, docusate sodium • Loratidine Pharmacy Comments/Recommendations: • IAR not delivered Medical Comments: No action required Discussion: There was no record review and therefore no comments related to seizure control with Pb.	
		167	2/8/11 No Date NA	• MOM • Atorvastatin • Phenytoin, phenobarbital • Vitamin D, Calcium/Vitamin D • Certagen Pharmacy Comments/Recommendations: • IAR not delivered Medical Comments: No action required Discussion: There was no record review. Monitoring needed included lipids, liver enzymes, drug levels and dental exam for dilantin.	
		476	11/3/10 No Date No Date	• Carbamide • Docusate, Sennosides • Ascorbic acid • Calcium/Vitamin D • Trazodone, risperidone, lorazepam Pharmacy Comments/Recommendations: • IAR not delivered – Scheduled 11/8/10 Medical Comments: No action required Psychiatry Comments: none Discussion: There was no record review. Monitoring was needed included prolactin, glucose, HbA1c	
		265	11/8/10 No Date No Date	• Certa-vite • Simethicone • Baclofen • Flunusolide • PEG, bisacodyl • Phenobarbital • Pantoprazole	

#	Provision	Assessment of Status			Compliance
				• Calcium/Vitamin D • Trazodone • Atorvastatin • Clonidine • KCL • Trazodone • Mirtazapine • Loratadine, pseudoephedrine, terbinbafine Pharmacy Comments/Recommendations: • IAR not delivered Medical Comments: No action required Psychiatry Comments: No action required Discussion: Monitoring was needed included lipids and liver enzymes	
		44	1/31/10 1/31/10 NA	• Lactase • Baclofen • Docusate, PEG • Vitamin D, Calcium/Vitamin D • Levetiracetam, dilantin, carbamazepine Pharmacy Comments/Recommendations: • IAR not delivered Medical Comments: No action required Discussion: Monitoring needed included AED levels and dental exam for Dilantin.	
		172		• Famotidine • Ferrous sulfate, folic acid, Golden age, Calcium/Vitamin D • Lansoprazole • Phenobarbital, levetiracetam, dilantin • Metoprolol • Lactulose • Ipratropium/albuterol • Chlorpheniramine • Metoclopramide Pharmacy Comments/Recommendations: • IAR not delivered Medical Comments: No action required Psychiatry Comments: No action required Discussion: Monitoring needed included AED levels, HR/BP, and Hb/HCt	
		352	1/31/11 1/31/11 NA	• Golden age • Docusate, lactulose • Scopolamine • Metoprolol • Lansoprazole • Metoclopramide • Vitamin D, Calcium/Vitamin D • Ipratropium Pharmacy Comments/Recommendations: • Next DISCUS 2/11; CMP WNL; lipids trig 217 HDL 28;	

#	Provision	Assessment of Status			Compliance
				Recommend dietary modifications 3-6 months then reassess Medical Comments: No action required Discussion: Monitoring needed included HR and BP.	
		184	1/31/11 1/31/11 NA	• Golden age, ferrous sulfate, Calcium/Vitamin D, calcitonin • MI acid • EES • Lansoprazole, metoclopramide, sucralfate • Docusate Pharmacy Comments/Recommendations: • Most recent iron panel is still dated 9/2006. Recommend monitoring of iron level with continuation of ferrous sulfate. Medical Comments: No action required Discussion: The primary provider did not address this recommendation in prior review.	
		361	1/31/11 1/31/11 NA	• Sennosides, PEG • Golden age, Vitamin D, Calcium/Vitamin D • Metoclopramide, lansoprazole • Meloxicam Pharmacy Comments/Recommendations: • IAR not available Medical Comments: No action required Discussion: No specific monitoring required per lab matrix.	
		597	2/10/11 No Date NA	• Methotrexate • Certagen • Carbamazepine • KCL • Atorvastatin • Lactulose, sennosides, bisacodyl • Vitamin D, calcium/Vitamin D • Baclofen • Prednisone • Azithromycin Pharmacy Comments/Recommendations: • CMP WNL, diff abn; CPK WNL. Recommend increasing atorvastatin to 15mg. tegretol level 9.8 Medical Comments: No action required Discussion: Liver enzymes should be documented.	

#	Provision	Assessment of Status			Compliance
		306	11/24/11 2/15/11 No date	• Sennosides, docusate, PEG • Certagen, Vitamin D • Trazodone, benzatropine • Biafine, levothyroxine • Lithium, risperidone • Lamotrigine, oxcarbazepine, valproic acid • Ammonium lactate Pharmacy Comments/Recommendations: • Critical lab values 2/1/11 – low ANC and plts; lithium, lamictal, Oxcarbazepine - WNL Medical Comments: No action required Psychiatry Comments: No action required Discussion: The critical lab value should have been addressed and documented as resolved by medical providers; TSH should have been recorded.	

(Table ends here)

Overall, the QDRRs were completed in a timely manner. Of the 32 records reviewed, 14 (44%) did not include information from integrated record reviews due to the lack of availability of the records. In most instances, this diminished the quality of the review since there was no comment on relevant clinical information. Additional examples of QDRRs that lacked record reviews are discussed in Section L1.

Several other concerns were noted with the QDRRs. Commentary on monitoring parameters, such as lab values was inconsistent. For individual #302 the TSH was monitored and for Individual #132 the TSH was not monitored. The use of benzodiazepines and anticholinergic burden was not discussed in any of the QDRRs reviewed. The most recently revised worksheet did include audit questions covering these issues.

The QDRRs included all prior comments/recommendations with the most current listed last. This made identification of the current recommendations difficult. Notwithstanding legitimate pharmacy recommendations, the medical providers consistently indicated that no action was required. This decision may have been the result of not being able to clearly identify the current recommendations. During discussions with the monitoring team, the medical staff reported that they believed the comments were frequently not valid. They cited inaccuracy in comments related to deficient labs and outstanding consults as examples.

When laboratory data were provided, it frequently included the interpretation of high, low, or normal. Laboratory data included in tabular format would make recognition of trends in values more recognizable. This would be especially helpful in determining adverse reactions related to statins (LFTs), new generation psychotropic (lipids and

#	Provision	Assessment of Status	Compliance
		HbA1c), and AEDs. The normal range of values should also be included. The recommendation section should include any items where action may be necessary on the part of the provider. This will ensure that recommendations are seen by the provider and will make tracking an easier task. <u>Additional Discussion</u> The facility implemented a newly revised QDRR format in late February 2011. The facility's document merged the QDRR report form with the QDRR worksheet and produced a four-page document signed by the pharmacist and providers on the last page. This document included all of the audit criteria normally included, in addition to tables containing lab values. The 32 QDRRs reviewed were not in this format. The facility should consider keeping the worksheet and actual report as separate documents. The pertinent data from the worksheet should be included on the report form in the form of comments, tabulated lab values and data and recommendations	
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 facility monitored for the metabolic side effects of new generation antipsychotics through the QDRRs. The facility implemented an expanded lab matrix and these criteria were used for the audits. The newly revised QDRR template captured issues related to anticholinergic burden and benzodiazepine use. The QDRRs reviewed, however, did not include that information. The Pharmacy maintained a log of stat drugs used. The pharmacy depended upon faxed drug orders to keep the list current. During meetings with the monitoring team, the clinical pharmacist reported that she was not receiving the required documents. A polypharmacy committee met to review and justify the use of polypharmacy. This process required the director of psychiatry to actually provide justification for polypharmacy prescribed by the other psychiatrists. Additional information on psychotropic polypharmacy is found in Section J. Data related to polypharmacy and the use of stat drugs was presented in the quarterly Pharmacy and Therapeutics Committee meetings.	Noncompliance
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the	The clinical pharmacist reported that verbal acceptance or rejection of recommendations of prospective recommendations was noted in WORx through the SPI report. Very few of the SPIs provided appeared to be prospective reviews. Compliance with this requirement could not be determined.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>The QDRRs were revised to include statements related to the medical providers' agreement or disagreement with pharmacy recommendations. Each medical provider was required to sign and date the form and check one of the following:
I agree with the pharmacist recommendations
I disagree with the pharmacist recommendations. Explain why the recommendation was not accepted
No action required/No changes
In the sample of the 32 QDRRs reviewed, the following data were tabulated:
32 of 32 reports had the no action required item checked.
10 of 32 reports had specific recommendations made by the pharmacist
10 of 10 reports had no action required checked
10 of 10 reports lacked acknowledgement of agreement or disagreement with the recommendations
4 of 32 reports clearly documented previous recommendations that were not followed
The monitoring team discussed adherence of recommendations with the medical director. The medical director reported that he did not receive data on provider compliance and was not tracking that information at the time of the onsite review.</td><td></td></tr>
<tr><td>N5</td><td>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.</td><td>The sample consisting of 42 MOSES and 32 DISCUS reports listed above was reviewed for timelines for completion and review, thoroughness, and physician response. The results are presented below.
<table>
<tr><td></td><td colspan="2">MOSES DATA</td><td colspan="2">DISCUS DATA</td></tr>
<tr><td colspan="5">-- Indicates no physician response
NAN Indicates physician response of no action necessary</td></tr>
<tr><td>Individual #</td><td>Reviewer Date
Practitioner Date</td><td>Comments</td><td>Last Review
Reviewer Date
Practitioner Date</td><td>TD</td></tr>
<tr><td>176</td><td>1/19/11
1/10/11</td><td>Total score: 24
MD Conclusion: --</td><td></td><td></td></tr>
<tr><td></td><td>7/15/10
7/19/10</td><td>Total score: 24
MD Conclusion: --</td><td></td><td></td></tr>
<tr><td>339</td><td>1/6/11
2/3/11</td><td>Total score: 25
MD Conclusion: NAN</td><td>8/23/10
11/15/10
11/16/10</td><td>No TD</td></tr>
<tr><td></td><td>7/9/10
7/19/10</td><td>Total score: 26
MD Conclusion: NAN</td><td>11/15/10
2/10/11
2/15/11</td><td>--</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status						Compliance
		382	1/6/11 2/3/11	Total score: 36 MD Conclusion: NAN	8/23/10 11/15/10 11/17/10	--		
			7/10/10 7/19/11	Total score: 37 MD Conclusion: NAN	11/15/10 2/10/11 2/15/11	No TD		
		424	1/10/11 1/13/11	Total score: 32 MD Conclusion: --	9/29/10 12/30/10 2/2/11	No TD		
			7/1/10	Total score: 24 MD Conclusion: --	6/23/10 9/2910 11/1/10	No TD		
		300	1/6/11 1/20/11	Total score: 23 MD Conclusion: --	9/15/10 12/4/10 12/14/10	No TD		
			7/11/10 7/15/11	Total score: 22 MD Conclusion: --	6/17/10 9/15/10 9/21/10	--		
		135	1/7/11 1/19/11	Total score: 10 MD Conclusion: --	9/10/10 12/5/10 12/14/10	No TD		
			7/10/11 7/15/11	Total score: 12 MD Conclusion: --	6/18/10 9/10/10 9/24/10	--		
		166	1/9/11 1/19/11	Total score: 35 MD Conclusion: --				
			7/13/10 7/19/10	Total score: 36 MD Conclusion: --				
		363	1/9/11 1/19/11	Total score: 17 MD Conclusion: --	11/1/10 2/16/11 2/22/11	No TD		
			7/12/10 7/19/10	Total score: 17 MD Conclusion: --	8/11/10 11/1/10 11/2/10	No TD		
		413	1/13/11 2/16/11	Total score: 7 MD Conclusion: --	9/7/10 12/8/10 12/15/10	--		
			7/7/10 7/29/10	Total score: 26 MD Conclusion: --	6/4/10 9/7/10 9/15/10	--		
		492	1/9/11 1/19/11	Total score: 37 MD Conclusion: --	8/11/10 11/1/10 11/2/10	--		
			7/12/10 7/19/10	Total score: 26 MD Conclusion: --	11/1/10 2/16/11 2/22/11	--		
		160	1/6/11 2/15/11	Total score: 10 MD Conclusion: --	11/1/10 2/11/11 2/15/11	No TD		

#	Provision	Assessment of Status						Compliance
				7/8/10 7/29/10	Total score: 25 MD Conclusion: --	8/23/10 11/1/10 11/16/10	No TD	
			569	1/12/11 1/26/11	Total score: 7 MD Conclusion: NAN	10/9/10 1/18/11 1/28/11	No TD	
				7/6/10 7/9/10	Total score: 7 MD Conclusion: NAN	7/6/10 10/9/10 10/27/10	--	
			177	1/16 1/26	Total score: 2 MD Conclusion: NAN			
				7/6/10 7/8/10	Total score: 5 MD Conclusion: NAN			
			92	1/12 1/26	Total score: 0 MD Conclusion: --	11/9/10 2/4/11 2/23/11	No TD	
				7/6/10 7/8/10	Total score: 10 MD Conclusion: NAN	8/2/10 11/9/10 11/18/10	--	
			469	1/16/11 1/28/11	Total score: 0 MD Conclusion: NAN	11/9/10 2/4/10 2/23/10	No TD	
				7/6/10 7/8/10	Total score: 3 MD Conclusion: NAN	8/2/10 11/9/10 11/18/10	--	
			169	1/16/11 1/28/11	Total score: 0 MD Conclusion: NAN	10/9/10 1/18/11 1/28/11	No TD	
				7/6/10 7/8/10	Total score: 6 MD Conclusion: NAN	10/9/10 10/27/10	--	
			257	1/16/11 1/28/11	Total score: 0 MD Conclusion: NAN			
				7/21/11 7/23/11	Total score: 6 MD Conclusion: NAN			
			116	1/16/11 1/26/11	Total score: 0 MD Conclusion: NAN	10/9/10 1/18/11 1/28/11	No TD	
				7/21/10 7/23/10	Total score: 17 MD Conclusion: NAN	7/19/10 10/9/10 10/21/10	--	
			221	1/16/11 1/28/11	Total score: 0 MD Conclusion: NAN	11/9/10 2/4/11 2/23/11	No TD	
				7/21/10 7/23/0	Total score: 23 MD Conclusion: NAN	8/2/10 11/9/10 11/18/10	--	
			23	1/19/11 1/26/11	Total score: 0 MD Conclusion: NAN	11/9/10 2/4/11	No TD	

#	Provision	Assessment of Status	Compliance

			2/23/11	
	7/21/10 7/23/10	Total score: 11 MD Conclusion: NAN	8/2/10 11/9/10 11/18/10	--
352	1/13/11 1/18/11	Total score: 9 MD Conclusion: NAN		
	7/28/10 8/4/10	Total score: 10 MD Conclusion: NAN		

Additional Discussion

The MOSES and DISCUS instruments, included in the sample, were completed by the reviewer within the appropriate timeframes. The documents were signed and dated. With few exceptions, providers promptly reviewed the documents. A more problematic finding was the providers' response to the information contained in the reviews:

- 18 of 42 Moses instruments had no provider response
- 23 of 42 MOSES instruments documented a provider response of no action necessary
- 15 of 32 DISCUS instruments had no provider response relative to the presence or absence of tardive dyskinesia
- 17 of 32 DISCUS instruments indicated that tardive dyskinesia was not present

The annual medical assessments and neurology clinic notes did not address side effects related to the use of psychoactive drugs and AEDs. Additional discussion on the use of this data is found in Provision J.

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 facility had approved and implemented an operational policy on adverse drug reaction and reporting. The procedure required the use of the Naranjo probability scale as well as a severity scale. The procedure did not include any thresholds for completion of an intense case analysis based on severity scale. The clinical pharmacist reported that training had been completed. Home managers, nurses, medical practitioners, and pharmacists were trained on the procedure. The home managers were responsible for training the direct care staff to report any possible ADRs to nursing. One adverse drug reaction was reported since the last on site review. The event was reported on 2/7/11. Tetracycline was believed to be the cause of a skin rash. The probability score was 0. The medical director should review the probability scale to ensure all questions were	Noncompliance

#	Provision	Assessment of Status	Compliance
		answered correctly. If the probability was 0, it is not clear why this drug was included in the individual's list of allergies. Given the large number of drugs administered in the facility, some adverse reactions are expected. Actions such as discontinuing or decreasing the dose of a drug due to hyperglycemia, hyponatremia, hyperprolactinemia and thrombocytopenia should result in generation of ADR report.	
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 a Drug Use Evaluation Calendar for the year. Drug selection was discussed in the February 2011 Pharmacy and Therapeutics Committee meeting and a decision was made to revise the calendar. The high risk, high use categories of drugs were targeted for review. Two Drug Use Evaluations were completed since the last onsite review. Reports were completed for both evaluations and the findings were presented to the Pharmacy and Therapeutics Committee. <u>DUE #1 – Calcium carbonate</u> • Date of Evaluation: July 2010 – August 2010 • Objective: To determine and analyze the age appropriateness of the calcium carbonate that is being given to the resident s of the facility in order to determine compliance with recommended guidelines. • Source of data elements: WORx Reports • Type of data collection: Retrospective review • Results of data analysis: A total of 281 individuals received calcium supplementation. • Recommendations/Conclusions: This was a baseline review. There were no interventions performed prior to the data collection. Most of the residents were receiving adequate calcium supplementation with most supplementation being provided to those in the range of 48 – 58 years. <u>DUE#2 Carbamazepine</u> • Objective: To determine (1) the use of appropriate indication, (2) use of indication according to 2010 Medication Audit Criteria Guideline (3) dosing for indication and (4) the presence of absolute or relative contraindications • Source of data elements: WORx Reports • Results of data analysis: A total of 53 individuals were receiving carbamazepine at the time of review. • Recommendations/Conclusions: o Approved indications were noted for 77% of individuals.	Noncompliance

#	Provision	Assessment of Status	Compliance
		o 22% of individuals were on appropriate dose of carbamazepine for seizure disorder o 0% of residents had absolute contraindications o 23% of individual had relative contraindications including anemia (8), agranulcytosis (2), thrombocytopenia (1), and right bundle branch block (1) o Recommend close and periodic monitoring of CBC with differentials and also for development of any cardiac abnormalities while on carbamazepine therapy. o It was concluded that LSSLC was utilizing carbamazepine within the confines of what is considered to be clinically appropriate. <u>Additional Discussion</u> The Carbamazepine DUE indicated that 77% of individuals had approved indications for use of the drug. The P&T minutes from 2/8/11 clarified this statement. The indication for 77% of the individuals was seizure disorder. The report also stated that 22% of individuals were on an appropriate dose of carbamazepine for seizure disorder, which could indicate that 78% of individuals were on inappropriate doses of medication. The clinical pharmacist should revise the DUE to accurately reflect the findings. A corrective action plan should be developed for problems noted. It should include specific action steps to impact the results/conclusions, timelines for implementation and a plan for follow-up The facility should draft an operational procedure for the DUE process. It should be consistent with the Health Care Guidelines and provide specific and clear directions for the process.	
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 maintained a process for collecting and analyzing medication variance data. The Medication Error Committee, which met every two weeks to review errors, was the primary forum for analysis and discussion of medication variances. There was no substantial discussion of medication variances documented in the minutes of the quarterly Pharmacy and Therapeutics Committee meetings. Review and analysis of medication error data by the monitoring team proved difficult due to data management issues, including lack of identify information on graphs and a lack of monthly data for key metrics. The majority of graphs presented data for the fiscal year and a few provided data by quarters. A table of total variance numbers was provided. Just prior to the conclusion of the onsite review, a revised table was provided to the monitoring team. The revisions reflected a change in reporting based on discovery dates. The nursing department maintained a spreadsheet that included information on	Noncompliance

#	Provision	Assessment of Status	Compliance
		every variance. The spreadsheet provided the date of error, date error discovered, and date reported to committee. Aggregate data and information on specific variances are included in the tables below.	

Medication Variances 2010 -2011							
	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Nursing	18	33	26	13	59	33	23
Pharmacy	20	26	13	20	17	19	32
Medical	0	0	1	0	0	0	1
Total	38	58	35	33	75	51	53

Medication Variances 2010 -2011 (By Discovery Date)							
	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Nursing	28	33	34	35	25	32	21
Pharmacy	28	27	61	6	22	30	12
Medical	0	0	1	0	0	0	2
Total	55	56	55	41	45	61	31

Based on data contained in graphs provided, 57% of medication errors occurred with nursing, 42% in the pharmacy, and 1% were attributed to physician error. Omissions were the most common type of error followed by extra dose, wrong dose, and unordered medications. Wrong patient and wrong medication errors were documented in each month of the medication variance log.

The pharmacy director had indicated during an earlier interview with the monitoring team that there were no significant issues with the pharmacy and medication variances. Moreover, the pharmacy director stated that returns to the pharmacy were 100% reconciled. The monitoring team inquired about the percentage of medication variances (approximately 42%) attributed to the pharmacy. The pharmacy director indicated that the department had only two pharmacists, a clinical pharmacist, and three pharmacy technicians. It was further reported that many of the errors were attributed to the technicians. During the October 2010 onsite visit, medication errors were attributed to a pharmacy technician that was no longer employed at the facility.

The monitoring team posed additional questions regarding (1) conclusions derived from data analysis, (2) the detection of trends or patterns, (3) determination of causal and contributory factors, (4) completion of any process or systems analysis, and (5) corrective actions taken.

The CNE responded that nurses received training, coaching, and counseling in response to errors. Nurses were also removed from duty for serious errors until further investigation and/or competency could be determined. There had been no

#	Provision	Assessment of Status	Compliance
		comprehensive review of the medication use system to determine causal factors or problems with systems and processes. Data contained in the medication variance log and Medication Error Committee minutes documented that errors involving the wrong individual, wrong drug, and wrong dose of drug were recurrent. Examples of administration errors are included in the table below.	

	Examples of Administration Errors and Actions/Changes September 2010 – March 2011
Wrong route	Ativan 4 mg given IM instead of po
Omission	Diphenhydramine, divalproex, gabapentin, and hydroxyzine not given
Unordered med	Prescription on hold for two days; medication in drawer with other meds with no note to hold; no copy of order was in the medication book.
Extra dose	Extra dose of lithium given
	Lisinopril given instead of Lipitor
Wrong person	Staff left cart; wrong meds given to individual
Wrong dose	250 mg Zoloft, 100 mg was given instead of the 150 mg
Omission	All 2100 meds omitted
Extra dose	75 mg of Topiramate given instead of 25 mg
Wrong dose	Risperidone .5 mg given instead of .25 mg
Unordered med	Two extra doses of Divalproex given after being d/c'd
Wrong person	New nurse gave wrong meds to individual
Wrong dose	Individual received 750 mg of Valproic acid instead of 500 mg. Nurse to be coached. RN to be placed with another preceptor for additional training.
Wrong dose	Gave 20 mg Lipitor to individual on 5 mg
Wrong med	Gave Zocor instead of HCTZ
Unordered med	Divalproex d/c'd 10/19/10, but given until December 10
Wrong dose	Gave too much seizure med
Wrong person	Individual received another's meds
Omission	All nine meds not given
Extra dose	Received 12.5 mg Zyprexa instead of 5 mg
Wrong person	Gave lorazepam .5 mg to wrong individual
Wrong person	Clonidine, calcium, colace, dxybutin, and Risperdal given to wrong individual
Unordered med	Gave individual med with no order
Wrong dose	Gave 9000 mg of lithium instead of 150 mg
Extra dose	Extra dose of phenobarbital
Extra dose	Lithium given QID instead of TID
Extra dose	Extra dose of clozapine 100 mg
Extra dose	Extra dose of dilantin 100 mg and 50 mg

Two serious errors had occurred in recent months. Individual #245 was administered 150 ml of lithium instead of the prescribed dose of 150 mg. This resulted in the individual receiving 9,000 mg of lithium. The individual experienced an acute deterioration, was hospitalized, and required hemodialysis. Corrective actions included immediate removal of the nurse from duty and an investigation. The monitoring team

#	Provision	Assessment of Status	Compliance
		asked both the medical director and CNE if a root cause analysis had been completed as a result of the error. It appeared that at the time of the onsite review, this had not been done. The monitoring team requested the "Unusual Incident Report" related to this event. The report documented that an investigation had been completed and a determination of proximal and contributory factors was made. Corrective actions included a plan for the pharmacy to generate labels to replace handwritten transcriptions on the MARS and training for pharmacy and nursing related to this new process. The MERC minutes dated 3/9/10 did not provide any data on individual variances. There was a summary of a discussion related to order changes that resulted in the corrective e action of the pharmacy printing two extra labels. The Joint Commission defines a sentinel event as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Root Cause Analysis is a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence, or possible occurrence, of a sentinel event. This case of lithium toxicity met the requirements for a sentinel event and should have resulted in a thorough and prompt root cause analysis. Root cause analysis is a thorough review of the event utilizing multiple processes and tools and poses the question "why" to every answer. An analysis of this depth should have been completed, but was not. The facility should re-assess its response to this event. Lithium is an effective drug with a significant side effect profile and a very narrow therapeutic index. Given the severity of this event and the fact that several medication errors related to lithium were identified by the monitoring team, the facility should prioritize a through analysis of its medication use system. The goal is to determine systems issues contributing to medication errors.	

Recommendations:

1. The physician order sheet should be utilized to document nursing clarification of orders. Interactions between the pharmacist and medical providers should be documented elsewhere. The Single Patient Intervention Report may be a suitable alternative.

2. The medical director should review the data related to the interactions between pharmacists and physicians. Data should be analyzed for trends and physician performance assessed. Corrective actions should be taken as necessary.

3. The QDRRs should include a record review when appropriate in order to review clinic visits, labs, etc.

4. The QDDR should include lab values important to the medications prescribed. The labs should be included in the actual report form that is reviewed by the practitioners. The most recent results should be provided with each review. If labs are outdated, a recommendation should be

made to obtain them. Organizing the labs in a small table is an easy way to accomplish this and will allow for detection of trends.

5. The QDRR Report form and worksheet should be two separate items. The report form is placed on the record and the worksheet maintained in the pharmacy department.

6. Recommendations that require action steps on the part of practitioners should be clearly identified.

7. The QDRR review should include specific information about benzodiazepine use and anticholinergic effects of medication.

8. Additional training is needed on recognition and reporting of adverse drug reactions.

9. The medication variance spreadsheet should always document the drug involved and the outcome for the individual.

10. There should be collaborative efforts to identify trends and options for systems improvement so that the same errors do not recur. This will require the involvement of many departments, including Pharmacy, Nursing, Medical, QA, and Residential Services. Efforts to resolve the issues should be documented in the Medication Error Committee meting minutes.

11. Medication variances should be discussed in the Pharmacy and Therapeutics Committee meeting. The membership of this committee is more diverse and provides an opportunity for additional review and analysis of problems by staff with expertise in other areas. The facility should consider having a representative from psychological services actively participate in this committee.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o PNM Team members list o CVs (Sharon Setzer, OTR, Ronda Hampton, MS, CCC-SLP and Maria Nash, PT, MSPT, JD) o LSSLC Organizational Charts o Habilitation Therapies staff list (4/20/11) o Staffing data o Section O Presentation Book o Client List (3/10/11) o At Risk List by Home (3/16/11) o Integrated Risk Rating Form o Comprehensive Lifting, Transfer and Positioning Monitoring tool o Comprehensive Positioning Monitoring Training o Completed Comprehensive Lifting, Transfer and Positioning Monitoring tools submitted o PNMP Monitoring tool o Completed PNMP Monitoring tools submitted o Comprehensive Meal Monitoring tool o Comprehensive Meal Monitoring Training o Completed Comprehensive Meal Monitoring Training o Monitoring Results spreadsheet (3/21/11) o Settlement Agreement Cross referenced with ICFMR Standards o List of individuals who were non-ambulatory or assisted ambulation o Primary Mobility Wheelchairs o Ambulation Assistive Devices o Orthotics, Braces and Gait Belts o Wheelchair Modifications (3/9/11) o 2010 and 2011 Wound Clinic Spreadsheet o Habilitation Therapy Competency Based Inservice Individual #450 (4/15/11) o New Employee Orientation PNM-related agenda and curriculum o Training Schedule for Eating and Lifting/Positioning o Assistive Equipment List o PNMPs submitted o PNMP/PSPA Tracking forms o List of PNMPs and Profiles o Dining Plan template o List of individuals on modified diets/thickened liquids

	o Individuals who require mealtime assistance o Individuals with fecal impaction in the last 12 months o Individuals with chronic respiratory infections in the last 12 months o List of individuals with choking incident in the last year o Infection Control Spreadsheet 2010 o Monthly Weight Worksheet (10% or more weight loss in six months) o Monthly Weight Worksheet (BMI <20 and >30) o Individuals with downgraded diet texture or consistency o List of individuals with poor oral hygiene o High At Risk List by Individual 3/15/11 and 3/16/11 o List of falls December 2010 to March 2011 o List of individuals who receive enteral nutrition o Drug order report (individuals with chronic and acute pain) o PNMP list 2/11/11 o List of Falls in Past 12 months (3/17/11) o List of Skin Breakdown o Fractures in the Past Year (3/17/11) o Wheelchair Priority List (3/10/11) o List of hospitalizations/ER visits o Pneumonia Tracking (4/1/10 – 3/18/11) o Information from the Active Record including PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms, PSP reviews by QMRP, PBSPs, annual Physician Summary, Active Medical Problem list, hospital summaries, GI consults, Orthopedic consults, diet order, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Aspiration Triggers Data Sheets (1/1/11 to present), Weight Record (last 12 months), documentation from Habilitation Therapies tab, all documents in PNMP tab, all documents in Nutrition tab, MBSS completed in the last 12 months, Mealtime, Communication, PNMP Monitoring sheets completed during the last three months, all PNMPs for last 12 months, all Dining Plans for last 12 months, NMT documentation last 12 months for the following individuals: • Individual #593, Individual #245, Individual #96, Individual #47, Individual #267, Individual #248, Individual #161, Individual #551, Individual #182, Individual #342, Individual #535, Individual #1, Individual #310, Individual #502, Individual #298, Individual #321 and Individual #385. Records for Individual #16, Individual #599 and Individual #172 were also requested but were not submitted. <u>Interviews and Meetings Held</u>: o Danielle Perry, Au.D, CCC-A, Habilitation Therapies Director o OTs and PTs, COTAs and PTAs, SLPs o PNMP Coordinators o Various supervisors and direct support staff

	Observations Conducted: o Living areas o Dining rooms o Day Programs o Wheelchair Clinic
	Facility Self-Assessment: LSSLC's self-assessment rated noncompliance for all items of this provision. Systems were in the process of development, particularly the new PNMT process. This self-assessment was consistent with the monitoring team's assessment of noncompliance. The POI may be more useful if there were also action steps listed designed to achieve compliance with the status of completion and evidence to illustrate this included in the plan. The current format merely listed activities, but did not present an understanding of the steps and strategies required to meet the provisions with timelines of completion. This kind of format would offer more of a roadmap for all staff and a means to direct their focus, effort, and energy.
	Summary of Monitor's Assessment: There was a new Habilitation Therapies Director, Danielle Perry, Au.D, CCC-A. She appeared to be a strong leader and already well-respected by her co-workers and staff. She appeared to have an intuitive understanding of what needed to be accomplished gleaned in a very short time since taking on this role. The PNMT process was not initiated, other than to begin to identify team members. Already the dietitian had resigned and an alternate will need to be identified quickly. By report, an RN had been hired but had not yet started work at LSSLC at this time. There had been no individual-specific reviews completed. The risk assessment process and aspiration initiatives were also new processes and will require significant and thorough review in six months. Two dietitians were insufficient to address the nutritional needs for nearly 400 individuals. One of these was to be assigned to the PNMT leaving a huge responsibility for the remaining dietitian. At the time that the resigning RD is replaced, strong consideration should be given to additional staffing in order to more adequately address needs in this area. There continued to be implementation errors during meals and related to position and alignment. Of particular concern was the implementation of dining plans in Woodland Crossing, position and alignment, use of special techniques and monitoring by the PNMPCs. Many of the problems observed should have been identified by professional staff as well. A significant focus should be directed toward professional support for training and oversight, as well as to the environmental barriers in this dining area.

#	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	**Standard: PNM team consists of qualified SLP, OT, PT, RD, and, as needed, ancillary members (e.g., MD, PA, RNP).** LSSLC had not formally initiated the new process for the Physical Nutritional Management Team (PNMT). The intended function of the team was to address individuals whose identified health status placed them at a high risk of potential or actual injury and/or illness. The initial step in this process was to identify PNMT members. The core members of the newly established Physical Nutritional Management Team (PNMT) included the following, per the documentation submitted: • Rhonda Hampton, MS, CCC-SLP • Maria Nash, PT, MSPT, JD • Sharon Setzer, OTR An RN had been hired for the nursing position but had not started at the time of this review. The dietitian who had been selected for the team had announced her resignation during the week of this review and a replacement had not been identified. It was of great concern to the monitoring team that the facility was significantly delayed in implementation of this policy that had been in place statewide since October 2010. They had continued to function in the old NMC model until recently. Supports, review, and follow-up for individuals previously served by the NMC were transitioned to the PSPs at the time of this onsite review. Referrals to the PNMT would be made by the PSTs if they were not successfully meeting the PNM needs of those individuals identified at highest risk via the risk assessment process. Evidence of current licenses was not submitted though license numbers were identified, Experience documented per the CVs submitted indicated that each of the currently identified clinicians had previous experience with individuals who had developmental disabilities and a varied clinical background. There was no evidence of continuing education in the last 12 months identified for any PNMT members. The POI documented that the PNMT members had participated in a webinar training provided by Karen Hardwick related to the PNMT process on 2/24/11. **Standard: PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.** The PNMT members had not been fully identified and no meetings to review or assess individuals had been held to date.	Noncompliance

#	Provision	Assessment of Status	Compliance
	medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.		
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.** Per a list submitted for this onsite review, there were 329 individuals identified with PNM needs at LSSLC or 84% of the current census (391). Each of these were provided a PNMP that also incorporated a profile sheet. Others had been provided a profile only. A new policy and process used to establish health risk levels had recently been implemented statewide. The goal was to have discussions of risk occur during each individual's PST meetings. At the time of this review, the teams were working to integrate the new PSP process. The PSTs will require significant clinical instruction and support regarding risk assessment and real time modeling by state leaders (as was the plan) to effectively implement these new policies and procedures. Meetings related to the risk assessment process with two PSTs was conducted by the monitoring team during the week of this onsite review with significant discussion about strategies for the team to consider as they implement this new policy. Further evaluation of the effectiveness of this process will be necessary during future onsite reviews by the monitoring team. The statewide system to identify and manage individuals at risk was outlined in policy #006.1, At Risk Individuals, with an implementation date of 1/1/11. This policy was intended to identify individuals who were at risk for illness or injury as well as to identify actions and supports to mitigate the risks. The PST was to initiate assessment upon change in status for any individual to examine the existing support plans to ensure the appropriate measures were in place. The PNMT was defined as follows per this policy: "A team of specialists with knowledge and expertise in the development of Physical Nutritional Management Plans who meet to provide comprehensive assessment and determine appropriate intervention for persons whose identified health status places them at highest risk for potential or actual injury and/or illness. Members of the PNMT include the following disciplines: registered nurse, physical therapist, occupational therapist, dietician, speech pathologist and others as needed. All core team members should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs. As requested the team shall include primary care providers, nursing case	Noncompliance

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		managers, therapists, psychologists, QMRPs, home supervisors, facility support services staff and others as needed." The PST was to refer individuals at high risk to the PNMT who were not stable and for whom the PST required assistance in developing a plan. The PNMT was to begin assessment within five working days of referral to determine possible causes for the change in status, to analyze assessment findings, integrate recommendations, and to propose an action plan with measurable goals and outcomes. There were a number of individuals with multiple PNM-related risk factors or issues who potentially would benefit from the coordinated, comprehensive supports and services of the PNMT. • There were 329 (84% of the current census) individuals identified with PNM needs and were provided a PNMP. • There were nearly 100 (26%) individuals with poor oral hygiene. • There were 14 (4%) individuals who sustained an injury resulting in a fracture in the last year. Seven of these individuals were either non-ambulatory or required assisted ambulation to some degree. • There were 22 (6%) individuals with incidence of skin breakdown in the past year, with 15 (4%) who were listed with pressure-related wounds. • There were 28 (7%)individuals whose diet had been downgraded in the last year. • There were 51 (13%) individuals who were obese with BMIs over 30. Eighteen of these had a BMI over 35. • There were 50 (13%) individuals with a BMI less than 20, with 14 (4%) individuals with a BMI under 18 (underweight). • There were approximately 60 (15%) individuals who had lost 10% or more in the last six months. • There were 12 (3%) individuals with chronic dehydration in the last 12 months. • There were 9 (2%) individuals who had experienced a choking event in the last 12 months. • There were four (1%) individuals with chronic respiratory infections in the last 12 months. • There was one individual with a diagnosis of fecal impaction. • There were 259 (66%) individuals who required assistance at mealtime. • There were 336 (86%) individuals with modified diet textures and/or thickened liquids. • There were 53 (14%) individuals who were enterally nourished, 14 (4%) of whom had tube placement with the last two years. • There were approximately 34 (9%) individuals with a diagnosis of pneumonia, 28 (7%) of which was aspiration pneumonia.	

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		• There were 180 (46 %) individuals identified as non-ambulatory or requiring assistance for ambulation. • There were 166 (42%) individuals who used a wheelchair as a primary means of mobility. • There were 34 (9%) individuals who used assistive equipment for ambulation. • There were 44 (11%) individuals who used transport wheelchairs as needed. • There were 172 (44%) individuals with upper or lower extremity orthotics, braces and/or gait belts. • There were over 81 (21%) individuals who had experienced falls in the last three months and 181 (46%) individuals in the last year. There were 18 individuals who experienced a slip, trip or fall resulting in a serious injury. Approximately 75 of these incidents occurred in the bathing or toileting area one of which resulted in a serious injury for Individual #14. There were 35 individuals who had more than one fall and were either non-ambulatory or required assistance for ambulation. For example: Individual #547 (20 falls), Individual #497 (15), Individual #151 (9), Individual #267 (8), Individual #365 (8), Individual #258 (9), Individual #481 (10), Individual #213 (14), Individual #562 (10), Individual #90 (6), Individual #298 (7), Individual #513 (5), and Individual #368 (17). All others had less than five falls. There were five individuals who had experienced a serious injury, including Individual #14, Individual #267, Individual #481, Individual #468 and Individual #271. • 45 individuals were listed with contractures in one or more joints. • 26 individuals were listed with chronic pain Eight individuals were listed at high risk for osteoporosis including Individual #14 who had experienced multiple falls including one resulting in a serious injury. The complexity of PNM-related risk indicators requires comprehensive and collaborative team assessment, intervention plan development, implementation, and monitoring. The process for risk assessment had been recently implemented and, as stated above, the PNMT was not yet functioning. Further review will be necessary as these two systems evolve during the upcoming months. The current system of risk identification continued to be inconsistent and the monitoring team hopes that these issues will be resolved as the new systems are implemented.	
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,	**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 329 individuals identified with PNM needs and all (100%) had PNMPs. The PNMPs were generally of a consistent format and contained information	Noncompliance

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	oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	related to the focus, hearing, vision, assistive equipment, mobility, transfers, handling, positioning, eating/nutritional instructions, eating equipment, diet and snacks, and communication. Oral hygiene or medication administration was not noted. The plans were dated and most were current within the last 12 months. The monitoring team selected 20 individuals for a record sample (included in the above list of documents reviewed). The records submitted for only 17 of the 20 requested included the PNMPs for each. It appeared that the PNMPs were generally of a standardized format, though content and detail were inconsistent from plan to plan, not only related to individual differences. The PNMPs submitted for each of the 17 individuals for whom individual records were submitted were reviewed with findings as follows: • PNMPs were submitted for 17 of 20 individuals included in the sample. Thus, the sample was considered to be 17 for the purposes of this review. • PNMPs for 17 of 17 individuals in the sample (100%) were current within the last 12 months. • In 17 of 17 of PNMPs reviewed (100%), mobility was addressed. • In 17 of 17 PNMPs reviewed (100%), positioning was addressed. Some instructions were extremely limited and in three cases "N/A" was listed (Individual #298, Individual #310 and Individual #161). • In 0 of 10 PNMPs reviewed (0%) for individuals who used a wheelchair as their primary mobility, general wheelchair positioning instructions for the wheelchair were provided. • In 15 of 17 PNMPs reviewed (88%), the type of transfer was clearly described or there was a statement indicating that the individual was able to transfer without assistance. • In 1 of 17 PNMPs reviewed (6%), the PNMP listed bathing instructions (Individual #248). Four only listed bathing equipment. One of the individuals' plans listed the need to use a shower device under the mobility sections which would be easy for staff to overlook. Another (Individual #593) listed the need for shower chair if having back pain under positioning, also making it difficult for staff to identify readily. Six did not have specific bathing strategies or equipment, though these individuals appeared to require significant physical assistance for mobility and transfers (Individual #96, Individual #535, Individual #1, Individual #245, Individual #502 and Individual #321). • In 17 of 17 PNMPs reviewed (100%), toileting instructions were identified. One listed only "requires assistance" (Individual #161). • In 6 of 12 PNMPs reviewed (50%), for individuals who were not described as independent with mobility or repositioning, handling precautions or instructions were included. In the case of Individual #502, for example, "N/A" was indicated under handling. However, she required full staff assistance for transfers and	

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		mobility and it was noted in her medical assessment that she presented with a diagnosis of osteoporosis and joint deterioration and, as such, would require special precautions. • In 17 of 17 PNMPs reviewed (100%), instructions related to mealtime were included. • Six of 17 individuals (35%) received enteral nutrition. This was clearly stated in their PNMPs. One individual (Individual #248) received enteral nutrition with an oral snack at 9:30 AM and oral intake at the noon meal. • In 7 of 17 PNMPs reviewed (41%), dining position for meals or enteral nutrition was provided. For Individual #248, there was a section for "Noon Meal Positioning" on a different page from the dining instructions, which would be difficult for staff to locate readily. The use of a headrest was listed under diet for Individual #502. It was presumed it was intended for use during meals, but it was also listed under mobility, so this was not clear. • In 17 of 17 PNMPs reviewed (100%), diet orders for food texture were included for those who ate orally with statements related to enteral nutrition and instructions for nothing by mouth for those with non-oral intake. • In 1 of 11 PNMPs for individuals who received liquids orally (9%), the liquid consistency was clearly identified (regular fluids for Individual #248). Five plans did not list the liquid consistency (Individual #310, Individual #502, Individual #593, Individual #342 and Individual #1). Five others listed thickened liquids, but this was embedded in other text under mealtime instructions (Individual #182, Individual #267, Individual #161, Individual #298 and Individual #245). • In 16 of the 17 PNMPs for individuals who ate orally or who were NPO (94%), dining equipment was specified in the assistive equipment section. This was listed as none or gastrostomy tube for those who received enteral nutrition. In the case of Individual #248, gastrostomy was listed as eating equipment, but there was no indication what he used for his oral snacks and noon meal. • In 1 of 17 PNMPs reviewed (6%), strategies for medication administration were included. Instructions for Individual #182 did not consistently specify position or head alignment. He was to use a Care spoon for meals, but this was not listed as required for medication administration. Strategies to address the use of adaptive mealtime equipment and liquid consistency were being discussed at the time of the onsite review by the monitoring team, but were not yet implemented. • In 0 of 17 PNMPs reviewed (0%), strategies for oral hygiene were included. By report, the therapists had met with the dental department staff to problem-solve acceptable positioning to be used for examinations and other dental interventions. Instructions regarding this were not noted in any of the plans included in the sample. Photographs for one individual (Individual #1) were included in the individual notebook, but there was no written cue in the PNMP	

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		instructions to alert staff that it was there. In addition, the primary intent of addressing oral hygiene in the PNMP was to ensure appropriate position and, most importantly, proper alignment during oral hygiene/tooth brushing activities conducted by the direct support professionals several times daily. This is critical to ensure effective oral hygiene in a manner that is safe for those at risk for aspiration. There were no written instructions or pictorial support to direct staff in these strategies and techniques. • 17 of 17 PNMPs (100%) reviewed included a heading related to communication, though the information included was very limited and inconsistent in content and detail. In addition to the typical categories of information in the PNMP, the facility had combined an individual profile for staff reference. For those with no PNM needs, this was intended to be a reference sheet for staff. The profile included the following: level of supervision, target behavior and intervention, behaviors to increase, approved restraints, restraint contraindications and guidelines for aquatics. These documents were maintained by Habilitation Therapy Staff with required changes emailed by the QMRP to request a change to the plan and an email back to confirm the change. These supports were not typically considered to be PNM-related and, as such, it did not appear to be appropriately assigned to Habilitation Therapy staff. Further, there was some confusion about these plans. The PNMP was printed in landscape format and the profile was not. In one case, a profile was printed that included the information for a PNMP, but was titled "Profile" and was not printed in landscape format (Individual #476). Individual #476 was listed with PNM needs so it would have been expected that he would have a PNMP. These discrepancies were potentially confusing to staff. In addition, it would be difficult to keep these documents current with information combined from so many sources. A brief meeting was held with the Habilitation Therapies Director, Director of Psychology, the QMRP Coordinator and the Nursing Director and QA staff to address this issue. The group agreed to consider separating the two documents with the profile maintained by the QMRP and the PNMP maintained by Habilitation Therapy staff. Another concern noted by the monitoring team was the inclusion of "restraints for involuntary self-injury" and "restraints for postural supports" in the PNMP. When used for postural support, equipment like the seat belt was not a restraint unless, in the case that the individual had the ability to fasten/unfasten their own seatbelt, the buckle was put in a location the individual could not access it. The use of restraints was not consistent with the provision of therapeutic supports as indicated through Physical and Nutritional Management. In addition, items used to prevent an individual from falling out of bed, such as a bedrail would typically be identified as assistive equipment. Of course, if	

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		used to prevent an individual from getting out of bed, then this would be considered to be a restraint and, as such, should be approved by the Human Rights Committee with appropriate behavior support plans in place. As the PNMP was intended to be a therapeutic support plan, a restraint would not typically be included. **Standard: PNM plans were incorporated into individual's Personal Support Plans.** Eight of the 16 PSPs submitted for the individuals included in the sample selected by the monitoring team were of the new format (Individual #551, Individual #182, Individual #321, Individual #96, Individual #161, Individual #535, Individual #248 and Individual #385). Discipline specific assessments were attached to the PSP, including Habilitation Therapies (OT/PT and SLP related to swallowing), Nutrition, Communication, Medical, Dental and Nursing, among others. PNM-related assessments included as follows: • Medical: 6/8 included • Dental: 7/8 included • Nursing: 6/8 included • Habilitation Therapies: 6/8 included • Nutrition: 2/8 included • Communication: 0/8 included PSP meeting attendance by PNM professionals was as follows: • Medical: 2/8 in attendance • Dental: 0/8 in attendance • Nursing: 8/8 in attendance • Habilitation Therapies: 5/8 in attendance (OT only) • Nutrition: 5/8 in attendance • Communication: 2/8 in attendance (one of these was SLP responsible for swallowing issues and one was the SLP responsible for communication) It would not be possible to achieve adequate integration with the high number of missing assessments and the clear limitations in PNM-related professional participation in the PST meetings when these plans were developed. Examples included: • Individual #385: His PSP (1/12/11) indicated that he had broken a hip in the last year and refused to ambulate. Only dental, nursing, and habilitation therapies assessments were available in the PSP and only the nurse, OT, and dietitian attended this meeting. The specialist for ambulation and gait (the PT) did not participate in this meeting. • Individual #248: Per his PSP (3/9/11), he had a PEG tube for enteral nutrition and was offered some oral intake, though showed limited interest. All assessments were included, but only the physician and nurse attended the	

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		meeting. There was no reference to oral intake in the Habilitation Therapies assessment with limited reference in the nutrition assessment with evidence of decreasing intake by tube and the addition of lunch. There was no mention of his resistance to oral intake and review of interventions and supports provided to address this. In both of these and other cases, it would not be possible to conduct an appropriate discussion of risk assessment and or to develop effective support plans to address these issues in the absence of key support staff and without comprehensive and timely assessment information. Documentation of the discussion of risk during the PSP meeting was included with Medical and did not reflect an interdisciplinary approach to discussion, risk identification, and intervention. For example, Individual #248 was considered to be at HIGH risk for aspiration and respiratory concerns, yet this was never clearly stated in his PSP. There was a statement in the PNM section that stated his aspiration rating was HIGH with the rationale as "continues enteral feeding." As the format lists "identification of health risks" under the Medical section of the document, this statement could be easily over looked by a reader. In addition, continuing enteral nutrition in and of itself would not necessarily result in a HIGH risk of aspiration. It was unclear that, since he was considered safe for oral intake, he continued to be at HIGH risk for aspiration. There was no evidence of discussion of other potential mitigating issues. Further there was a recommendation that lunch be discontinued and that the snack at 10 am and 8 pm should continue in the OT/PT section. This had not been mentioned in the nutrition assessment. There was no evidence of team discussion related to this issue. His most current PNMP, dated 4/8/11, continued to identify that he was to be offered oral lunch and snack. There was no indication or precaution on his PNMP that Individual #248 was at HIGH risk for aspiration and respiratory concerns. There was no evidence that the PST understood and considered the interrelationship between the risk issues the individual had or considered the effectiveness of the supports the PNMP provided in mitigating risks to an individual's health and safety. **Standard: PNMPs are developed with input from the IDT, home staff, medical and nursing staff.** As stated above, availability of assessments, poor attendance at PSP meetings, and the lack of integration in the PSP negatively impacted the ability to develop the PNMPs in comprehensive and collaborative manner. There was no evidence of PST discussion of the elements of the plan, its effectiveness, or need for modification. The PSP process had been revised and implementation was evolving at the time of this review. The PSTs were	

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		struggling with integration of the new PSP process and the new risk assessment process. Further assessment of this element will be required during the next review when these two systems are more familiar to the staff and well established. **Standard: PNMPs are reviewed annually at the PSP meeting, and updated as needed.** There was evidence in each of the annual OT/PT assessments that the PNMPs were reviewed by therapy clinicians though, as stated above, there was no evidence of review by the PST in relation to identified risk and the efficacy of the interventions implemented. In the case of Individual #248, there were modifications dated as effective on 3/9/11 (the date of his PSP), yet the revised plan was dated 4/8/11, nearly 30 days later. His previous plan had been dated 7/2/10. The modifications were related to his nutritional intake and given that he was considered to be at HIGH risk for aspiration and respiratory concerns, changes to his plan should be reflected immediately to ensure his health and safety status. A number of individuals had multiple revisions throughout the year. There did not appear to be sufficient collaboration related to these changes among the PST members.	
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 generally developed by the therapy clinicians with limited input by other PST members as described above. Generally, the PNMP was located in the individual notebook in the back of an individual's wheelchair if he or she had one, or was to be readily available nearby, otherwise. In most cases, pictures were available with the PNMPs related to wheelchair and bed positioning, and the use of orthotics or braces. The pictures provided were large and clear enough to show detail for staff reference. These instructional plans also usually had written cues and instructions, in addition to the photographs. However, a number of these were very outdated and the individual no longer looked the same and, in some cases, the equipment was different. While intended to provide cues for staff related to positioning and application of special orthotics, outdated pictures could easily result in staff error or, at the very least, confusion. Wheelchair positioning instructions were generally not specific in the PNMPs and there was generally no greater detail included on the photographs included in the notebooks. Limited instructions in the PNMP 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, but not specified in the PNMPs. Dining Plans were noted to be consistently available in the	Noncompliance

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		dining areas. Staff were observed to read the plan when asked a question, though reference to the plan before beginning the meal was inconsistent. In some cases where an error was noted by the monitoring team, the staff was asked to read the plan. They were also inconsistently able to recognize the error observed. Based on observations of individuals during meals across a variety of homes, a number of errors were noted in staff implementation of interventions and recommendations outlined in the mealtime plan portion of the PNMP. Some examples are presented below: • Individual #1: Dining plan indicated that food should be cut into quarter size pieces. A number of pieces were much larger than this. When asked, staff did not recognize this as an issue and, even when pointed out, the staff had to be prompted to make the correction. At times, the individual was offered very large bites and again was prompted. The dining plan did not specify an acceptable bite size. • Individual #9: The diet texture was not specified on the dining plan dated 11/3/10. • Individual #546: He was presented fluids from a cup permitting his tongue under the cup rim. This resulted in significant fluid loss. • Individual #504: There was no dycem mat provided as per his Dining Plan. The plan was dated 4/23/10, nearly 12 months old. He was eating a chopped up sandwich from a paper plate for snack in day program and was using a plastic fork. It was of concern that dining plan instructions were not properly implemented in this setting. • Individual #167: Pictures in the individual book showed conflicting pictures of the head rest up in some and not up in others. It was not clear which was intended during mealtime. • Individual #458: She was noted to be coughing. When staff was asked why this was happening, the staff indicated that she was just clearing her throat. The monitoring team noted that Individual #458 was drinking half of a glass of her beverage without pausing and with no intervention from staff. After she had completed three-fourths of the glass, staff finally prompted her to slow down. • Individual #31: Her dining plan indicated that her food should be cut into bite-size pieces. She was served her meal with none of the food cut up. She ate her mashed potatoes and asked for more. A sandwich and squash were not cut as prescribed and staff had to be prompted to do so. She was at serious risk for choking if she had eaten any of these foods that were not properly prepared before serving. • Individual #310: He was seated in a wheelchair, though his dining plan stated he should sit in a wooden chair. When asked, the staff and PNMPC reported that he had possibly had a stroke and since that time was seated in the wheelchair. A	

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		therapist had added a handwritten notation on the PNMP on 3/24/11 with no permanent change in the plan since that time. There had been no changes to his dining plan. • Individual #142: His dining plan dated 4/7/11 indicated that he should receive one cup of lemon ice before and after his meal, as well as two bites, two sips, then one bite of lemon ice throughout the meal. Staff began the meal without presenting the lemon ice and had to be prompted to provide it. • Individual #430: His plan was dated 11/17/10. His diet texture was ground yet the instructions indicated that food should be cut into nickel size pieces. Staff were to encourage small bites, yet there were no prompts from staff during the observation. • Individual #447: His dining plan was dated 1/31/11 and indicated that he should receive a chopped diet, yet the instructions stated that food should be cut into quarter size pieces. • Individual #211: She was to use her laptray for dessert. Staff assisted her and without the laptray. When asked about this, the staff stated that she had provided the laptray, when she clearly had not. • Individual #527: The picture in her dining plan did not show use of the head rest, yet she was using one during the meal observed. Staff were not clear which was correct. • Individual #433: She was seated in a very wide wheelchair and was seated at a high table for her meal. • Individual #459: The staff person assisting her was acting impatient with her during the observation. This monitoring team interacted with the staff to provide feedback regarding assistance techniques in order to redirect the staff to more appropriate assistance strategies. A number of these were related to issues with the Dining Plan itself. The concerns were either not noticed by the PNMPCs and/or were not addressed in a timely manner to make the corrections. Examples of issues related to positioning outside of the mealtime are described in section P below. The number of errors related to mealtime was even more significant give that there had been 10 incidents of choking for nine individuals in the past 12 months as of 1/29/11 on food items. Five of the individuals required staff assistance. One individual (Individual #191) had two choking incidents in just over a month (6/13/10 and 7/21/10). **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	

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		verbalize the rationale for specific strategies they were using as directed in the PNMP and/or Dining Plan, however, many did not appear confident. As described above, there were a number of errors in implementation, suggesting that staff did not fully understand the importance of these plans and the risks presented by the individuals they served. In addition staff were not able to recognize when alignment was inappropriate in order to remedy or report it as a problem. See examples below in Section P.	
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.** Some improvements to staff training were noted by the monitoring team. Changes to the length of time allotted for PNM training in NEO resulted in two full days for positioning that included day of hands-on practice in the newly established practice lab with mannequins. In addition, the eating skills aspect of the training had doubled from four to eight hours. Class size had been decreased from approximately 30 to 40 in each class with an average of 20. These changes had recently been implemented in March 2011. The Competency Training and Development staff taught the lifting and transfer portion of the training, though Habilitation Therapy staff completed the competency check-offs. SLPs and a COTA currently taught the Eating Skills portion of the training. Per the documentation submitted, staff training for New Employee Orientation related to PNM included the PNMP, Dining Plan, repositioning in the wheelchair, positioning (prone, supine, sidelying, and supported sitting), body mechanics, lifting and transfers (stand pivot, two person, mechanical lift), thickened liquids, adaptive equipment and monitoring. There were skills-based checklists and or written or verbal tests related to adaptive equipment, mealtime and functional eating skills, thickened liquids, positioning, wheelchair positioning, and transfers to establish competence. Skills-based performance was monitored by the PNMPCs after the new staff were assigned to a home. The curriculum related to diet texture was not submitted. There was insufficient distinction established between position (sitting, prone, supine, sidelying) and the alignment of the body and extremities in each of these. There was insufficient information provided related as to what optimal alignment was for an individual and how to achieve it and support it through equipment or other items such as pillows. For example: • It was noted by the monitoring team that staff had significant difficulty repositioning Individual #1 in his wheelchair. Staff made three attempts, but were still unsuccessful in achieving appropriate alignment. It appeared that the wheelchair did not fit him properly. It was reported that staff did not tilt the wheelchair back in order to achieve optimal alignment. This was not addressed in his PNMP, pictures or in the general staff training provided. If this was taught in a individual-specific inservice, there was no written or picture reference for	Noncompliance

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		staff to reinforce this strategy. Staff were not able to recognize the physical cues that Individual #1 and other individuals in the home were not properly aligned in their seating device, though they were positioned in sitting. Their heads were well below their headrest, there were large gaps behind their hips in the seat, the seatbelt would not fasten, and/or they were leaning forward or to the side. The content of the training and the check-off sheets did not discretely outline specifics as to how to align an individual in the prescribed position. There was no instruction about the importance of supporting body parts in a variety of positions, aligning the body in a manner that was optimal for the individual, or recognizing the need for re-aligning/re-positioning the individual. Further the training had not been effective for staff who failed to recognize the need to correct food pieces that were larger than a nickel or quarter as prescribed in the Dining Plan. Most of the feeding techniques required for mealtime were tested via a verbal response rather than return demonstration. **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.** Completed competency-based training checklists were not submitted as used for NEO staff training in the area of PNM. By report and per the curriculum materials submitted, inservice training for direct support staff required verbal, written, and/or return demonstration. Checklists were insufficiently discrete so as to ensure proper evaluation of their abilities to demonstrate and apply specific skill necessary for knowledgeable and accurate implementation of PNMPs and Dining Plans. As described above, staff were not consistently able to demonstrate competence in the implementation of the PNMPs and Dining Plans. It was planned that existing staff were to participate in the revised PNM training over the next 12 months. **Standard: All foundational trainings are updated annually.** Lifting and transfer training was to be updated annually after initial NEO training. It was reported, however, that CTD staff conducted that training rather than Habilitation Therapy staff and there was no evidence that those trainers had received competency-based training to provide adequate instruction in this area. Annual retraining curriculum was not submitted for PNM. There was no evidence that there was any annual refresher training related to mealtimes or other aspects of the PNMP at this time. **Standard: Staff are provided person-specific training of the PNMP by the**	

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		appropriately trained personnel. Tools and checklists used to establish competency and documentation for staff trained to implement PNMPs and Dining Plans for five individuals were not submitted as requested. Rather, the curriculum for NEO was submitted for this request. By report, licensed professional staff conducted inservice for available staff and home managers who, then with PNMPCs, were required to complete the training for other staff, 10-6 shift, and float staff. There was no mechanism to ensure that home managers or PNMPCs provided the same level of training to ensure consistency and competency of all staff. No evidence of individual-specific staff training was available for review. Further review of progress in this area will occur during subsequent onsite reviews by the monitoring team. **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 consistently competency-based, so while staff may have received some level of training for implementation of PNMPs for those at high risk, it was not generally performance-based, and did not require successful performance of clearly established competencies. Training was not consistently effective as evidenced by the implementation errors noted by the monitoring team and described above. The current system of monitoring did not provide targeted review of individuals at highest risk at an individually prescribed frequency to ensure appropriate implementation of supports designed to mitigate PNM risks. **Standard: Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.** There was no evidence that there was competency-based individual-specific training for staff before they worked with individuals who were at high risk or for pulled/float staff. Training for changes to plans were conducted by therapists, PNMPCs, and in some cases, by home managers. This training was not consistently documented and competency had not been clearly established.	
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	**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 formalized policy related to the process of PNM monitoring (lifting, transfers, positioning, mealtime, and communication). There were guidelines on the back	Noncompliance

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	that the staff demonstrates competence in safely and appropriately implementing such plans.	side of the monitoring sheets for lifting, transfers, and monitoring. There was training intended for the PNMPCs to direct them in how to complete each of the monitoring sheets. There were also a consistency check for diet orders sheet and the PNMP monitoring sheet. Mealtime monitoring had been a focus since January 2011 for a six-week period and included Habilitation staff. Staff were to monitor everyone on their caseload one time weekly. QMRPs, psychology, and RN Case Managers were trained to complete mealtime monitoring with schedules developed by the Unit Directors. It was not known how consistently this additional monitoring was done or what happened to the findings. The monitoring team observed one psychology staff conducting monitoring at a meal during this onsite review. There had not been specific competency check-offs for monitors. The PNMPCs had been transferred under the habilitation Therapy department for supervision as of 4/1/11. A process to review each monitor's performance was to be initiated in May 2011 with a plan to reorganize their caseloads. A train-the-trainer process and mentoring with stronger staff will also begin during that month. **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 mealtime, transfers, and positioning. There was no mechanism to ensure that monitoring occurred during bathing, medication administration, or oral care. The Comprehensive Lifting, Transfer, and Positioning Monitoring form required the monitor to circle the activities monitored and included bedtime, leisure, training, mealtime, and self-care/grooming. Routinely the monitors did not indicate this. Of 120 completed forms submitted, only 70, or 58%, had the activity observed marked. The majority occurred during leisure (40), with others during grooming (14), training (11) and mealtime (5). There were only 24 PNMP Monitoring Sheets submitted. The form included an item for the monitor to indicate if the position for medication administration and oral hygiene was correct, but most were marked not observed or not applicable (2). Forms for Individual #91 and Individual #490 were marked as "yes" for both oral hygiene and tooth brushing. This was questionable because there were no comments related to observations of these activities, and other sections of the form were marked with mealtime also implemented properly. The comments in this section merely restated what was in the plan. There did not appear to be direction, training and oversight provided to PNMPCs to reinforce the importance of accurate and consistent review of all activities that involved potential risk of harm including as bathing, medication administration, and oral hygiene.	

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		A random sample of mealtime monitoring sheets submitted was reviewed (407). Of these, 129, or 32%, identified one or more concerns during the mealtime observation. There were 51, or 40%, of the monitoring sheets marked with a "no" due to the activity being observed being a medication pass. There was no mechanism on the form to clearly mark that the observation was a medication pass. Clarification of whether the nursing staff were to use the Dining Plan, PNMP and/or Profile was indicated with clear direction to monitors as to how this item should be scored. There were 16 forms that reported that the activity was not safe or was not completed at a safe rate because the individual refused to eat. This again would skew overall findings for tracking and trending purposes. Three indicated that the Dining Plan was not out because the individual was enterally nourished. It was understood by the monitoring team that all individuals had Dining Plans regardless of whether or not they ate orally. In some cases, the monitor merely stated that the techniques were not followed, but did not specify what the issue was (e.g., Individual #317, 2/18/11). In another case, the monitor marked that an upright head position was not maintained, but stated in the comment section that "good posture" was noted (Individual #371, 2/28/11). There were three forms that indicated the activity as evidence of intervention (Individual #238 (2/18/11). There were at least 44 forms that identified a concern for which there was no evidence that the problem was reported. In some cases, the PNMPC reported that he or she made a correction or provided a reminder to staff. In many other cases, issues identified required intervention or review by a licensed clinician, such as for Individual #218 (2/24/11, 3/23/11, and 3/23/11) and Individual #460 (3/17/11). For Individual #547 (2/23/11) coughing was documented with no indication that this had been reported to nursing or that there had been any follow-up by a licensed clinician. In another case, the PNMPC made a judgment as to the safety of a gastrostomy tube feeding, indicating that the "feeding might have been slower" (Individual #11, 2/17/11). Clarification of roles was needed for PNMPCs. Twelve of the forms had informal (unsigned, undated) notations that there had been some form of follow-up related to an issue identified. A number of others indicated that the charge/home manager had been notified. A nurse was notified in only one case (Individual #11, 2/24/11) related to meal refusal. There was no clearly identified schedule of frequency established that was driven by health risk levels. Though there was a spreadsheet to document findings for all the monitoring sheets completed since October 2010 by the Habilitation Therapy staff and PNMPCs, there had not been any analysis of the findings to date. There was no oversight to track and trend compliance with the intended frequency and scope of the monitoring conducted. There was no existing policy that outlined the process of monitoring,	

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		identifying the roles and responsibilities of monitors, training and validation of monitors, frequency, distribution, documentation, or follow-up and communication of findings. **Standard: All members of the PNM team conduct monitoring.** The PNMT was not yet a functioning team. There was no system of routine review established to be conducted by the clinicians relative to the health status of those individuals at high risk who were followed by the PNMT. **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 system implemented to address monitoring by the PNMT at the time of this onsite review. There was no mechanism to analyze the information obtained by the PNMPCs and it would be difficult to track individual-specific issues through to resolution or to track and trend concerns noted in homes or across the facility. A system of emails was intended to notify the clinicians that an issue had been identified during monitoring that required attention. There were some notations that indicating that some action had been taken. It was not known who had taken the action and when or if the problem was resolved in a number of cases. For example, Individual #117 in home 559B was monitored on 2/16/11 and an issue with fluid loss was documented. A need to consider alternate liquid consistencies was noted by the monitor on this date, which was a concern. The monitor should only report what was observed and then report it to permit the licensed professionals to determine what should be done about the problem. • On 2/24/11, Individual #300 was reported to have a small dining plan with no picture which was inconsistent with the current format. The response was that he had an annual meeting in March 2011, rather than remediation of this issue in timely manner. • In the case of Individual #487, he was monitored on 2/27/11 and it was reported that he too needed a large Dining Plan in the current format. The notation stated that he had been staffed on 10/6/10. • In the case of Individual #367, he too was reported on 2/27/11 to have a mealtime card in the older format. The notation indicated that he had a staffing on 2/2/11 and the revised plan was still "in process" 25 days later. It was of concern that there was no evidence in these cases that the corrections would be made in a timely manner. There were many more issues identified per the monitoring sheets reviewed with no indication that any intervention had taken place to evaluate the problem and to establish and implement a plan to remedy the concern. An example of a	

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		more serious issue was noted with Individual #310 on 3/25/11 when the monitor reported that he was leaning and spilling food off his spoon. The undated notation merely stated that he "had a stroke." There was no indication that the problems identified had been evaluated. **Standard: Immediate intervention is provided if the person is determined to be at risk of harm.** There was an expectation of immediate intervention when an individual was determined to be at risk of harm and that the monitor would notify the appropriate person, such as the charge, home manager, nurse, or therapist. They were to list the name of staff notified, or request a signature in the case that they reported to the home manager or charge. If inservice was required, the staff person trained was also to sign the form, though this was infrequent. In some cases, there was staff signature with no evidence of an issue requiring training (e.g., Individual #22, 2/17/11 and Individual #334, 2/22/11). Typically there was a signature by the charge/home manager, although a signature was also noted for over 60% of the forms submitted that did not identify any concerns, so it was not certain that these signatures had any meaning other than a routine procedure. There was a section at the bottom of the observation forms to circle concerns noted by the monitor. Concerns were circled for only six of the completed forms submitted for December 2010. Though the monitors identified issues during their observations, they rarely documented that they had notified anyone else of these issues. There continued to be a number of issues identified throughout this report that suggested the PNMPCs were insufficiently trained to consistently identify concerns that required attention by the therapists or the PNMT.	
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 new health risk assessment process was only recently introduced and the teams continued to face challenges in order to fully implement this process. Discussions with two PSTs were conducted with the monitoring team in an attempt to understand where the teams were with this and to hopefully move it along. The PNMT was not yet initiated and will present additional challenges as that process is implemented and integrated into the system. Further review during the next onsite visit will be necessary to determine the effectiveness of each of these systems. **Standard: Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.**	Noncompliance

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		Individuals with PNMPs were reviewed on an annual basis with changes in the interim, generally, indicated based on referral or the identification of a problem. Routine, proactive review of the plans was not conducted by the clinicians with frequency based on health risk level. In the case that an individual participated in direct therapy, progress notes were written, though very few individuals received this as discussed in section P below. There was no consistent link of the PNMP to health risk issues and there was no formal and consistent review of the plans relative to how well the plan addressed or minimized these concerns. Even during the annual assessments, the plans were reviewed in a more rote manner to continue a strategy with no clear review to measure or evaluate the actual efficacy of the plan to the issue itself. For example, there was no review to determine if strategies to address falls for an individual effectively resulted in a reduction from the previous period. There was no detailed comparative analysis of data or assessment findings. PNMP and Dining Plan monitoring were conducted by the PNMPCs and, as paraprofessionals, they would not be able to make judgments as to efficacy of the plans and to determine if there was a positive outcome related to PNM risks. Currently, there was no other system of monitoring of PNMP effectiveness for those at highest risk. As stated above, there was no routine documented review of the supports and services conducted by the licensed clinicians to address effectiveness for those at highest risk unless a problem had been identified and, as such, was reactive rather than proactive. A large number of completed monitoring forms were submitted for the last three months, as requested. Forms included were completed in during the last three months. There was no system established to analyze these extensive findings. Therapists had completed a mealtime monitoring forms for individuals on their caseloads over the last six weeks.	
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 approximately 52 individuals listed as receiving enteral nutrition. Eight of these individuals had been included in the sample reviewed by the monitoring team. There was a new system as an aspect of the At Risk Individuals policy that provided a format for the annual review of those who received enteral nutrition by the PST using the Aspiration Pneumonia/Enteral Nutrition Evaluation, to be completed by 3/31/11. Evaluations completed since 1/1/11 for individuals in the sample were requested by the monitoring team. These assessments were noted for five of the eight individuals in the sample. As this process had just recently been implemented, further review will be conducted by the monitoring team in the future.	Noncompliance

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		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 in the selected sample had been provided a PNMP that included the same elements described above. **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.** There was no protocol outlined for this process, however, as all individuals were provided a PNMP and Dining Plan, these elements would likely also be provided to an individual who transitioned back to oral intake, however, competency-based training was limited, so staff training may likely be limited. A draft protocol outlining therapeutic pathways for resuming oral intake for an individual who was enterally nourished had been developed for statewide review, but as yet had not been implemented. **Standard: A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT).** One aspect of the new At Risk Individuals policy, implemented as of 1/1/11, was an outline for an Aspiration Pneumonia/Enteral Nutrition Evaluation. This form was to be used for all individuals who were at high risk for aspiration pneumonia or who were hospitalized for aspiration pneumonia multiple times within the last year, as well as a means to conduct an annual assessment of individuals who received enteral nutrition. The assessment was to be compiled by the nursing case manager based on information provided by the PCP, nursing, Habilitation therapists, dietitian, pharmacist, and other members of the PST. As stated above, five of the eight individuals reviewed had completed assessments. Individual #96 had been provided three within a two month period for some reason. Further assessment will be necessary by the monitoring team in the future to assess the quality of these assessments. **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. Further focus on these areas should occur as the At Risk and PNMT systems are implemented.	

Recommendations:

1. Identify a dietitian member of the PNMT immediately and initiate the process as soon as possible.

2. Develop a policy or, at least, comprehensive written guidelines, related to the monitoring system.

3. Consider a significant increase in nutritional staff. Two dietitians for the facility and then one only when the other is assigned to the PNMT was insufficient to adequately meet the needs of all individuals living at LSSLC (391 individuals).

4. Identify and address risk issues consistently in the focus of the PNMP, dining plans and assessments. Clinical justification for supports should be stated with a clear link to the health risk indicators identified by all PST members.

5. Ensure improved attendance at the PSPs and PSPAs by Habilitation Therapies and Nutrition Services staff. Attendance by the PNMT will also become critical as they begin to conduct assessments and develop intervention plans.

6. Ensure that competency-based training is skills-based whenever indicated. Staff generally learn better by learning and trainers get a better idea of the effectiveness of their training through return demonstration rather than mere verbal responses. Read and sign inservice training is not competency-based.

7. 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.

8. Conduct trend analysis of all monitoring data. Review findings and make system adjustments. It is critical to establish a mechanism to review the overall trends and findings to drive staff training in the homes and other settings in which the PNMP is implemented. This review is an important quality improvement element.

9. 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. These same steps could be applied to training techniques and skills as well. This will require the development of a comprehensive curriculum and learning objectives. The outline of training related to completing the monitoring forms was a good start, but more information and content will likely be needed to ensure that the rationale for interventions and supports is well understood. This is particularly important with the expectation that PNMPCs will train others. They will need competency-based training to learn how to support other staff in a manner that is positive rather than judgmental in order to build constructive outcomes.

10. More oversight and directions were indicated for the PNMPCS in order to ensure that there is consistency in the schedule and frequency of monitoring. This should be reviewed for compliance on a routine basis. There were a number of observations noted by the monitoring team that should have been picked up through the monitoring procedures.

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 List of OT/PT Clinical Staff list o Continuing Education documentation for clinical staff o LSSLC POI for Section P o LSSLC Organizational Charts o Habilitation Therapies staff list (4/20/11) o Staffing data o Section P Presentation Book o Client List (3/10/11) o Admissions Activity (3/9/11) o At Risk List by Home (3/16/11) o Comprehensive Lifting, Transfer and Positioning Monitoring tool o Comprehensive Positioning Monitoring Training o Completed Comprehensive Lifting, Transfer, and Positioning Monitoring tools submitted o PNMP Monitoring tool o Completed PNMP Monitoring tools submitted o Settlement Agreement Cross referenced with ICF-MR Standards o Primary Mobility Wheelchairs o Ambulation Assistive Devices o Orthotics, Braces and Gait Belts o Wheelchair Modifications (3/9/11) o 2010 and 2011 Wound Clinic Spreadsheet o Habilitation Therapy Competency Based Inservice Individual #450 (4/15/11) o New Employee Orientation PNM-related agenda and curriculum o Training Schedule for Eating and Lifting/Positioning o Assistive Equipment List o PNMPs submitted o PNMP/PSPA Tracking forms o List of PNMPs and Profiles o OT/PT evaluations: • Individual #521, Individual #379, Individual #46, Individual #279, Individual #402, Individual #332, Individual #108, Individual #211, Individual #527, Individual #45, Individual #238, Individual #60, Individual #457, Individual #24, Individual #157, Individual #308, Individual #273, Individual #330, Individual #16, Individual #12, Individual #111, Individual #133, Individual #560, Individual #213, Individual #586, Individual #296, Individual #44, Individual #42, Individual #164, Individual #470, Individual #422, Individual #114 and Individual #158 o Documentation for last three months for individuals in TIR program (Activity Plans and progress

notes
- OT/PT/SLP Evaluation template
- High At Risk List by Individual 3/15/11
- List of falls December 2010 to March 2011
- Individual receiving Direct Occupation and Physical Therapy
- List of individuals who receive enteral nutrition
- Drug order report (individuals with chronic and acute pain)
- PNMP list 2/11/11
- List of individuals receiving direct OT/PT services
- List of individuals who were non-ambulatory and assisted ambulation
- List of Falls in Past 12 months (3/17/11)
- List of Skin Breakdown
- Fractures in the Past Year (3/17/11)
- Wheelchair Priority List (3/10/11)
- Mat Evaluations for Individual #284, Individual #530, Individual #106, Individual #335, Individual #385
- List of hospitalizations/ER visits
- List of individuals who were non-ambulatory and assisted ambulation
- Information from the Active Record including PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms, PSP reviews by QMRP, PBSPs, annual Physician Summary, Active Medical Problem list, hospital summaries, GI consults, Orthopedic consults, diet order, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Aspiration Triggers Data Sheets (1/1/11 to present), Weight Record (last 12 months), documentation from Habilitation Therapies tab, all documents in PNMP tab, all documents in Nutrition tab, MBSS completed in the last 12 months, Mealtime, Communication, PNMP Monitoring sheets completed during the last three months, all PNMPs for last 12 months, all Dining Plans for last 12 months, NMT documentation last 12 months for the following individuals:
    - Individual #593, Individual #245, Individual #96, Individual #47, Individual #267, Individual #248, Individual #161, Individual #551, Individual #182, Individual #342, Individual #535, Individual #1, Individual #310, Individual #502, Individual #298, Individual #321 and Individual #385. Records for Individual #16, Individual #599 and Individual #172 were also requested but were not submitted.

<u>Interviews and Meetings Held</u>:
- Danielle Perry, Au.D, CCC-A, Habilitation Therapies Director
- OTs and PTs, COTAs and PTAs
- ATP / DME provider
- PNMP Coordinators
- Various supervisors and direct support staff

<u>Observations Conducted</u>:
- Living areas

	o Dining rooms o Day Programs o OT/PT Assessment o Wheelchair Clinic
	Facility Self-Assessment: LSSLC's self-assessment identified noncompliance for all items in this provision. The self-assessment was consistent with the monitoring team's assessment of noncompliance for each aspect of this provision. Comments in the POI stated actions taken that were determined to be related to each provision item, but there was no clearly stated plan to achieve compliance with progress tracked by completion of each specific action step. This approach appeared to be random and reactionary rather than a plan to direct focus, work products, and effort by staff. Action steps should be stated in measurable terms with evidence required to demonstrate completion of the interim steps.
	Summary of Monitor's Assessment: There was a new department director and though she had been in this role for only a short period, it was evident that she was a respected leader and had made significant progress with developing a familiarity with the department, procedures, roles, and responsibilities, as well as a sound understanding of the expectations related to the Settlement Agreement. The monitoring team looks forward to continued opportunities to work with this competent and energetic Director. Staffing levels remained essentially unchanged since the last review. Based on this review, a very limited number of individuals were provided with OT or PT services beyond the PNMP (only six in direct therapy). A number of individuals had participated in the TIR (Tone, Inhibition, and Relaxation) program provided by therapy technicians. As discussed with the clinicians during the previous onsite visit, this program did not include any functional or measurable outcomes. As such, this program was being discontinued for individuals for whom a functional, measurable goal could not be established. The existing assessments generally only included recommendations related to the PNMP; additional needs had not been adequately identified for many individuals. The OT/PT assessments inconsistently addressed movement, mobility, range of motion, independence, and functional status. The clinicians did not generally document functional examples of systems level findings, such as range of motion, strength, and muscle tone. Observation of activities outside of the clinic setting was not documented. This limited the clinicians' ability to identify potential for skill acquisition and therapy consultation for program development in these areas. There was no discussion of potential for skill acquisition across a variety of areas, including eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning. In many cases, clinical information was merely reported, but was not utilized to guide decisions regarding intervention. In the cases that therapy supports had been provided, there was no assessment as to the effectiveness of the interventions. There was no comparative analysis of health and functional status from the previous year. There was no analysis of findings that was based on the

	data reported and compared to a previous comprehensive assessment or update, or that provided a rationale for the recommendations for interventions and supports. Specific health risk ratings established by the PST were not identified and interventions, primarily the PNMP, were not specifically linked to these ratings. Comprehensive assessments were not provided upon a change in status, but rather OT or PT consults were noted for some of the individuals reviewed. In some cases, there was no evidence of follow-up for some consults and it was unclear if the supports and services were completed. There were few intervention plans and measurable goals were not established with performance criteria clearly outlined. Documentation was consistent and in some cases described progress, but without a clear baseline and/or specific measurable goal, continued intervention was not well justified. As a result, the decision to continue therapy or discharge was not supported. It was likely that there was an adequate justification for many of the supports and services provided but they were not consistently or well documented. There was limited change noted since the previous review regarding the requirements of the items of this provision, though it was clear to the monitor that significant efforts to improve the process used for wheelchair assessment had been made. There continued to be no clearly established link between the health risk indicators identified by the PSTs with the PNMPs. There continued to ongoing concerns related to positioning and alignment of individuals in wheelchairs. Direct support staff did not demonstrate sufficient knowledge and skills to implement plans appropriately. There were several levels of oversight by home managers, PNMPCs, and therapy clinicians that failed to adequately address this issue. Monitoring was not clearly driven by level of risk. While the PNMPCs had recently been shifted to the Habilitation Therapies Department for direct supervision, they continued to require more training and oversight in order to ensure that monitoring provided the appropriate data to evaluate the efficacy of individual-specific plans as well as the training provided to staff related to implementation of PNM. There had not been any system of trend analysis established to date.

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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	**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 Department had a new Director Danielle Perry, Au.D, CCC-A. OT and PT staffing levels were essentially unchanged from the previous onsite review. Current staffing included two PTs, one PTA, three OTRs, and three COTAs. All were full	Noncompliance

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	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.	time except one of the PTs who worked approximately 60% and one of the COTAs who worked half time. There was one PT tech, though there was no therapy technician assigned specifically to OT. There were 11 therapy technicians assigned various responsibilities, including staff training, PNMP updates, TIR (Tone, Inhibition, and Relaxation program), and adaptive equipment. There were nine Physical Nutritional Management Plan Coordinators (PNMPCs) and their supervisor. There was one unfilled position each for OT and PT. The calculated ratio was 1:75 for PT and 1:48 for OT. This was somewhat deceptive in that the assistants could not be considered equal in responsibility because the COTAs were not able to conduct assessments; they were licensed to assist with data collection only. In addition, they were not licensed to design therapy treatment programs. Continuing education records were submitted, with participation, since the previous review by each of the OTRs and COTAs, but not by the PTs or PTAs. There was no evidence that the PTs had participated in continuing education in the last 12 months based on findings from the previous review. Regardless of experience, it is critical that all therapy clinicians routinely participate in continuing education and clinical instruction routinely in order to remain current with regard to assessment and intervention. Fabrication of seating systems continued to occur onsite with additional support via an ATP vendor. There were three wheelchair/orthotic technicians who served as fabricators and conducted maintenance work on equipment. A durable medical equipment (DME) vendor with ATP certification participated in seating system assessment design and fittings. Fabricators were responsible for collaborating with therapy clinicians and the ATP to design seating systems for individuals living at LSSLC, fabricating custom components, and completing repairs and modifications. Based on a list of PNM needs submitted, 329 individuals or 84% of the current census (391) were identified as requiring PNM supports and were provided a PNMP. Another 66 individuals were listed with Profiles, but no PNMP. Based on the reported census and identified PNM needs, as currently staffed, the OT caseload sizes were 130 for the general census, or 110 for those reported with PNM needs. The PT caseload was considerably higher at approximately 117 for the part-time PT and 274 for the full time PT for the general census or 164.5 for the part-time PT and 263 for the fulltime PT for those reported with PNM needs. Clinicians were responsible for the annual assessments or updates, providing supports and services as needed, reviewing and updating the PNMP, and responding to any additional needs as they came up for each individual on their caseload, with additional supports available from the therapy assistants. Annual assessments/updates were	

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		completed by OT and PT collaboratively. Some of those who did not have established PNM needs would likely require occasional supports to address acute injuries or to address more chronic conditions associated with aging. Many others would likely benefit from skill acquisition/enhancement programs related to movement and mobility, as well as fine motor skills and independence. This level of supports and services could not be adequately met with the current staffing levels for PT. Current utilization of the OTs did not appear to be appropriate to adequately address individual needs beyond those related to the PNMP. Based on this review, a very limited number of these individuals were provided with OT or PT services beyond the PNMP (only six were in direct therapy). A number of individuals had participated in the TIR (Tone, Inhibition, and Relaxation) program provided by therapy technicians. As discussed with the clinicians during the previous onsite visit, this program did not include any functional or measurable outcomes. As such, this program was being discontinued for individuals for whom a functional, measurable goal could not be established. The existing assessments generally only included recommendations related to the PNMP. Based on review of the assessments submitted, there were at least 33 out of the 49 (67%) individuals with identified concerns related to movement, mobility, range of motion, limitations in levels of independence, and/or regression of functional skills. Recommendations for interventions beyond the PNMP were noted for only four individuals including: Individual #470 and Individual #586 (to participate in TIR program); Individual #330 (for range of motion therapy), and Individual #45 (for an ambulation training objective). There was no justification for the intervention recommended stated in the assessments for any of these individuals. Others were recommended for a variety of indirect services via the PNMP and the provision of assistive equipment and/or orthotics. **Standard: All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.** Assessments were completed as a more discrete measure of status rather than screenings, for most individuals. The assessments submitted were completed by both OT and PT. An assessment was submitted for individuals in the sample for whom personal records were requested as well as for an additional 33 individuals. Documentation for individuals included in the sample was pulled directly from the active record for 17 of the 20 individuals requested and there were generally multiple evaluations for each. Review was limited to the most current evaluation submitted. Fourteen were evaluation updates and two were for individuals newly admitted to LSSLC. The updates were completed in 2003 (Individual #342), 2007 (Individual #551), 2008 (Individual #535, Individual #47, and	

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		Individual #245), 2009 (Individual #298, Individual #502, and Individual #161) and 2010 (Individual #385, Individual #310, Individual #1, Individual #593, Individual #321, and Individual #248). The two new admission evaluations were completed for Individual #96 (2007) and Individual #267 (2004). No more current assessments were submitted for these individuals. The procedure described by the clinicians was to complete a comprehensive evaluation every three years with an interim update for those individuals who received direct or indirect supports and services by OT and/or PT. From the selected sample of assessments were submitted, there were at least 12 of the 17 individuals who should have been provided one or more annual updates, but were not. Per the POI, a chart audit had been conducted as of 3/2/11 to ensure that the most current assessments were contained in the active record. Of the additional 33 assessments submitted and listed above in the list of documents reviewed, there were six assessments identified as baseline, 26 as evaluation updates, and one was a new admission evaluation. Each of these was current with the last 12 months. The evaluation completed for Individual #279 was completed within 30 days of his admission. This was reported to be a consistent practice for all new admissions. Most of the updates referenced a previous evaluation completed: 1994 (2), 1995 (6), 1996 (5), 2002 (2), 2004 (2) and 2005(1), 2008 (1), 2009 (2), and 2010 (1). Most also listed subsequent updates, though it had been at least three years since the previous update for most of these (16). Updates for Individual #42, Individual #527, Individual #108, and Individual #44 were each dated in March 2011, but did not reference a previous baseline assessment or updates. There was no clear and consistent plan implemented at this time to comply with the facility policy for completion of evaluations. **Standard: All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.** All individuals included in the sample received an OT/PT assessment and subsequent updates, though many were not considered to be current based on the proposed assessment schedule. There did not appear to be a standard for additional comprehensive assessment when new issues were identified or referred by the PST, however, new issues that required additional assessment by OT or PT were generally addressed well within the 30-day period. There was no formal system to track specific referrals generated by the PST or via PNMP monitoring through to resolution. Based on the documentation submitted, 36 out of 49 (92%) of individuals had a current OT/PT assessment within the last year. The update assessments for some of the individuals had been completed three or more years ago despite evidence of PNMPs and other supports and included Individual #267 and Individual #342 who had not received an evaluation or update since 2004 and 2003, respectively. Additional discipline-specific	

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		consultations were completed per referral for specific issues. While the Settlement Agreement indicated that assessment should occur within 30 days of the identified need, this standard is not acceptable when there are urgent issues with potential for further injury or health and safety risks. Most of these appeared to have been completed in a timely manner. There was no mechanism for the department to track this, however. The POI reported that there was plan in place to complete this as of 5/1/11. **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.** As stated above, there was no consistent practice to ensure that a comprehensive evaluation was conducted every three years with annual interim updates for those receiving direct or indirect supports and services. The majority of the updates had been completed every three years. In addition, a comprehensive evaluation was not conducted for a change in status, but rather an issue-specific consult was documented. A list submitted to identify those who had received direct OT or PT services in the last six months was titled "Individuals Receiving Direct Occupational and Physical Therapy" and identified five individuals (Individual #521 was listed as receiving both OT and PT). The following individuals participated in PT: • Individual #14 to address ambulation post hip surgery • Individual #46 to promote improved knee extension for dressing and wheelchair positioning • Individual #379 for daily placement of an ankle gauntlet • Individual #544 for a trial with a May walker • Individual #521 for movement and developmental facilitation to enhance her ability to participate in her environment. She was also listed as receiving direct OT with the same focus. Though assessments were requested for each of these individuals, only those for Individual #521, Individual #379 and Individual #46 were submitted. Of these, only Individual #379 had not received an annual update. His most current assessment was dated 6/30/10 and the previous update had been provided on 7/10/07. It was not clear if he had previously been provided any level of supports or services that would require annual review. At the time of this most recent assessment, he was referred to the Orthotic Clinic and an ankle gauntlet and orthotic insert were recommended. His current direct PT service involved application of the gauntlet on a daily basis. A new OT/PT evaluation format was submitted. Health risk issues were not addressed in	

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		the template and this was lacking in the assessments submitted. Recommendations for supports were not linked to the specific health risks identified by the PSTs, nor were they clearly linked to the specific findings of the therapy clinicians. There continued to be no focus on skill acquisition via functional outcomes and training objectives. There were 11 assessments reviewed that followed this format that had only recently been implemented. Each of these was dated 2/7/11 or later. These assessments inconsistently contained most of these same headings and, as such, also inconsistently addressed movement, mobility, range of motion, independence, and functional status. The clinicians did not generally document functional examples of systems level findings, such as range of motion, strength, and muscle tone. Observation of activities outside of the clinic setting was not documented. This limited the clinicians' ability to identify potential for skill acquisition and therapy consultation for program development in these areas. During an observation of an assessment, the OT clinician merely demonstrated several basic upper extremity positions and asked Individual #252 to imitate these. By report, the clinician planned to observe the mealtime, but not any other functional activities in which the individual engaged. Assessment of fine motor skills was not observed by the monitoring team during this assessment and, generally, only discussion of upper extremity range of motion was included in the written reports. Most of the assessments that were of the new format did not discuss postural control or alignment in sitting. For example, for Individual #527, it was reported that she was able to maintain a seated position on the edge of the bed. A description of this was not offered, however. A description of sitting skills in other settings or a discussion of transitions to and from sitting was also not discussed. Additional concerns noted in the assessment reports reviewed included: • There was no discussion of potential for skill acquisition in areas such as eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning. • In many cases, clinical information was merely reported, but was not utilized to guide decisions regarding intervention. • In the cases that therapy supports had been provided, there was no assessment as to the effectiveness of the interventions. • There was no comparative analysis of health and functional status from the previous year. • There was no analysis of findings that was based on the data reported and compared to a previous comprehensive assessment or update, or that provided a rationale for the recommendations for interventions and supports. • Specific health risk ratings established by the PST were not identified and interventions, primarily the PNMP, were not specifically linked to these ratings.	

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		Approximately 33 out of 49 (67%) assessments reviewed described individuals with significant movement disorders and limitations in self-care and/or functional skills. The following information was also noted based on the documents submitted and these individuals would likely require supports and interventions by OT and/or PT beyond only a PNMP. There were: • 329 (84% of the current census) individuals identified with PNM needs per the list submitted. • 180 (46 %) individuals identified as non-ambulatory or requiring assistance for ambulation. • 166 (42%) individuals who used a wheelchair as a primary means of mobility. • 34 (9%) individuals who used assistive equipment for ambulation. • 44 (11%) individuals who used transport wheelchairs as needed. • 172 (44%) individuals with upper or lower extremity orthotics, braces and/or gait belts. • 14 (4%) individuals sustained an injury resulting in a fracture. Seven of these individuals were either non-ambulatory or required assisted ambulation to some degree. • More than 81 (21%) individuals had experienced falls in the last three months and 181 (46%) individuals in the last year. There were 18 individuals who experienced a slip, trip or fall resulting in a serious injury. Approximately 75 of these incidents occurred in the bathing or toileting area one of which resulted in a serious injury for Individual #14. There were 35 individuals who had more than one fall and were either non-ambulatory or required assistance for ambulation. For example: Individual #547 (20 falls), Individual #497 (15), Individual #151 (9), Individual #267 (8), Individual #365 (8), Individual #258 (9), Individual #481 (10), Individual #213 (14), Individual #562 (10), Individual #90 (6), Individual #298 (7), Individual #513 (5) and Individual #368 (17). All others had less than five falls. There were five individuals who had experienced a serious injury, including Individual #14, Individual #267, Individual #481, Individual #468 and Individual #271. • 29 (7%) individuals had one or more incidences of pressure ulcers/skin breakdown in the last year based on several lists submitted. • 45 individuals were listed with contractures in one or more joints. • 26 individuals were listed with chronic pain • Eight individuals were listed at high risk for osteoporosis, including Individual #14 who had experienced multiple falls, including one resulting in a serious injury. Both a new PSP process and Health Risk Assessment process were recently implemented and would likely further impact the OT/PT assessments over the next year.	

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		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)** As stated above, the assessments generally addressed range of motion and movement skills, such as transfers and ambulation. Other functional skills where not typically addressed, particularly in the area of fine motor skills and activities of daily living. Some examples included: • Individual #211's fine motor skills assessment was limited to a statement that she used a palmar and cylindrical grasp on either hand and that she required assistance with all ADLs except drinking. There was no indication that these had been observed to determine if she participated in any way or had the potential to participate in any activities. Specific information in these functional areas would offer more useful information to the clinicians and other team members for training or active treatment purposes. • Individual #108 ate with hand over hand assistance by report. There was only a statement that he required assistance for all other ADLs. Again there was no evidence that these activities had been observed to determine his level of participation or his potential for skill acquisition in these areas. • Individual #248 had training objectives related to bathing in his PSP yet his abilities related to self-care were not mentioned in his OT/PT evaluation updated on 3/9/10. **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.** Comprehensive assessments were not provided upon a change in status, but rather OT or PT consults were merely noted for some individuals in the Integrated Progress Notes. The date of referral was not generally documented, so it was not possible to determine the timeliness of these consults. In some cases, there was no evidence of follow-up, and it was unclear if the supports and services were completed. Some examples included: • Individual #551 was reviewed by PT on 12/21/10 following discharge from a hospitalization. OT completed a head of bed elevation review following	

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		gastrostomy tube placement. No additional follow-up to assess the effectiveness of these interventions was noted in the integrated progress notes. A nursing note reported that a new wheelchair had been delivered to the home on 4/8/11, but there was no documentation by OT or PT. • Individual #502 had received an OT/PT evaluation update on 3/26/09 (report dated 4/27/09). Since that time, she experienced a fracture of her tibia on 11/1/10. There was no evidence that she had been re-assessed by OT/PT since then. A PSP addendum meeting was documented on 11/15/10 to make an acute change in the transfer method used. Staff were to use a mechanical lift with two people, the second person was to support her right leg. An inservice was documented related to transfers on 11/10/10, but there was no mention of the fracture. Her PNMP submitted as current was dated 11/15/10 and had not been modified since. A subsequent Addendum meeting was held on 11/18/10. There was no therapy representation at that meeting. A referral for PT assessment of Darco shoes was recommended, but there was no evidence of follow-up. • Individual #502 was seen for a wheelchair assessment on 5/25/10. There was no further documentation until 9/30/10 when the OT reported that she had added a new seat and back to her wheelchair. There was no further follow-up to document whether these changes were effective. • Individual #47 received a wheelchair assessment on 6/29/10 secondary to a doctor's order to address leaning. There was no further follow-up related to this until a review by the NMT on 12/6/10 following discharge from the hospital with aspiration pneumonia. It was noted that the RN had requested a chest harness to prevent leaning prior to the hospitalization on 11/5/10. He had been experiencing fever and hypothermia and was in the infirmary at that time. On 12/8/10, the OT completed a final fitting of the chest harness to address trunk flexion. When this was placed, it was determined that he then was leaning to the right and a work order for a lateral support was to be submitted. This was an example of an inappropriate approach to assessment of seating. A full re-assessment should have occurred rather than a "band-aid" approach. There was no documentation in the progress notes that a lateral support had been provided. He had not received a comprehensive OT/PT assessment since 7/18/08. • It was recommended by OT that Individual #321 be provided a right hand splint on 4/26/10. There was no further documentation until 6/8/10 when it was documented that bilateral palm grips were provided. There was no rationale documented as to the selection of the splints and no follow-up until 6/16/10. At that time, it was reported that the splints were appropriate. Subsequent follow-up was not documented to review efficacy, fit, and consistency of application. • Individual #321 was issued a new wheelchair on 5/5/10. There was documentation by nursing that she had a wound on her buttocks on 5/12/10 and	

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		that Habilitation Therapies was to conduct an assessment related to pressure, but there was no evidence that OT or PT had conducted an assessment. • Individual #161 was seen by PT on 5/17/10 and it was documented that a rolling walker with rear gliders would be ordered. There was no documentation in the progress notes that this had been provided. • Individual #245 was diagnosed with aspiration pneumonia in November 2010 and had a PEG tube placement on 12/1/10. She was reviewed by PT on 11/24/10, 11/30/10, and 12/1/10, though the purpose of the review was not stated. PT recommended follow-up over the next 30 – 45 days to address wheelchair and equipment needs. She was subsequently seen by OT on 12/7/10 to assess head of bed elevation and for a wheelchair assessment on 12/22/10. At that time a new wheelchair was recommended. There was no evidence that this, or that further follow-up by OT or PT, had been provided despite an open area on her coccyx reported by nursing on 12/29/10 and a significant change in status following a Lithium overdose on 3/5/11. She had not received a comprehensive OT/PT assessment since 7/23/08. • Individual #96 was seen on 4/27/10 for a wheelchair assessment. There was no further documentation of follow-up. She was evaluated for head of bed elevation on 10/18/10, but there had been no additional follow-up since that time. She had not received an OT/PT assessment since 3/14/07. **Standard: Findings of comprehensive assessment drive the need for further assessment such as a wheelchair/ seating assessment.** The assessments reviewed did not typically recommend further specialized evaluations for wheelchair seating or for other issues, though this was noted in the case of Individual #470 (2/8/11). Referrals to medical or to the orthotist were noted for some, however. Generally, referrals related to concerns or problems with the wheelchairs or seating were made and the individual was scheduled for wheelchair clinic. As noted above, a progress note was typically written to initiate the assessment, but follow-up, fitting, and delivery documentation were not completed. The Wheelchair Priority List submitted did not consistently reflect the documentation noted in the active records for some individuals (e.g., Individual #96, Individual #245). There was no evidence that there was frequent review of the appropriateness of seating equipment and wheelchairs other than when problems were identified. The annual assessments typically described the seating system components for individuals, but did not consistently address whether the system was appropriate as to fit, function, and condition. Some examples included: • Individual #527: Her current wheelchair was described in the OT/PT assessment dated 2/7/11, but there was no statement as to appropriateness or fit. It was recommended that she receive a new wheelchair due to the age of the existing	

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		one. A mat evaluation was conducted and lateral trunk supports and an abduction contour were recommended, but without rationale. This system was rated a Priority 3 for completion again without rationale or expected completion date. There was no evidence that this had been provided to her. • Individual #42: Her current wheelchair was described in the OT/PT assessment dated 2/9/11. There was no statement as to whether it continued to meet her needs, though it was reported that she had been seen on 4/6/10 for an assessment for a new wheelchair. Over one year later, there was no evidence that she had been provided a new wheelchair/seating system. • Individual #164: His current wheelchair was described in the OT/PT assessment dated 2/8/11. There was no statement as to whether it continued to be appropriate, though it was recommended that he continue to use it. • Individual #470: Her OT/PT assessment dated 2/8/11 indicated that she should be added to the Wheelchair Priority list because it did not appropriately support her and she leaned to the left. She would also require elevating leg rests and a tilt-in-space system. There was no evidence that she had received a wheelchair assessment; she had been referred on 11/16/10 for a new system. • Individual #321 was recommended for a knee extension splint for tightening left hamstrings to minimize contractures per her OT/PT evaluation dated 10/20/10. There was no evidence that this had been provided at the time of this review. Further there had been a progress note on 4/26/10 by the PT who indicated that Individual #321 had knee extension limitations that interfered with transfers. The PT stated that Individual #321 may be considered for a left hamstring stretching program, but required further assessment. There was no evidence that further assessment had been conducted or that the stretching had been provided. **Standard: Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.** The assessment format only offered a list of diagnoses. In some cases, there was a reference to a health issue elsewhere in the report, but there was no specific review of health events, special consults, or diagnostics conducted during the previous year. References to the PST risk assessment and ratings were not noted and, in some cases, the issues were not addressed adequately in the assessments and supports. Some examples: • Individual #1 had received a 12 on the Braden Scale related to risk of skin breakdown, yet this was not mentioned in his OT/PT assessment dated 6/8/10. Further, he had had a left hip dislocation reported in the physician's report and was not mentioned in the OT/PT assessment. He had a previous femur fracture and related open reduction internal fixation (ORIF) procedure in 1995 that was	

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		significant orthopedic history not reported in the OT/PT assessment. He had a diagnosis of osteoporosis, yet there were no references to this as a precaution. • Individual #321 had a diagnosis of osteoporosis and was considered to be at high risk. This risk factor was not mentioned. • Individual #96 was considered to be at high risk for aspiration, choking, osteoporosis, and respiratory concerns, yet she had not received a comprehensive OT/PT assessment since March 2007. There were no precautions related to osteoporosis in her PNMP dated 12/31/10. • Individual #385 was considered to be at high risk for aspiration, dental, fluid imbalance, fractures, infection, and respiratory concerns, yet he had not received an OT/PT assessment/update in over 12 months (12/29/09). There were no precautions highlighted in this PNMP dated 3/15/11. Efforts to identify the rationale for some supports were noted. There was no comprehensive analysis of findings that included both health and medical concerns with a description of functional skill abilities and potentials for the development of an integrated therapy intervention plan, and to provide a foundation for non-clinical supports and programs. There was a new PSP and risk assessment process that should result in changes in the way this is addressed in the clinical evaluations completed by OT and PT. **Standard: Evidence of communication and or collaboration is present in the OT/PT assessments.** The OT and PT clinicians conducted their annual assessments together. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment, such as wheelchairs, and other supports and services as indicated.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall	**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.** Plans were generally limited to the PNMP that was reviewed at the time of the annual PSP and were updated as needed due to a change in status. There was evidence that the majority of the plans were reviewed and updated at the time of the annual staffing and at other times related to program changes. Changes were identified by text highlighting to alert staff to a change from the previous version. Among the other plans/profiles submitted, there were five plans that were expired at the time of this review (Individual #226, Individual #138, Individual #328, Individual #142, and Individual #199) and two others that expired within a week of this review (Individual #599 and Individual #524). There were, however, several changes to plans used by staff in the homes where handwritten notations were made on the plans, but the changes were not formally made	Noncompliance

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	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.	to the PNMP, even after a month or more. In some cases, there was no date or initials by a clinician authorized to make these changes (e.g., Individual #131, Individual #310). Other interventions were typically outlined in a specific activity plan or a skill acquisition plan and included as an aspect of the PSP. While there were not many of these, PSPAs were held routinely by the PSTs to add an intervention or modify an existing plan including the PNMPs. Examples of these were submitted. It was reported that therapists attempted to attend PST meetings when possible, though attendance was not consistent as described above in section O above. As discussed with the clinicians, most of these plans were not considered to be skill acquisition plans with functional measurable goals and objectives. For example, one skill acquisition plan by PT was implemented for Individual #46 on 12/16/10. The goal listed was, "Individual #46 will demonstrate measurable progress toward increasing knee extension for functional dressing and for upright wheelchair positioning." The objective was "Individual #46 will present with -74 degrees left knee extension and -65 degrees right knee extension in a one year period." Knee extension in and of itself may or may not impact functional dressing or wheelchair positioning. As an objective, this was measurable, but there must also be a link to measurable progress related to both dressing and wheelchair positioning to be functional. In fact, the plan had a step in which Individual #46 was to be encouraged to straighten his leg to "simulate" dressing. It is well known that simulation of a task uses different motor learning and motor planning skills than actually doing a real task. Practicing similar tasks in addition to the actual task are generally effective, but pretending is typically considered to be ineffective. For example, it has been demonstrated that people who are asked to reach their arm over their head demonstrate less range of motion than when they are asked to reach for a specific item held over their head. The environment of real meaningful and functional tasks greatly influences effort and intrinsic feedback. Individual #46's OT/PT assessment had been completed on 12/13/10. Though his diagnosis was changed to CNS deterioration from CVA, rather than Multiple Sclerosis, this was not mentioned in this evaluation. It stated that there had been no changes in his range of motion in the last year, however, a skill acquisition plan to address knee extension was recommended without any rationale. This was not included in his PSP dated 12/15/10. The PT did not attend the PSP meeting. There was only one progress note submitted as written by the PT dated 3/16/11. It stated that his previous range of motion measurements were at the target measures identified in this SAP, and that they were now improved. If the individual had met the existing goal, yet it was identified that continued intervention was indicated, then clinical justification was needed and the goals should be revised. There was no mention of his functional abilities related to dressing or	

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		wheelchair positioning. The data collection sheet should track measures of participation and/or performance during each session however the monthly progress note must document progress over the month and compare one month with previous months to demonstrate progress toward the goal/objective. **Standard: Within 30 days of development of the plan, it was implemented.** As there were very limited interventions provided beyond the PNMPs, this element was not in compliance. Generally, however, when an action was identified as necessary to address a more acute issue, these actions were taken well within the 30-day period, per the progress notes reviewed. However, there were some cases described above where there was no documentary evidence that therapy supports and services had been provided or that appropriate follow-up and monitoring had been conducted. Documentation by the clinicians was consistent in most cases and documentation was daily for each session or weekly. Monthly review to summarize progress across the month or quarter was inconsistent, however, in some cases, there was no documented rationale for the need for therapy. Despite an order for therapy, the clinician had a responsibility to establish a clear justification for therapy and a specific plan of treatment with measurable and functional goals and outcomes. Likewise, continuing or discontinuing an intervention required an adequate and appropriate rationale and justification. Some examples were cited above. While documentation was included in the integrated progress notes section, these were not a consistent aspect of documentation for quarterly PSP reviews. Documentation by the QMRP in those cases merely indicated to continue the intervention rather than an actual statement of progress. **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.** There was inconsistent analysis of findings in the assessment reports to provide a rationale for the PNMPs developed for individuals or for other interventions as described above. There was no rationale identified in the PNMPs themselves other than a couple of statements of focus. However, as described above, these statements were not consistent with the risks identified by the PST. The new format and process for the development of the PSP had potential for improved integration of the PNMP, though this was not evident as yet in the new format PSPs reviewed as listed above. There were consistent PSP Addendums to address modifications to PNMPs and other therapy interventions for	

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		Individual #379, Individual #521, and others were noted with consistency. **Standard: Interventions are present to enhance: movement; mobility, range of motion; independence; and as needed to minimize regression.** Other than the limited evidence of direct intervention discussed above, the primary support provided was via the PNMPs. PNMPs and several activity plans/SAPs addressed areas related to positioning, transfers, handling, and mobility, but interventions were limited related to promoting independence and skill acquisition. PT intervention was generally designed to address gait, ambulation, and transfers and range of motion. OT intervention was designed to promote range of motion or to provide splints. The few interventions in place were generally well documented, however, the scope of service was limited to a handful of individuals only, and none of these had established measurable and functional goals. Justification for continued therapy or discharge was not well justified as a result. Programs and interventions for other skill acquisition were not identified as a need and, as such, were not provided. PNMPs included staff instructions or precautions in the areas of movement, mobility, transfers, handling, positioning, toileting, communication, diet order, mealtime equipment and instructions. Vision and hearing and assistive equipment were included, as well. Instructions for medication administration was noted for one (Individual #182) of the 17 individuals included in the sample, and instructions related to bathing were noted for only one (Individual #248) of 17 individuals. There were no instructions for oral hygiene in any of the PNMPs reviewed. The focus of the PNMP was listed, but did not clearly relate to the health risk system in place at the facility. These plans also included a variety of information not related to physical and nutritional management. For example, level of supervision, restrictions and restraints, and behavior support plan target behaviors were listed. Email exchanges documented the need for changes and many of these areas appeared to be outside the scope of the PNMP. This issue was discussed with a number of personnel onsite and it was determined that separating these two documents would be more efficient and less confusing for staff. Another section of the PNMP addressed restraints for involuntary self-injury and restraints for postural support. These did not appear to be an appropriate category for this plan. It was of particular concern that seatbelts were listed as restraints when they were supports needed for postural support. They become a restraint when not needed for postural support and/or if the individual cannot undo the buckle at will. Interestingly, gait belts or transport wheelchairs were not listed as restraints for postural support or involuntary self-injury, so it was unclear why bedrails, bed bolsters or seatbelts were.	

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		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 assessments inconsistently provided a brief rationale for the equipment recommended for use. Pictures were provided for staff reference as an adjunct to the PNMP with details for alignment and support for bed, wheelchair seating, and use of braces or orthotics. These were not consistently present in the individual books and, in some cases, were not current within the last 12 months. They were not submitted with the request for all current PNMPs. PNMPs and pictures for several individuals observed onsite were requested as follows: • Individual #1: His PNMP was dated 3/1/11. Eight accompanying photographs were undated and a photograph for positioning in a recliner was dated February 2006. None had evidence of review by the therapists. A picture of a bed with bedrails and bolsters was included, but there was no picture of how he should be positioned in bed. There was a picture of Darco shoes and a picture of him wearing his bilateral TED hose, AFOs, and Darco shoes. Darco shoes were not listed in his PNMP under assistive equipment. The PNMP stated that he should not wear booties (also not listed) with his AFOs and the pictures were not dated so it was unclear if this was accurate. There was a picture of his recommended position in the dental chair. Though this was an excellent addition, it was undated. There was no reference to this position in his PNMP. Additionally, the PNMP described positioning in a tear drop bean bag, but there was no picture to guide staff or instructions as to when or why this should be used. A bath wedge was also pictured, but was not listed as assistive equipment and there were no bathing instructions provided. • Individual #117: His PNMP was dated 3/1/11. There were 12 undated photographs for the following: wheelchair (2), recliner (1), ear plugs (10) booties worn in bed (1), bath wedge (10), cushion boots (1), booties (1), Darco shoes, bed with bed rails and bolsters (1), head of bed elevation (1), and teardrop bean bag (1). The cushion boots and booties appeared to be the same per the pictures. His PNMP stated he should wear the Darco shoes when up in his wheelchair or recliner. He was only wearing them in the pictures of wheelchair and teardrop beanbag positioning. There were ear plugs pictured, but not included in the PNMP. He was described as required to remain up at 30 degrees at all times, yet he was nearly flat in his bed in the picture of him wearing the booties in bed. A bath wedge was pictured and listed, but there were no bathing instructions. • Individual #47: His PNMP was dated 3/1/11. The picture of him in his wheelchair was dated 5/3/03, nearly eight years old. Another undated picture of	

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		him in a wheelchair appeared to be more current, but was undated. Seven other pictures were included, but were also undated. The PNMP described available positions as supine and semi-right and left sidelying. Another statement listed a recliner, wheelchair or semi-sidelying. Another listed the teardrop beanbag. Pictures noted were large and generally clear with useful highlights for staff as cues or reminders of the critical components of the prescribed supports, however, the inconsistencies noted above had the potential to confuse staff. **Standard: Therapists provide verbal justification and functional rationale for recommended interventions.** There were few intervention plans and measurable goals were not established with performance criteria clearly outlined. Documentation was consistent and, in some cases, described progress, but without a clear baseline and/or a specific measurable goal, continued intervention was not well justified. As a result, the decision to continue therapy or discharge was not supported. It was likely that there was an adequate justification for many of the supports and services provided, but they were not documented. **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.** In the case that an individual received direct therapy, documentation was noted for each session. Documentation for direct services were generally included in the integrated progress note section when provided by the PT or OTR, and on a data sheet when conducted by therapy assistants. Reviews of the PNMP were conducted on an as needed basis upon referral or based on the findings of monitoring, though this appeared to be unreliable. Monitoring by the PNMPCs was intended to ensure routine monitoring of the PNMPs, however, this was not consistently completed and there was no mechanism to track frequency. There was evidence of the therapists addressing some issues identified through monitoring or referral, yet documentation of follow-up through to resolution was inconsistent. As described above, there were some oversights in documentation, though it appeared likely that the support or service had been provided.	
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	**Standard: Staff implements recommendations identified by OT/PT.** Though equipment generally was available and improvements since the last review were noted, implementation by staff was not consistently performed as intended per the PNMP or per the generally accepted professional standards of care. A number of individuals were observed sitting with a posterior tilt, loose seatbelt, or pelvis not well back into the	Noncompliance

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	have successfully completed competency-based training in implementing such plans.	seat of the wheelchair. The PNMPs and pictures were not consistently updated and current as described in P2 above. In home 549B during a meal, there were at least eight individuals lined up in their wheelchairs, either waiting for their meal or separated from the dining area as they were enterally nourished. One staff was reading and the television was on behind her. There was no active engagement with any of the individuals observed. Concerns for alignment and support were noted for five of the eight individuals observed. Staff had to be prompted to address these concerns. Some examples included the following: • Individual #47 was observed in a posterior tilt and leaning to the right in his wheelchair. • Individual #1 was observed in a wheelchair that appeared to be too small for him. The seat was narrow and seat depth short. Staff had a difficult time fastening his seat belt. Different staff repositioned him three times and were unsuccessful each time. When he was repositioned the staff could not fasten the chest strap and the head rest was too low. • Individual #518 was not wearing a seatbelt though his PNMP indicated that he should be wearing one. Staff appeared surprised to see this. • Individual #117 was not positioned in his wheelchair as pictured in his PNMP. There was a continued need for improved staff attention to the details of proper positioning and alignment and compliance with the PNMPs. Transfers observed were generally completed appropriately. However, the therapists and direct support staff were observed to transfer an individual using a mechanical lift, but not properly position and align the pelvis before fastening the seatbelt. The mechanical lift serves to make the transfer from one place to another, but all staff must take care to attend to the pelvis, trunk, head, and extremities after the transfer in order to properly align and support the individual. Of further concern, it was reported by staff that the problems observed for Individual #47, Individual #1, and Individual #117 had been ongoing problems, yet the staff had not reported them, nor had the PNMPC noted any concerns. The therapist had not conducted sufficient oversight, monitoring, and review to identify and remediate these issues. After this observation, the OT indicated that staff were not completing the transfer for Individual #1 correctly back. These special instructions were not included in his PNMP,. This was also not a strategy taught in the lifting and transfer training provided to new staff or in the annual retraining required of all staff per the training materials submitted. **Standard: Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.**	

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		Transfers and lifting training offered in New Employee Orientation (NEO) was now competency-based. The positioning section was a full two-day training with the second day providing a lab session to permit additional practice of necessary skills using mannequins. In addition to new employees, existing staff will complete the PNM area training over the next six months. Previously there were 30 to 40 staff in each class and they were now being split so that there were generally only 20 individuals in the lifting class, for example. There was also a plan for a longer annual retraining to be required related to lifting and transfers. CTD staff were to teach the class with check-offs conducted by Habilitation Therapy staff. It will be critical to ensure that all CTD staff were identified as competent to teach the content and demonstrate the basic skills taught in the class. This goes well beyond merely attending the class and being checked off as competent to perform the skills taught. Individual-specific training was reported to be competency-based. Licensed therapy staff provided inservice to available direct support staff and to PNMPCs. The PNMPCs were checked-off to establish competency to complete the skill required and, as such, were deemed competent to teach the inservice to others. Training documentation reviewed consisted of a list of competencies and a Habilitation Therapy Competency Based Inservice sheet. This sheet was signed by participants and the corresponding verbal response and/or demonstration of skills was marked by the instructor as completed satisfactorily. The instructor initialed to indicate that each staff participant was then competent to implement the intervention. The need for a standard curriculum provided to the PNMPCs and technicians was discussed to ensure that they were provided with the necessary skills required. If they were only checked off as competent to implement a plan, it did not ensure that they were competent to teach and check off others as competent. Measures to teach them to train others, interact appropriately, and to provide constructive criticism would also be necessary. Steps required to plan and conduct an effective inservice and how to complete a competency check off were also critical aspects of training the PNMPCs to do their jobs. The monitoring team looks forward to further review of this newly implemented system for competency-based training. **Standard: Staff verbalizes rationale for interventions.** Staff were not consistently able to discuss the rationale behind recommended interventions. The rationale for interventions and supports was also not included in the PNMP related to specific strategies. This is an important aspect of staff training as well as monitoring and coaching. The focus of the PNMP highlighted the overall risk issue for the individual as a rationale for the plan, but detail as to why a specific strategy was used was not consistently indicated on the PNMP. As described above, however, there were significant risk issues for individuals that were not listed in the PNMP.	

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P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	**Standard: System exists to routinely evaluate: fit; availability; function; and condition of all adaptive equipment/assistive technology.** The form used for monitoring was titled "Comprehensive Lifting, Transfer, and Positioning Monitoring" and another titled "PNMP Monitoring Sheet." Both were described in section O above. This system monitored for availability and condition of adaptive equipment and assistive technology, but did not address fit or function as it related to a specific individual. Additional maintenance requests were addressed via work orders. There was no data base submitted related to these, though there was a database of work completed. There were several incidents of issues noted with wheelchairs identified by the monitoring team with no evidence that these concerns had been previously identified or reported to ensure remediation. Occasionally, a notation in the integrated progress notes section of the individual record was noted related to a wheelchair or splint, but this was not common, consistent, or routine. To date, there was no analysis of the monitoring completed for validity or consistency or to examine trends in and across homes to drive a focus for staff training. Assessments were conducted as needed for new seating systems or for modifications to existing systems. It did not appear, however, that specific wheelchair assessment reports were produced by the therapists. Typically, a progress note was written in the active record to document that the individual had been seen in the wheelchair clinic**.** During a mat evaluation observed by the monitoring team, documentation on a mat evaluation form by the therapy clinicians was noted. This documentation should provide the data obtained from the assessment, a clear outline of the individual's functional needs and goals for the system, and the rationale for the selection of specific products that were determined to match the identified needs/goals. Further, any reviews of wheelchairs and seating, as well as fittings and delivery notes, should be well documented by the therapists. It was not always possible to determine in the individual record whether a specific piece of equipment had been delivered. **Standard: Person-specific monitoring was conducted that focused on plan effectiveness and how the plan addresses the identified needs.** Since the majority of monitoring was conducted by PNMPCs, it was primarily limited to availability and condition of equipment as well as staff implementation, rather than efficacy of the interventions in the PNMPs. The frequency of monitoring was not driven by level of risk, though this will continue to be modified as the new risk assessment process is implemented.	Noncompliance

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		Monitoring sheets for the last three months were submitted for review. There were numerous forms submitted, most completed by the PNMPCs. The forms generally identified where observation took place (the individual's home). The date and time were consistently reported. The activity observed was not consistently checked, but the name of the staff working with the individual was typically recorded. As described above, records for 20 individuals had been requested, including completed PNMP monitoring sheets for the last three months, but records for only 16 individuals were submitted. Twelve completed monitoring forms for the last three months were submitted for six out of the 16 individuals included in the sample. Forms submitted for Individual #267 (3), Individual #96 (1), Individual #248 (4) , and Individual #593 (2) were the Comprehensive Lifting, Transfer, and Positioning Monitoring forms. Two other forms for Individual #310 and Individual #535 were PNMP Monitoring Sheets. Additional monitoring forms completed by PNMPCs, Habilitation Therapy staff, QMRPs, psychology, and RN case managers for the last three months were also requested. Another 111 forms for 79 individuals and another 12 PNMP Monitoring Sheets for 11 additional individuals were submitted for a total of 133 forms, for only 94 individuals, completed over a three month period. This represented only 29% of those identified with PNM needs. Individuals identified at high risk were monitored over the last three months as follows: Individual #323 (1), Individual #146 (3), Individual #444 (2), Individual #290 (2), Individual #265 (1), Individual #387 (3), Individual #248 (4), Individual #535 (1) and Individual #96 (1). There were approximately 44 individuals listed at high risk who also had PNMPs. Only seven of these had been monitored in the last three months. There was no evidence that the other 37 individuals had been monitored at all during the same period. There was no consistent mechanism for issues identified via this system of monitoring to be communicated to the therapists for remediation. For example, a PNM data sheet was submitted that direct care staff repeatedly documented a missing brace for a month and yet this had not been identified by the PNMPC or other monitor, nor had it been communicated to the therapist. As described above, there were a number of issues noted by the monitoring team related to wheelchair seating that had not been previously noted by the PNMPCs or reported by staff. Of concern also was that the clinicians themselves did not conduct sufficient monitoring to identify these issues themselves. **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 policies or guidelines to address the monitoring process. Procedures were communicated to staff via inservice training. There was no formal method to validate PNMPCs to ensure consistency for the monitoring process. A data base had been	

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		developed but there was no formal analysis of findings to identify and track trends or to drive staff training. **Standard: On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.** Staff were monitored as an aspect of the individual-specific monitoring conducted by PNMPCs with staff names listed on the monitoring forms. There was no method to track if this covered all staff who were responsible for implementation of PNMPs. **Standard: Intervention plans are reviewed monthly by the program author to include observation of staff implementation.** Data sheets for activity plans were generally reviewed on a monthly basis by the therapy clinicians. These did not involve a measurable, functional goal so there was no consistent analysis of progress. For the few SAPs developed, there was also a data sheet completed by the person responsible for implementation. The clinicians marked that the individual did or did not demonstrate progress and whether the program should continue. There was no evidence that a progress note was written to provide a comparative analysis of progress. For example: • Individual #75 had an SAP for transfers to his right side in 10 seconds or less for 15 trials per month. Over a three month period, Individual #75 participated in only 29 sessions with absences documented 11 times. He did not perform any transfer during that time in 10 seconds or less yet the therapist documented on 4/15/11 that he would likely be assessed for discharge in 30 days. There was no explanation as to why he had not demonstrated progress, but rather an actual increase in time since 1/1/11 from 12 seconds to as much as 17 seconds. There was certainly no rationale provided as to why discharge was being considered. There was no consistent review of PNMPs on a monthly basis or routine monitoring even for those considered to be at highest risk for PNM concerns. **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.** There was no system to assure that those who were most at risk were assisted by competent and well-trained direct support staff only. Specific examples were described in section O above.	

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		Standard: Responses to monitoring findings are clearly documented from identification to resolution of any issues identified. There was no standardized method to document action on findings from the PNMP monitoring through to problem resolution. There was no mechanism to track findings, problems or resolution. **Standard: Data collection method is validated by the program's author(s).** A few direct treatment plans were implemented and the data were reported in daily or weekly progress notes. Those conducted by assistants generally also had data sheets. There were no monthly summaries intended to summarize the individual's progress. There were very few measurable, functional goals provided as SAPs. There were a number of active treatment programs conducted by technicians with data sheets essentially serving to track attendance rather than any skill acquisition. Notations by therapists were completed monthly with little rationale offered to continue or discontinue. As more programs are developed for implementation by assistants, therapy technicians, and direct support staff, validation of the accuracy of data collection should be a critical aspect of review as a component of establishing competency. This should be well-integrated into the PSP process. Further assessment in this area will be needed during future onsite reviews by the monitoring team.	

Recommendations:

1. It is critical that the all therapy clinicians participate in continuing education and clinical instruction. Hands-on opportunities would be critical to ensure continued improvement particularly in the area of wheelchair seating assessment. The ATP/DME provider may serve as an important contact to assist in the development of these. The facility may want to consider the development of specialists to complete seating assessment for the design and fabrication of these systems. Each system should have clearly identified outcomes expected from the system to ensure appropriate product matching to individual needs.

2. Integrate new risk assessment process into the OT/PT assessment, in the development of intervention/support plans, as well as to guide monitoring and staff training needs. Risk indicators should be considered in a more integrated manner throughout the report. A comparison of health and functional status from the previous year should be documented and reference to the baseline should be made in the update. The analysis of findings should cross all systems or clinical areas and should formulate the foundation or rationale for why specific aspects of the PNMP as well as other supports, service and interventions were indicated. These should then be listed as recommendations.

3. Address skill acquisition in the OT/PT assessment. More discreet task analysis and observation generally will yield greater specificity, laying a better foundation for potentials for learning and the design of implementation programs and plans. Provide functional descriptions of skills rather than general statements to describe motor skills. Specific examples will be more useful to therapists and other team members.

4. There is a significant need to develop programs to address increasing or expanding functional skills. Formal programming is indicated for a number of individuals. OT/PT staff should also model ways to promote skill acquisition and capitalize on opportunities during groups already implemented by direct support staff in the homes and day programs. A program of this nature could be especially effective if implemented with the SLPs and/or psychology. A temporary shift in focus from assessment to action and implementation to address the intense need for active treatment may be necessary. Working with the home and day program environments on a day to day basis promotes improved and relevant supports as well as ultimately permits ongoing assessment over time throughout the year rather than only at the time of the annual review. It permits observation and interactions in a meaningful way and allows the clinician to take note of potential for skill acquisition.

5. 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. All PNM-related risk issues must be considered when assigning needed frequency of PNMP and mealtime monitoring.

6. Integrate direct and indirect supports into the PSP through the development of SAPs that included measurable goals with performance criteria. Ensure that there is a clear measure of progress related to the goals and that these and other critical clinical measures as well as functional health status indicators to justify initiation, continuation and/or termination of interventions.

7. 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. These same steps could be applied to training techniques and skills as well. This will require the development of a comprehensive curriculum and learning objectives. The outline of training related to completing the monitoring forms was a good start, but more information and content will likely be needed to ensure that the rationale for interventions and supports is well understood. This is particularly important with the expectation that PNMPCs will train others. They will need competency-based training to learn how to support other staff in a manner that is positive rather than judgmental in order to build constructive outcomes.

8. More oversight and directions were indicated for the PNMPCS in order to ensure that there is consistency in the schedule and frequency of monitoring. This should be reviewed for compliance on a routine basis. There were a number of observations noted by the monitoring team that should have been picked up through the monitoring procedures.

9. PNMPs should provide justification for supports outlined as well as a clear link to the health risk indicators identified by all PST members.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o LSSLC Dental Procedures Manual, 3/10/11 o Oral Care Competency and Training Manual o Oral Care PowerPoint Presentation Copy o Attendance Tracking Sheet o Listing, Individuals with PALS for Dental Desensitization o Listing, Individuals who have refused dental services o Listing, Individuals who have had preventive dental care o Listing, Individuals receiving emergency care o Listing, Individuals with extractions Interviews and Meetings Held: o Louis Kavetski, DDS, Dental Director o Brian Carlin, M.D., Medical Director o JoAnne Lancaster, RDH o Marill Gerth, RDH o Frances Tucker, RDH o Evelyn Barnes, Dental Assistant o Nancy DeVore, Dental Clerk o Richard Mendola, M.A., Associate Psychologist Observations Conducted: o Dental Department o Dental Clinic
	Facility Self-Assessment: The facility rated itself noncompliant for both provision items. Significant progress, however, was seen in the dental department with implementation of a home oral care program, increased training of direct care professionals, and the collection and use of data. Most of the changes were implemented less than three months prior to the onsite review, which translated into little impact on outcomes at the time of the onsite review. The majority of individuals supported by the facility continued to have poor hygiene ratings. In addition to this, the facility's attempts at desensitization were by all accounts unsuccessful and actually resulted in a delay of definitive care. The monitoring team, therefore, agrees with the facility's findings of noncompliance.

	Summary of Monitor's Assessment: Progress was noted in the processes related to the provision of dental services. Staffing had been increased, a comprehensive dental procedures manual was developed, an oral hygiene maintenance program was implemented, and data on dental services were collected. The clinic staff was expanded to include two part-time hygienists as well as part-time clerical support. This resulted in a fully staffed dental department consisting of a full time dental director, part-time dentist, a full time hygienist, two part-time hygienists, and a full time dental assistant. The part time hygienists provided oral care in the homes as well as training to the direct care staff. This program was known as the Oral Health Maintenance program and was implemented in January 2011. The addition of the clerical support resulted in development of databases for tracking the work being done in the clinic. The dental director was very enthusiastic about this process and stated that a significant amount of data had been collected and reviewed. The staff found this information very useful in assessing progress and determining causal factors of problems. Failed appointments continued to be problematic and presented significant barriers to the provision of dental care. Desensitization appointments accounted for slightly more than 20% of all clinic visits. There were more than 150 individuals considered to be enrolled in desensitization programs. In spite of this, these plans resulted in successful treatment for just one individual. While the dental staff had put forth substantial efforts and remained eager to move forward, there was no evidence that support was received in developing and implementing desensitization plans. Missed appointments and refusals resulted in many individuals not receiving appropriate care. These barriers were outside of the reach of the clinic staff. Clinical outcomes documented that 67% of the individuals had poor oral hygiene ratings and several individuals were required to have multiple tooth extractions. These outstanding issues resulted in an overall rating of noncompliance.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this	The Dental Department was staffed with a full time dental director, part-time dentist, full time hygienist, two part-time hygienists, a full time dental assistant, and part time clerical support. <u>Data Collection</u> Since the last onsite review, the dental department had began tracking numerous indicators including clinic visits, missed appointments, refused appointments, annual assessments, and oral hygiene ratings. This data were entered into spreadsheets and allowed generation of data and graphs for analysis. This was a tremendous improvement since the last onsite review when a large handwritten log of appointments was	Noncompliance

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	Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	maintained. Notwithstanding implementation of a data management system, problems were identified with data accuracy. Multiple reports and lists were generated for the monitoring team. There was some degree of inconsistency noted across these various documents. The attendance tracking sheet contained nomenclature that varied from month to month. When an appointment was for a procedure it was difficult to determine in which data set the item was included, and there appeared to be some overlap in counting. For example, the attendance tracking sheet listed the total number of individuals receiving treatment as 763. The number 763 was actually the number of appointments completed. Although this contributed to concern about data integrity, it was good to see that the clinic had started the process of collecting data and attempting to transform the data into meaningful information. <u>Oral Health</u> The facility began tracking oral hygiene ratings for individuals. Aggregate data for the facility indicated the 67% of individuals had poor hygiene, 6% had good hygiene and 27% had fair hygiene. The "Oral Health Maintenance Program" was implemented in January 2011. The purpose of the program was to maintain optimal oral health on a daily basis for each individual. In order to achieve this goal, each individual's oral hygiene preferences, strengths, and needs were determined. Challenges and barriers were identified. Providing assessments, oral hygiene, and training within the individuals' natural home environment was a fundamental concept for the program. The program was in the early stages at the time of the onsite review, so outcome data were not available. <u>Staff Training</u> All staff received training during new employee orientation. Additional training was provided through presentations, desensitization video, and a skills lab. The PowerPoint presentations and Oral Care Training Manual provided very detailed information to staff and it was reported that staff were receptive to learning. <u>Services Provided</u> A document entitled "Monthly Procedural Log" was included in the presentation book. This spreadsheet contained all individuals who had appointments and the reason for the appointment. It also indicated if the appointment was missed or refused, or if anesthesia was required. The type of appointments and any referrals generated were also included in the spreadsheet.	

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Visit Type	Sept	Oct	Nov	Dec	Jan	Feb	Total Appointments
Annual	27	40	17	30	32	15	161
Preventive	35	71	35	43	39	87	310
Restorative	3	1	15	8	12	10	49
Extractions	5	10	10	2	43	21	91
Missed	28	36	31	25	24	25	169
Refused	34	42	34	47	25	27	209
Appointments	219	241	173	184	152	171	1141
Desensitization	76	29	42	6	6	0	
Emergency	5	5	5	7	7	7	

Annual assessments were completed on 161 individuals. Approximately 83% of those visits were completed in a timely manner. The assessment was considered timely if it was completed no later than the calendar month of the previous year's assessment.

Preventive care was provided to 220 individuals for a total of 310 visits. This represented 56% of the population based on an average census of 391. Barriers related to the provision of dental care are discussed further in Section Q2. Restorative care was provided during 49 appointments for 19 individuals.

Eighteen individuals had dental extractions completed. Several individuals had multiple extractions. Fifty six percent of the individuals with extractions required removal of two or more teeth. Dental progress notes related to extractions were reviewed for the following:

- Individual #33 had 5 extractions for non-restorable teeth. The individual was edentulous following extraction.
- Individual #50 had a single extraction.
- Individual #526 had a single tooth extracted due to a facial fracture.
- Individual #267 was seen in the dental clinic on 2/16/11 and had multiple extractions. Twelve days later the individual returned to dental clinic with a mandibular abscess and was referred to a local oral surgeon for treatment.
- Individual #267 had a total of 14 teeth extracted. Dental records documented repeat visits to dental clinic that were not successful.
- Individual #64 had five teeth extracted on 10/19/10. Multiple appointments dating back to January 2010 documented periodontal disease and the need for extractions. Desensitization was not successful.
- Individual #229 had four teeth extracted. Dental records documented visits back to early 2009 due to decay and abscess. The individual returned to clinic several times, but refused treatment. Extraction was completed 9/21/10 using TIVA.

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Individual#	Teeth Extracted
567	2
497	4
64	5
306	3
267	8
590	7
371	2
33	5
267	6
534	2

Several of the records reviewed included documentation over two to three years of the need to improve hygiene and receive dental treatment. Lack of aggressive interventions and adequate desensitization plans may have contributed to loss of functional teeth.

Thirty-three individuals had a total of 37 appointments for dental emergencies. The following summarizes a few of the cases submitted for review:

- Individual #43 was seen on 1/24/11 due to bleeding at the gum line of a loose tooth. The progress notes documented that the tooth may gain firmness if left alone.
- Individual #286 was seen on 12/9/10 due to bleeding gums secondary to chronic gingivitis. The recommendation was to achieve good oral care and return for desensitization and possible TIVA.
- Individual #526 was seen on 11/17/10 due to a broken tooth. The tooth was extracted on 1/3/11.
- Individual #305 was seen by the primary care provider on 2/22/11 due to a broken tooth. The individual was seen in dental clinic the same day. Dental notes documented that the only way to restore the tooth should be to utilize sedation and/or TIVA.
- In 271 was seen on 9/13/10 due to dry mucosa. Chapstick was recommended.
- Individual #99 was seen on 9/13/10 for a chipped tooth. This finding had been previously noted and required no treatment.
- Individual #580 was seen in clinic on 2/10/11 with mild facial swelling. The individual was started on antibiotics and pain medication. Multiple follow-up visits occurred. On 3/8/11 the individual had definitive treatment utilizing TIVA.

The records of emergencies did not provide documentation to resolution. The initial treatment and treatment plans appeared appropriate for the presenting problems.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>Q2</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.</td><td><u>Failed Appointments</u>
The document Attendance Tracking Sheet provided the following data for the past six months (September 2010 – February 2011):
• Total appointments 1141
• Total individuals receiving treatment 763
• Total individual refusing services 209
• Total missed appointments 169

<table>
<tr><td></td><td>Sept</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td></td></tr>
<tr><td>Total Missed Appointments</td><td>28</td><td>36</td><td>31</td><td>25</td><td>24</td><td>25</td><td>169</td></tr>
<tr><td>Total Refused Appointments</td><td>34</td><td>42</td><td>34</td><td>47</td><td>25</td><td>27</td><td>209</td></tr>
<tr><td>Total Failed Appointments</td><td>62</td><td>78</td><td>65</td><td>72</td><td>49</td><td>52</td><td>378</td></tr>
</table>

There were a total of 1141 appointments.
• 763 of 1141 appointments (66%) were completed
• 209 of 1141 appointments (18%) were refused
• 169 of 1141 appointments (15%) were missed
• 378 of 1141 appointments (33%) failed

There were a total of 169 missed appointments. The clinic staff attempted to identify the reason for missed appointments and included these data in the monthly procedural log. The list of individuals who missed appointments contained the reason and next clinic date. Reasons for missed appointments included:
• 12 of 169 (18%) were due to no shows
• 32 of 169 (19%) were due to illness or medical appointments
• 14 of 169 (8%) were due to lack of medical records
• 12 of 169 (7%) were due to staffing issues in the homes
• 17 of 169 (10%) were due to off campus activities
• 23 of 169 (14%) were due to inclement weather
• 9 of 169 (5%) were due to dental clinic staffing issue

A total of 56 individuals refused 209 appointments. When an individual refused or missed an appointment, the dental director sent a report to the QMRP, home manger, and unit director. This report informed the parties that the individual had a failed appointment. It further requested feedback on what was needed to increase the chance of a successful appointment. The team was requested to return the form to dental clinic. Two responses were provided. One suggestion was to have the individual seen on a day that a preferred staff member was working. The other, from a home manger, stated " I am sorry, but I do not have any ideas for individual we are having the same problems with other appointments." Overall, the clinic staff indicated that some improvement was</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		seen in collaborative efforts and staff appeared eager to learn and correct problems. TIVA was used for a total of 31 times. Pretreatment sedation was used 13 times. In each instance, it was documented that the individual had been undergoing desensitization and failed. More than 150 individuals were enrolled in the desensitization program. Ninety-four percent of the desensitization appointments occurred during the months of September 2010– November 2010. There were no desensitization appointments in February 2011. According to the Dental Procedures Manual, the dental staff reviewed the clinic record for a current personal dental desensitization plan if none was in the record he dental clinic contacted the QMRP to request a plan. . The monitoring team discussed the desensitization program with the medical director, dental director, RDH, and Psychologist. All acknowledged that at the time of the onsite review, there were no formal desensitization plans in place and psychology had no active role in the development of desensitization plans. Desensitization plans for the dental clinic were actually developed by the full time RDH who completed the Positive Assessment of Living Skills. This was a 20-step process intended to gradually introduce individuals to the clinic and treatment process. The clinic staff reported that most individuals did not progress past step 16, which required that the individual open his or her mouth. In fact, the dental director reported that this program resulted in a successful outcome for only one individual. The dental director and RDH expressed that they felt that they did not have adequate training to properly write and implement desensitization plans. Several individuals had been participating in this program for up to two years with no success and oral treatment was delayed.	

Recommendations:

1. The Dental Department should continue to fine-tune its data management system. Data should be reviewed to ensure that data is accurate and that multiple entries do not occur. The terminology used in the various documents should be consistent.

2. The facility must introduce accountability with residential managers to ensure that there is full collaboration with the dental clinic in resolving missed and refused appointments.

3. The PSTs must intervene when the desensitization plans do not progress and treatment is not received.

4. The Psychology Department must take an active role in the desensitization program. Persons identified as needing desensitization should be

assessed for appropriateness of desensitization plans. It is unlikely that 157 individuals are appropriate candidates for desensitization.

5. Documentation related to emergency care should be continued until the problem is resolved.

6. The facility should expand the use of suction toothbrushes to include all individuals who are at high risk for micro-aspiration of salivary secretions.

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 SLP Clinical Staff o LSSLC POI for Section R o LSSLC Organizational Charts o Habilitation Therapies staff list (4/20/11) o Staffing data o Section R Presentation Book o Client List (3/10/11) o Admissions Activity (3/9/11) o At Risk List by Home (3/16/11) o Comprehensive Communication Monitoring tool o Comprehensive Communication Monitoring Training o Completed Communication Monitoring tools submitted o Settlement Agreement Cross referenced with ICF-MR Standards o PNMPs submitted o PNMP/PSPA Tracking forms o List of PNMPs and Profiles o Communication Master List o Priority 1a Individuals Receiving Therapy and Those with Service Objectives o People Who Have AAC on Their Homes o People Who Should Have AAC on Their Homes, but Do Not Have It, or Do Not Have a Training Objective for It o Communication Skills Therapeutic Equipment (3/11/11) o List of individuals with Behavioral Issues and Coexisting Severe Language Deficits o List of Individuals with PBSPs and Replacement Behaviors Related to Communication o Communication evaluations: • Individual #300, Individual #57, Individual #84, Individual #385, Individual #133, Individual #253, Individual #410 and Individual #480. o Communication Evaluation template o Individual receiving Direct Speech/Language Therapy o PNMP list 2/11/11 o Information from the Active Record including PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms, PSP reviews by QMRP, PBSPs, annual Physician Summary, Active Medical Problem list, hospital summaries, GI consults, Orthopedic consults, diet order, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Aspiration Triggers Data Sheets (1/1/11 to present), Weight Record (last 12 months), documentation from Habilitation Therapies tab, all documents in PNMP tab, all documents in Nutrition tab, MBSS

completed in the last 12 months, Mealtime, Communication, PNMP Monitoring sheets completed during the last three months, all PNMPs for last 12 months, all Dining Plans for last 12 months, NMT documentation last 12 months for the following individuals:

- Individual #593, Individual #245, Individual #96, Individual #47, Individual #267, Individual #248, Individual #161, Individual #551, Individual #182, Individual #342, Individual #535, Individual #1, Individual #310, Individual #502, Individual #298, Individual #321 and Individual #385. Records for Individual #16, Individual #599 and Individual #172 were also requested, but were not submitted.

Interviews and Meetings Held:

- Danielle Perry, Au.D, CCC-A, Habilitation Therapies Director
- SLPs
- PNMP Coordinators
- Various supervisors and direct support staff

Observations Conducted:

- Living areas
- Dining rooms
- Day Programs

Facility Self-Assessment:

LSSLC's self-assessment identified noncompliance for all items in this provision. The self-assessment was consistent with the monitoring team's assessment of noncompliance for each aspect of this provision. Comments stated actions taken that were determined to be related to each provision item, but there was no clearly stated plan to achieve compliance with progress tracked by completion of each specific action step. This approach appeared to be random and reactionary rather than a plan to direct focus, work products, and effort by staff. Action steps should be stated in measurable terms with evidence required to demonstrate completion of the interim steps.

Summary of Monitor's Assessment:

There was little progress noted since the previous review. The speech staff reported that not all individuals who needed AAC and other communication supports and services received them. There was only one full time clinician assigned to provide communication services and one part time therapist one day a week. This was a gross understaffing of a critical aspect of comprehensive supports and services that potentially impacted every individual living at LSSLC. Everyone communicates in some way and many require interventions and supports to enhance or augment those efforts and many others would benefit from refinement and expansion for skill acquisition in the area of communication. Only 10 evaluations were listed as complete, per the Master Plan, and at the current rate, it would take over six years to complete assessments for all individuals. Not only were the clinicians unable to complete assessments in a timely manner, implementation of supports and services was limited. Many of the existing AAC systems in use at

	this time had previously been in use and did not reflect newly identified supports. There were recommendations made within the last year that had not yet been implemented. Recognition of the priority for the communication needs of individuals living at LSSLC was not reflected in the current staffing allocation and assignment. The majority of the AAC systems were portable and intended to be functional in a variety of settings. These were few in number. During observations, devices were not observed to be in use. Staff did not appear to understand how to use these in programming or functionally throughout the day. Direct support staff and classroom instructors were insufficiently trained to integrate informal communication programming throughout the day or to capture those teachable moments that occurred in order to promote communication skill acquisition. A focus on activities designed to promote actual participation, making requests, and other communication-based activities, using assistive technology, is critical. This will require that the clinicians are sufficiently available to model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts. Another significant concern involved those individuals who may have been more verbal or partially verbal, but exhibited maladaptive behavior that had a foundation in their difficulty with communication skills. These individuals may not be viewed as a priority related to their communication risks, however, significant problem behaviors emphasized the necessity for a strong collaborative approach by PSTs, led by psychology and speech clinicians, in order to develop effective interventions to address these needs. Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology, should be made a priority. This will only be possible when the clinicians are sufficiently available to model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and	**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 two full-time SLPs employed at LSSLC, (Rhonda Hampton, MS, CCC-SLP and Kristi Hodges, MS, CCC-SLP). Two other SLPs previously employed had resigned since the previous review. Candace Crawford, MS, CFY/SLP worked full time and was scheduled to complete her fellowship year and would become fully licensed in June 2011. She was supervised by 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. Candace Crawford started her fellowship at LSSLC in June 2010 and became a	Noncompliance

#	Provision	Assessment of Status	Compliance
	implement programs, provide staff training, and monitor the implementation of programs.	fulltime SLP on 9/7/10. A stipend student was scheduled to begin on 6/1/11 and would complete her clinical fellowship at LSSLC over the next year. A contract therapist, Debra Brown, MS, CCC-SLP with significant background in AAC and assistive technology provided services eight to 15 hours a week at the time of this review. She implemented the Campus-Wide Augmentative/Alternative Communication Program. Each of these clinicians was documented to have current licenses to practice as an SLP. Graduate student clinicians from Stephen F. Austin University were also to begin completing assessments with supervision by Ms. Brown. Additional consultation services were provided by a Dynavox representative and an OTR with Technology Access, Incorporated, related to AAC as well an SLP with bilingual skills to complete assessments for those whose primary language was Spanish, were bilingual, or for those with family history of speaking Spanish. There was one speech technician working with the clinicians for approximately three hours per day, five days a week. There were two full time positions for SLPs currently unfilled. As stated above the department Director was Danielle Perry, Au.D, CCC-A. Each of the full time clinicians had participated in continuing education related to communication since the previous review. Other than supervision of the CFY clinician (Candace Crawford), Ms. Hodges' work focus was in the area of dysphagia. Ms. Hampton's primary work focus was also related to dysphagia. Only Ms. Crawford had primary responsibilities in the area of communication. In her first year of practice as a speech language pathologist and still requiring supervision, she was assigned to 20 homes for communication services (391 individuals) and to three homes for swallowing/dysphagia. Assigned work responsibility related to communication was very limited to only one full time CFY clinician, one part time clinician with a focus on AAC (eight to 15 hours per week) and outside assistance from graduate students to complete assessments (not yet implemented). Recognition of the priority for the communication needs of individuals living at LSSLC was not reflected in the current staffing allocation and assignment. **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.** Each individual had been previously screened and ranked based on need for AAC and documented in the Master Plan. The schedule for communication assessments was based on these priorities and had been implemented as of 12/1/10. Based on the Master Plan submitted, there were 77 individuals identified as Priority 1a	

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		(individuals in communication therapy or who had service objectives), 86 individuals as Priority 1b (individuals who were nonverbal with BSPs), 101 individuals as Priority 2 (individuals who were nonverbal without BSPs), 64 individuals as Priority 3 (individuals with limited speech), and 70 individuals as Priority 4 (individuals who had very little difficulty communicating). The Master Plan identified only 10 individuals with completed communication assessments and another two who were newly admitted with completed evaluations (Individual #340 and Individual #256). The first estimated completion dates had been scheduled for 11/3/10 (Individual #133, Individual #480, Individual #542, Individual #27, Individual #51, and Individual #104) and 12/31/10 (Individual #57). There were no other established due dates until 3/4/11. Only three others had been completed and were not completed in order of the established due dates, including Individual #84 (6/10/11), Individual #300 (3/11/11), and Individual #568 (7/1/11). It was not clear why these had been completed out of order. The Master Plan indicated that the remaining 67 individuals identified as Priority 1a would be assessed by 7/1/11. To date, however, only seven evaluations had been completed in December 2010, one was completed in January 2011, and two completed in March 2011. No evaluations had been completed in February 2011 or April 2011. Only two of the completed assessments had been completed prior to the date estimated in the Master Plan. These 10 assessments had been completed by the CFY clinician and the part time contract therapist. Per the existing Master Plan, evaluations for Priority 1b individuals would be completed from 7/8/11 to 9/30/11, Priority 2 individuals would be completed from 9/30/11 through 11/11/11, and Priority 2 individuals would be completed from 11/11/11 through 1/13/12. Priority 2 and 3 individuals would be completed from 1/13/12 through June 2012. At the current rate, assessment for the individuals with the highest needs for communication supports and services would take over six years. Even with graduate student assistance for completion of assessments, implementation of supports and services indicated would take considerably more time and resources. At the current staffing levels and work load assignments, LSSLC would not be able to meet the provisions outlined in section R of the Settlement Agreement. During a group interview with the monitoring team, the speech staff reported that not all individuals who needed AAC and other communication supports and services received them. A Communication Skills Therapeutic Equipment spreadsheet submitted and dated 3/11/11 listed 401 individuals. Findings included the following: • There were 19 individuals listed with communication books, and another two who were recommended for books, but they were not yet issued. Only five of these had been issued in the last two years; a number had been provided over 10	

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		years ago. The book for Individual #309 was listed as recommended in 1999, but had never been issued. Two others previously had books that had been discontinued. • There were 40 individuals with community posters. Most of these had been issued within the last two years, though there were six that had been implemented for over 10 years. Another eight individuals were recommended for a poster. All but one of these had been recommended over a year ago and none had yet been issued. There were nine individuals who previously had a community poster, but it had been discontinued per the database. • There were seven individuals listed with communication boards. Most of these had been in place for over 10 years. • There were 15 individuals listed with a Dynavox system, four of which had been provided by the school district and were unavailable to the individual at home. Each of these had been issued within the last three years, though the device for Individual #263 had been issued on 5/27/10 and reported lost in July 2010. It had not been replaced to date. Another five had been recommended or requested and one was on order, but none of these had been issued. • There were five individuals listed with a recommendation for a PECS system though none had been issued. The recommendations were dated from June 2009 to December 2010. • There was one individual for whom a voice output device had been issued. Another 13 were recommended for a device, but had not been issued to date. Some of the recommendations dated over one year ago and had not yet been provided. A device for Individual #425 had been recommended in August 2009 and again on 7/13/10, but had not yet been provided to him. • Access switches that were not likely communication-related devices, but rather environmental control switches were recommended for 52 individuals, but none of these had been issued per the spreadsheet submitted. Over 70% of these had been recommended more than a year ago with some nearly three years earlier, and two individuals had been recommended for this device twice and it had not yet been provided to them (Individual #369 and Individual #540). • There were approximately 60 individuals listed with 79 communication systems of some type. Over 30% of these devices had been in place prior to 2009. • There were another 32 communication systems for 30 individuals that had been recommended, but not provided. Five of these systems were for individuals listed with another device already issued. Nearly 60% of these had been recommended over one year earlier and had not yet been provided. Another list submitted identified 89 individuals with the following AAC in their home: • 40 communication posters	

#	Provision	Assessment of Status	Compliance
		• 11 Dynavox devices • 3 voice output devices • 14 communication books/notebooks • 2 talking photo albums • 5 communication boards • 1 communication builder device • 21 capability/pancake/joystick/other switches • 4 environmental control switches In addition, there were 38 individuals identified who should have AAC, but did not and/or they did not have a training objective for the device available. In some cases, the device recommended by the SLP was not available in the home and, in some cases, a device was in use, but it was not the one recommended by the SLP. Records of 17 of 20 individuals included communication-related assessments and documentation. Five communication assessments completed by each speech clinician were also requested. A statement submitted indicated, as reported above, that Ms. Hodges and Ms. Hampton did not provide communication assessments at the time of this review. Two assessments completed by Debra Brown (Individual #410 and Individual #253) and five completed by Candace Crawford were submitted (Individual #84, Individual #133, Individual #57, Individual #300 and Individual #480) for review. In addition, as assessment for Individual #104 dated 12/3/10 was submitted as an aspect of the presentation book submitted for section R. Of the assessments reviewed as submitted, 87% (21 of 25) indicated that the individuals presented with significant communication deficits. Three individuals (Individual #310, Individual #57 and Individual #267) were reported to be verbal with functional expressive and receptive communication skills. One individual (Individual #321) did not have a communication assessment submitted with the records as requested. A single page document dated 11/12/07 was submitted that indicated she was not seen due to her medical status at that time. The recommendation was that she would be assessed when her health status had stabilized. There was no evidence that she had been evaluated since that time. It appeared that only 13 of the 25 individuals (52%) for whom assessments were reviewed had assessments that were current within the last two years. Of those with identified communication skill deficits, only seven were recommended for specific communication supports and services designed to improve or augment existing language and communication skills. Assessments submitted for Individual #267, Individual #321,	

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		Individual #47, Individual #551, Individual #96, Individual #182, Individual #1, Individual #298, Individual #535, Individual #385 and Individual #245 were not current within the last 12 months. Additionally, in several cases, strategies for staff use to address communication skills were outlined in the assessment, but were generally designed to encourage use of existing abilities rather than to promote further skill acquisition in the area of communication. There were 32 individuals living at LSSLC who received direct communication services as evidenced by the documentation submitted and as reported by the clinicians. Approximately seven individuals had formal SAPs designed and monitored by SLPs with implementation by technicians, day program staff, or direct support professionals designed to expand or enhance existing communication skills. The 25 others were involved in exploratory or diagnostic therapy for the development of AAC systems or for training in the use of a specific device with no established training objectives. Overall, there were at least 264 individuals living at LSSLC who were identified as nonverbal or minimally verbal and were not considered to be functional communicators. They had significant communication limitations with likely potential to benefit from AAC supports and services. Per the Communication Master Plan Database, there were approximately 60 (23%) individuals who had potential to benefit from AAC who had some type of AAC system other than a Communication Dictionary. Another 64 individuals were identified with limited speech skills and may also benefit from communication supports.	
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.** A newly implemented assessment format had been implemented as of 2/1/11 and a Master Plan designed to prioritize completion of assessments was in place, however, as stated above, only 10 assessments had been completed and it would not be possible to complete communication assessments in the timeframe designated by the Settlement Agreement. All but one of the assessments (Individual #248) included in the sample reviewed by the monitoring team had been completed prior to implementation of the new format. The five most current SLP assessments for each clinician with the related PSPs were requested by the monitoring team. Only seven assessments for the two clinicians responsible for communication services were submitted (listed in the documents reviewed above). Each was a baseline assessment and only four had been completed since implementation of the new assessment format. An additional assessment for Individual #104 was submitted in the presentation book. The assessments completed by the contract SLP, Debra Brown, loosely followed the newly implemented format as outlined with better consistency noted in the assessments	Noncompliance

#	Provision	Assessment of Status	Compliance
		completed by Candace Crawford. The baseline assessment format was generally comprehensive. **Standard: All people received a communication screening or assessment within 30 days of admission, readmission, or change in status.** Per the list submitted, there had been three admissions to LSSLC in the previous six months including Individual #256, Individual #340, and Individual #279. Per the Master List submitted, assessments had been completed for Individual #340 and Individual #256, but not for Individual #279. There was no evidence that assessments were completed for individuals who had experienced a change in status. For example, as described above, an assessment for Individual #321 was not completed due to her medical status change in November 2007 and there had been no subsequent update since that time. Per the Master Plan, she was designated as Priority 1b and was not scheduled for a communication assessment until 7/8/11. It appeared unlikely, however, based on the current rate, that this would occur in a timely manner because there were nearly 70 other individuals who had yet to be evaluated and were considered to be higher in priority than Individual #321. **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 new communication assessment format generally addressed both verbal and nonverbal skills and expressive and receptive language skills. Each of the assessments in the new format had recommendations related to AAC and direct therapy. **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.** Individuals were to be provided an assessment based on the Master Plan, per the prioritized schedule. The intended plan was to provide re-evaluation every three years for each individual with interim updates on an annual basis for those who received supports and services. The intent of the interim update was to review the individual's	

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		status and the relevance and appropriateness of the supports provided. It did not appear that the updates were being completed consistently at this time as there were two individuals (Individual #1 and Individual #535) who were listed as receiving direct services, yet neither had been evaluated by the SLP since 2008. With the recent implementation of the assessment template and the Master Plan it was not possible to assess the consistency of re-assessment to review the adequacy of the supports provided. **Standard: Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.** As stated above, there were seven individuals listed with measurable goals and objectives listed related to direct therapy with an SLP. Approximately 25 others also participated in direct communication-related services. In most of these cases, however, there were no measurable outcomes for the individuals outlined (training objectives), but rather service objectives were listed to explore potential for AAC and/or to provide training related to a specific device. **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.** There was no policy or assessment/screening to identify those who received behavioral supports and interventions, such as a PBSP, and would benefit from AAC or other communication-related interventions. There were at least seven individuals for whom assessments were reviewed who had PBSPs with communication-related behavioral concerns: Individual #161, Individual #182, Individual #593, Individual #245, Individual #321, Individual #410 and Individual #480. Only Individual #593, Individual #410 and Individual #480 had communication evaluations current within the last two years. There was only a brief reference to these plans in these communication evaluations. There was evidence of collaboration with psychology in the case of Individual #480 only. There was limited analysis of the relationship of communication to these behavioral concerns. A list of individuals with PBSPs and replacement behaviors related to communication was submitted that listed approximately 86 individuals. Another list submitted identified Individuals with Behavioral Issues and Co-existing Severe Language Deficits and identified 126 individuals. Approximately, 92 individuals were included on one list, but not the other. It did not appear that the facility had a consistent method to identify individuals who	

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		required communication-related behavioral supports or to provide appropriate communication supports to those with associated behavioral concerns. **Standard: Communication programs were integrated into the BSP as indicated.** Though requested for the individuals included in the sample selected by the monitoring team, only three PBSPs (Individual #248, Individual #161 and Individual #182) of the five individuals who were listed with a plan were submitted for review. As stated above, neither had an assessment current within the last two years and, as such, adequate and relevant communication programs or supports would not be appropriately integrated into the design of these behavior plans. There were a number of other individuals who were described as verbal, yet presented with significant challenging behaviors that would benefit from collaboratively designed and implemented supports, interventions and programming. For example, there were 14 individuals whose speech was described as limited and who also had PBSPs with replacement behaviors related to communication. There were nine individuals identified as a Priority 4, or individuals who communicated without difficulty, yet these same individuals were listed with PBSPs and replacement behaviors related to communication. Clearly there was inadequate collaboration between speech clinicians and psychology to appropriately address communication-related behaviors. **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. The Master Plan recorded completion of assessments. The plan was intended to prioritize those individuals who would most benefit from AAC devices or equipment. AAC provided to individuals was to be listed in the Master Plan as well. There was no facility policy that outlined the communication assessment schedule, guidelines to prioritize assessments, or that established specific staff responsibilities. A Master Plan had been developed and was being implemented at the time of this 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	**Standard: The PSP contained information regarding how the person communicated and strategies staff may utilize to enhance communication.** The information contained in the PSPs related to communication was extremely inconsistent across the plans reviewed. Of the 15 PSPs submitted, only nine were of the new format and the potential for improved descriptions was noted, but was not well	Noncompliance

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	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.	implemented at this time. There were no communication assessments as an aspect of the PSP for any of those individuals. There were a few very limited descriptions of how the individual communicated and no descriptions of strategies that staff were to use to enhance communication. For example: • Individual #551 (2/2/11) was described in the Social Update with no functional communication skills with some vocalizations. There were no strategies described for staff use to enhance communication though there were training objectives listed that were communication-related. As there was no communication assessment completed, it was not possible to assess if these were appropriate. There was no SLP present at the PSP meeting. • Individual #182 (12/8/10) was described in the Social Update as nonverbal, but used noises, reaching, gestures, and facial expressions to communicate. He presented with aggressive behaviors. There were no communication-related training objectives and no communication assessment completed. There was no SLP present at the PSP meeting. • Individual #321 (11/3/10) was described as nonverbal. There was no communication assessment completed though there were several communication-related training objectives identified. There was no SLP present at the PSP meeting. • Individual #161 (2/9/11) was described as able to speak in short phrases, but was difficult to understand. She was reported to point or gesture toward what she wanted. The psychology assessment described a need to teach her more appropriate forms of communication to express her desires. There was no communication assessment completed by the SLP and there were no communication-related training objectives in her PSP to address her behaviors concerns. An SLP did attend her PSP meeting on this date. • Individual #385 (1/12/11) was described as nonverbal and that staff had to anticipate his needs and wants. He had a training objective to respond to his name or greeting. There was no communication assessment completed and no representation by speech at his PSP meeting. • Individual #535 (10/13/10) was described as nonverbal and used eye contact, vocalizations, and facial expressions to communicate. There was no communication assessment available for the PSP. There were no communication-related training objectives and an SLP did not attend this meeting. There was a PSP Addendum dated 1/25/11 to implement the use of a Dynavox M3. There had been no communication assessment for Individual #535 since 10/30/08 and, per the Master Plan, he was considered to be Priority 1a and scheduled for assessment by 7/1/11. • Individual #248 (3/9/11) was described as nonverbal, using gestures and signs similar to sign language to communicate. He also was reported to use a Dynavox	

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		V per the psychology assessment. There was no communication assessment included in the PSP, though it was recommended that he use the Dynavox during daily activities and training. The only communication-related training objective involved him taking his device to be charged each evening. There was no SLP present at this PSP meeting. There was a PSP Addendum dated 4/7/11 to review the findings of his communication assessment completed on 3/3/11. Recommendations included the provision of a sign language interpreter, use and support of a Dynavox V, and the implementation of a skill acquisition program for direct communication therapy. • Individual #96 (3/15/11) was described as expressing herself using facial expressions and vocalizations. There was no assessment or training objectives related to communication. An SLP attended this meeting. • For the other seven PSPs submitted that were in the previous format, only three meetings had been attended by an SLP and only four presented a communication assessment. **Standard: AAC devices were portable and functional in a variety of settings.** The majority of the AAC systems recommended were portable and intended to be functional in a variety of settings. There were no instructional plans submitted as requested to guide staff implementation or support of the devices issued to individuals per the Master Plan. During observations throughout the facility, there were no devices that were observed in use. Communication posters were intended to be in use in day programs and were not consistently available. As described above, there were a number of AAC systems recommended, but not yet issued per the spreadsheet submitted. **Standard: Communication programs and AAC devices were individualized and meaningful to the individual.** The existing AAC systems, though few in number, appeared to be individualized and there was an obvious effort to make them meaningful as well. The facility was planning to contract with a bilingual SLP to complete assessments for individuals who spoke Spanish, understood Spanish, or who had a family history of Spanish language use. In addition, the facility had acquired the services of a sign language interpreter for Individual #176 during meeting and appointments. In addition, a technician was available who also used sign language. There were recommendations for these services for others also including Individual #248, for example. While a number of individuals participated in direct communication therapy and the assessment process was more comprehensive, the majority of individuals had not yet received an assessment.	

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		Standard: Staff were trained in the use of the AAC. Direct support staff were insufficiently trained to integrate informal communication programming throughout the day or to capture those teachable moments that occurred in order to promote communication skill acquisition. There were limited formal communication programs and no SLP support was provided to most of these. Debra Brown, MS, CCC-SLP implemented the Campus-Wide Augmentative/Alternative Communication Program (3/2/11) which was designed to ensure that all direct support professional staff were appropriately trained. The focus of this program included identification of skills, referral procedures, training methods and basic AAC product information. There were no instructional plans submitted or observed as available for AAC use. The Communication section of the PNMPs provided very limited information about how the individuals communicated and rarely provided instruction as to how staff could support or enhance both expressive and receptive language other than a reference to the communication dictionary. As described above, staff did not demonstrate a good understanding of how to promote language or communication opportunities in the daily routine or during structured programming throughout the day. **Standard: Communication strategies/devices were implemented and used.** There were few AAC systems observed being used throughout this onsite visit. Much of the interaction observed by the monitoring team was specific to a task with little other interactions that were meaningful, such as during a meal. The AAC Program recently implemented was a good start. Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology, should be made a priority. This will only be possible when the clinicians are sufficiently available to model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts. **Standard: General AAC devices were available in common areas.** A number of community-use devices were available in the homes. These non-portable devices may be useful as a backup or extra system for individuals, but should not be used as a primary augmentative or alternative means of communication for an individual. None of these were observed in use during the onsite review by the monitoring team.	
R4	Commencing within six months of	**Standard: A monitoring system was in place that: tracked the presence of ACC;**	Noncompliance

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	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.	**working condition of AAC; the implementation of the system; and effectiveness of the system.** There were no policies related to a monitoring system for AAC. It was reported that there had been intense monitoring related to mealtimes and that, only recently, had communication monitoring been initiated. Only 14 Comprehensive Communication Monitoring forms had been completed for eight individuals from 1/14/11 through 3/18/11. These were completed by PNMP monitors from 1:00 pm through the evening hours. None were completed in the morning. Each review occurred in the home and none appeared to have been conducted in the day program areas. The indicators required the monitor to make a judgment as to the effectiveness of the device, but that was not within the scope of a paraprofessional's role. For example: "Is the AAC device effective for the individual?" and "Is the AAC meaningful to the individual?" The SLPs should have routine and frequent responsibilities to monitor communication programs beyond the annual assessment or requests and referrals to assess actual use of the devices issued as well as the effectiveness for the individual. **Standard: Monitoring covered the use of the AAC during all aspects of the person's daily life in and outside of the home.** As stated above, it appeared that monitoring occurred in the homes only at this time. **Standard: Validation checks were built into the monitoring process and conducted by the plan's author.** There was no validation check provided for monitors at the time of this review. Training was provided with written guidelines intended to guide completion of each indicator to be monitored. Further assessment of this element will be necessary in future reviews.	

Recommendations:

1. Develop a clearly delineated plan to address staffing and assignment of roles and responsibilities. There is currently insufficient focus on communication supports necessary to meet the needs of the individuals living at LSSLC or to meet the requirements of this Settlement Agreement provision. Provide assessment and collaboratively (PSTs guided by psychology and speech clinicians) designed and implemented supports, interventions, and active programming for individuals who were currently identified as Priority 2 or 3 and verbal, but presented significant challenging behaviors. Also see #3 below.

2. 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. Ensure all of these are integrated into the PSP process.

3. There is a need to develop programs to address increasing or expanding language skills, ability to make requests and choices, and other basic communication skills. Formal programming is indicated for a number of individuals. Speech staff should also model more informal ways to promote interaction and capitalize on opportunities during groups already implemented by direct support staff in the homes and day programs. A program of this nature could be especially effective if implemented with OT and PT and/or psychology.
    a. A temporary shift in focus from assessment to action/implementation may be necessary. Working with the home and day program environments on a day to day basis promotes improved and relevant supports as well as ultimately permits ongoing assessment over time throughout the year rather than only at the time of the annual review. It permits observation and interactions in a meaningful way and allows the clinician to take note of potential for skill acquisition.

4. Consider expanding the NEO training to teach staff to understand how to be an effective communication partner. As AAC is developed, it then becomes a method much like speech, rather than a unique entity in which the functional purpose becomes lost on staff. When that happens, it loses meaning for them as well. It becomes a "task" and is not integrated into the individual's daily routine.

5. Routine monitoring needs to include a review by professional staff as to the effectiveness of AAC systems, as well as formal and informal programming rather than only availability and condition of existing systems.

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

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:** Documents Reviewed: o Personal Support Plans for: • Individual #24, Individual #170, Individual #600, Individual #587, Individual #221, Individual #27, Individual #435, Individual #119, Individual #410, Individual #166, Individual #258, Individual #267, Individual #498, Individual #349, Individual #162, Individual #157, Individual #557 o Dental Desensitization Plans for: • Individual #226, Individual #145, Individual #29, Individual #385, Individual #133, Individual #231, Individual #532, Individual #271, Individual #397 o Skill Acquisition Plans for: • Individual #518, Individual #75, Individual #132, Individual #93, Individual #21, Individual #244, Individual #344, Individual #479, Individual #126, Individual #392, Individual #27, Individual #587, Individual #600, Individual #119, Individual #221, Individual #24, o Skill Acquisition Plan data for past 6 months for: • Individual #518, Individual #75, Individual #132, Individual #93, Individual #21, Individual #244, Individual #344, Individual #479, Individual #126, Individual #392, Individual #600, Individual #435, Individual #587, Individual #27, Individual #119, o Quarterly reviews of Skill Acquisition Plan data for: • Individual #21, Individual #132, Individual #424, Individual #244, Individual #223, Individual #404, Individual #262, Individual #90, Individual #91 o Personal Support Plan Format (form 6609.1, 2011) o List of individuals who are employed on- and off-campus, undated o Progress notes for individuals receiving skill acquisition training in the community o Action plans for improvements in active training, undated o Active treatment staff training, undated o Active treatment schedule for 561A, 549B, undated o Instructions for conducting various activities, undated o Active treatment monitoring tool, dated 10/26/10 o Engagement monitoring form, dated 4/18/11 o Active treatment engagement scores summarized across several homes, 2/22, 3/11 o Performance Improvement Team meeting minutes, 3/1/11, 3/10/11 o List of individuals who lived at LSSLC and received services from LISD, dated 4/7/11 o MOU between LSSLC and LISD, 8/16/10 o List of individuals returned to LSSLC from LISD, including date and reason, 10/25/10-4/18/11

	o LISD LSSLC classroom schedule o List of individuals who graduated, prior to age out and reasons why (four individuals) o ARD/IEP, LISD progress report, and LSSLC PSPs for • Individual #162, Individual #157, and Individual #557 <u>Interviews and Meetings Held</u>: o Luz Carver, QMRP Coordinator and LSSLC Liaison to LISD o Robert Cheshire, QMRP and Delaina Dearing , QMRP Assistant o Barbara Draper, Active Treatment Director o Marvin Stewart, M.A, Program Compliance Monitor o S. Oliver, SAP trainer, vocational services o Ms. Gainsforth, LISD teacher who attended an annual PSP at LSSLC for her student o Ms. Antley, LISD classroom teacher at LSSLC <u>Observations Conducted</u>: 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; 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 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, there were several improvements since the last review. These include: • Modification to PSP to attempt to better ensure that SAPs are based on need and preference • Consistent graphing of skill acquisition plan outcomes

	• Development of a new engagement tool • Establishment of individual engagement goals • Training of all direct care professionals (DCPs) in the implementation of individual engagement • Development of a data system to track and improve training of individuals in the community The monitoring team believes that these improvements could result in a dramatic improvement in this provision if they are coupled with a reorganization and simplification of how skill acquisition programming is organized, implemented, and monitored at the facility.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision required an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at LSSLC. As indicated below, more work needs to be done at the facility to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance with this provision. <u>Skill Acquisition Programming</u> Personal Support Plans (PSPs) reviewed indicated that all individuals at LSSLC had multiple skill acquisition plans. These plans consisted of Skill Acquisition Plans (SAPs) that were written and monitored by QMRPs (qualified mental retardation professionals). QMRP assistants trained direct care professionals (DCPs) in the implementation of SAPs, and monitored progress. Vocational SAPs were written and monitored by employment services personnel. As discussed in the last report, an important component of effective skill acquisition plans is that they are based on each individual's needs identified in the Personal Support Plan (PSP), adaptive skill or habilitative assessments, psychological assessment, and individual preference. In 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. The facility has made some progress in this area since the last review. The PSP format had been modified to include specific questions concerning how an Individual's SAPs addressed the needs of each individual. Nevertheless, in reviewing 17 PSPs, 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 are based on individual needs and preference. A direct way to ensure and document that SAPs are based on individual needs and preference is to simply include on the SAP training instructions the reason/rationale for the selection of each new skill. An example would be: • A SAP for drying feet was implemented, because nursing determined that	Noncompliance

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		repeated skin breakdown on the individual's feet was due to inadequate drying after a shower. • A SAP for measuring lengths of wood was implemented because the individual wants to work in a woodworking shop, but he cannot measure. Once identified, 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 As discussed in the last report, the SAPs at LSSLC consistently <u>included</u> many of these components, such as task analysis, behavioral objectives, operational definitions, specific training instructions, the documentation methodology, and the use of consequences for incorrect responses. The <u>quality</u> of some of these components, however, was not found to be adequate. For example, Individual #518's socialization SAP was defined as "… will relax when the instructor rubs lotion on his hands…." This objective is not operationally defined because the DCP implanting it would need to infer when Individual #518 is relaxed. Additionally, the SAPs reviewed did not 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. Another direct way to accomplish this would be to modify the SAP training instructions to ensure that the above components have been included. For example, SAP instruction sheets could include the use of relevant discriminative stimuli, specific consequences for correct responses, and a plan for maintenance and generalization of skills. At the time of the onsite review, the training methodology for SAPs at LSSLC consisted of the training of one step of a task analysis. For example, turning on the water, for a goal of	

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		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. PST members at the PSP review meeting for Individual #476, for example, were very interested in learning about new and different instructional procedures. It is likely that most, if not all, PSTs would have this interest. <u>Desensitization skill acquisition</u> The dentistry department developed dental desensitization plans designed to teach individuals to tolerate dental procedures without sedating medication. These plans consisted of a series of visits to the dental clinic with gradually increasing intensity and time of dental procedures. These plans used the same training methodology as the other SAPs at LSSLC and, therefore, they were subject to the same strengths and weaknesses discussed above for all SAPs at the facility. It is recommended the desensitization plans, be incorporated into the general training methodology, and conform to the standards of all skill acquisition programs listed above. <u>Replacement/Alternative behaviors from PBSPs as skill acquisition</u> 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. For example Individual #479's replacement/alternative behavior was making choices within his environment. This was defined as making the choice of just saying no to staff when he is experiencing depressive symptoms. It is unlikely that DCPs could consistently implement this plan without more specific instructions and better operational definitions of depressive symptoms. 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. <u>Communication and language skill acquisition</u> The monitoring team did not encounter any acquisition programs targeting the enhancement or establishment of communication and language skills. It is	

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		recommended that the facility expand the number of communication SAPs for individuals with communication needs. <u>Service objective programming</u> Finally, the facility utilized service objectives to establish necessary services provided for individuals (e.g., brushing an individual's teeth). These were also written and monitored by the QMRPs. The monitoring team did not review these plans in this provision of the Settlement Agreement because these were not skill acquisition plans (see provision F for a review and discussion of service objectives). <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 facility has made many improvements in this area since the last onsite review. These improvements include: • New engagement data monitoring tool • Specific engagement goals for each individual and home • Several trainings of DCP in the implementation of engagement • Additional activity plans and schedules • Preparation of specific activities • Introduction of group activities • An interdisciplinary Performance Improvement Team (PIT) was developed to address aggression between individuals. The PIT found that it appeared a low level of engagement was related to increases in this type of aggression. As a result, specific actions were taken to increase engagement in a few of the homes. As during the last onsite visit, the monitoring team was encouraged by the generally positive and caring interactions between staff and individuals at LSSLC, and by the	

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		consistently high level of productive engagement in the workshop. Although the majority of activities observed in the residences consisted of individuals sitting at a table, the monitoring team did observe more group activity than during the last onsite review. Another notable difference from the last review was that DCPs told the monitoring team that they had been trained in conducting engagement, and that active engagement was an important part of their jobs. The average engagement level across the facility was 48%, a slight increase over that observed during the last review (i.e., 46%) and the baseline review (42%). An engagement level of 75% is a typical target in a facility like LSSLC, indicating that the engagement of the individuals at LSSLC continued to have room to improve. The monitoring team anticipates that this score will be substantially improved in the next onsite review, as a result of these newly initiated procedures at LSSLC. <u>Engagement Observations</u>: Location / Engaged / Staff-to-individual ratio 549 D — 2/8 — 2:8 549 D — 2/8 — 2:8 549 B — 0/7 — 1:7 549 B — 1/2 — 1:2 557 A — 2/3 — 2:3 557 A — 2/3 — 1:3 557 B — 3/9 — 2:9 557 B — 0/6 — 1:6 559 A — 1/5 — 1:5 506 — 2/9 — 2:9 506 — 1/4 — 1:4 520 B — 2/2 — 1:2 520 B — 2/2 — 1:2 524 — 2/8 — 1:8 563 B — 2/2 — 1:2 563 A — 3/8 — 2:8 520 B — 5/7 — 4:7 520 B — 4/5 — 3:5 565 Workshop — 10/15 — 5:15 565 Workshop — 13/15 — 5:15 <u>Educational Services</u> In both the baseline report and the previous monitoring report, the monitoring team noted concerns regarding the educational services received by those individuals at LSSLC	

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		who qualified for these services. LSSLC was responsive to the monitoring team's comments and recommendations and, as a result, progress had been made in some of these areas. For the most part, however, services remained as they had been at the time of the last review, that is, at the beginning of the academic year. LSSLC had been designated as one of two SSLCs to receive all new admissions of children (i.e., individuals under age 18). Therefore, given that the number and percentage of the population that attends school and that will receive services from LISD will grow, it will be important for LSSLC to increase the resources it devotes to ensuring these children receive the educational services to which they are entitled as well as to ensure the continuation of a good working relationship with LISD. To that end, the monitoring team recommends that LSSLC form a work group for educational services. It might meet periodically, as needed, perhaps no less than quarterly. Its responsibilities might include: • Relationship with LISD • Carryover of objectives and activities from LISD to LSSLC and vice versa • Students rights • Hours of school, extended school year, graduations • Returns from school (see below) • Data submission to QA program at LSSLC Further, this group might collaborate with the other SSLC that was designated for children as well as the Mexia SSLC and San Angelo SSLC. These two SSLCs were designated as forensic facilities, including children committed under Chapter 55. As a result, a large number of individuals at both of these facilities attend school and these two SSLCs must also work closely with their local public school ISD. It may be helpful to share best practices across facilities. Twenty-nine individuals at LSSLC received educational services. They lived in six different homes at the facility. Most attended the LISD high school. Of these 29, 25 attended full day at an LISD public school, two attended half day at LISD and half day at the LISD classroom at LSSLC, and four only attended the LISD LSSLC classroom. Of these four, two lived in the infirmary and had only recently begun to attend the LISD LSSLC classroom. This was a major accomplishment. Further, the parent of one of these two individuals was reported to be extremely pleased with this for her son. The other two continued to attend school for a minimal number of hours each day (two or three), however, it appeared that the PSTs and the LSSLC were discussing these two cases on a more individual basis than they had been doing.	

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		The LISD LSSLC classroom was staffed by an LISD special education teacher along with LSSLC direct care staff. The teacher had been there all school year. She was engaging and energetic. She was highly motivated and appeared to thoroughly enjoy her work. She would, however, benefit from consultation regarding appropriate educational curriculum for students with autism and other language delays. This was also recommended in the previous report. Luz Carver remained as the facility's primary liaison with LISD. She continued to be assisted by Tawnya Baker. In addition to the increased attendance of the two students who lived at the infirmary, and under the guidance of Ms. Carver and with the support of the LSSLC QMRPs, LSSLC had made other progress in supporting educational services. First, the facility acted to have students (for whom it was appropriate) remain in school until they aged out (e.g., Individual #233, Individual #475) . This was noted in the previous monitoring report and it was good to see it was being addressed. Second, LSSLC continued to collaborate with LISD to have students attend school as many hours as possible. Ms. Carver provided an example of a collaborative discussion regarding a problem with the bus transportation for Individual #148. Third, the facility had begun, six months ago, to keep track of every time a student was returned to LSSLC from LISD. Since October 2010, this had occurred 61 times. Of these, 24 occurrences were due to behavior problems, the remainder was primarily due to medical and health related problems. This information could be reviewed by the type of work group recommended above. Fourth, Ms. Carver worked with the LSSLC director of psychology to have psychologists attend LISD meetings when appropriate and needed. Fifth, the new style PSPs contained more information in the narrative than had been included in the old style PSPs. Nevertheless, ongoing work will be required by LSSLC. This includes: • Working on carryover from LISD instructional activities to the individuals' homes at LSSLC o Conducting some sort of review of the LISD progress reports • Ensuring that there is proper documentation in the record for any student who does not receive a commensurate school day, as per Texas Education Agency requirements • Pursuing extended school year services for those individuals for whom this is appropriate. This was discussed at some length in the previous monitoring report. Ms. Carver reported that she had been addressing this with LISD and would continue to do so.	
S2	Within two years of the Effective Date hereof, each Facility shall	LSSLC conducted annual assessments of preference, strengths, skills, and needs. As discussed in S1, the facility was beginning to make improvements in the documentation	Noncompliance

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	conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	of how this information impacted the selection of specific program objectives. Overall, however, more work is needed to achieve substantial compliance for this item. 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. Finally, LSSLC had been using PALS for the assessment of individual skills, and as part of the method of identifying skills to be trained. DADS was in the process of evaluating several assessments as an alternative to PALS. The monitoring team is supportive of the identification of an alternative to PALS, and looks forward to learning how this new assessment is combined with the results from clinical assessments (e.g., nursing, speech/language pathology, etc.) and individual preference, to identify meaningful individualized skill acquisition programs.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	LSSLC was making progress on this provision item. More work, however, in the areas of integrity of the implementation, and the practicality and function of SAPs is needed before this item can be rated as being in substantial compliance. QMRPs at LSSLC summarized SAP data monthly and presented those data at quarterly meetings. As recommended in the last report, the QMRPs had begun to graph SAP outcome data. This improvement enhanced the QMRP's ability to evaluate the effectiveness of each individual SAP. A QMRP interviewed indicated that he believed the graphing of SAP outcomes did help him to make data-based decisions concerning the continuation, discontinuation, or modification of an individual's skill acquisition plan. Reviews of SAP data revealed that skill acquisition plans were producing meaningful behavior change for some individuals (e.g., pulling a wipe from the container for Individual #24; dusting of her cedar chest for Individual #75). Many other SAPs, however, indicated no improvements (e.g., rubbing lotion for Individual #262; dressing	Noncompliance

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		skills for Individual #91) without any indication of a modification of the plan, retraining of staff, etc. Additionally, SAP data indicated that Individual #75's SAP of dusting her cedar chest was achieved on 1/31/11. The objective, however, continued for at least two more months (data on this SAP was only available to the monitoring team until 3/31/11). The implementation of graphed data is an encouraging development at LSSLC, however it is only a tool for improving decisions. The facility needs to use this, and other available tools, to ensure that decisions concerning the continuation, discontinuation, or modification of SAPs is based on outcome data. The skill acquisition plans at LSSLC appeared practical and functional for some individuals (e.g., teaching Individual #424 to count out her change following a purchase), however, for many others (e.g., teaching Individual #223 to indicate that he is enjoying listening to a story) it was not clear how or why these are practical without a specific rationale as recommended in S1. The facility should ensure that SAPs are consistently practical and functional. The monitoring team observed the implementation of SAPs in several day programs and homes during the onsite review to evaluate if SAPs were implemented as written. Additionally, SAP data sheets were also reviewed to evaluate if data were completed as scheduled. The results from those observations were encouraging. For example: • Individual #134 was working on his SAP of participation in leisure activity for 15 minutes. The DCP appeared to implement the acquisition programs as prescribed in the teaching methodology/task analysis steps. Additionally, all SAP data were completed. • In six of the seven SAP data sheets reviewed in the homes and vocational sites, the data were present. These observations ere encouraging and represented an improvement from the last review. The only way, however, to ensure that SAPs are conducted as written is to conduct integrity checks. It is recommended that a plan be developed to collect and graph integrity data to ensure that SAPs are conducted as written. Finally, despite the improvements in this area since the last review, the monitoring team does not believe that LSSLC will be able to achieve substantial compliance with this provision item until they restructure the process of skill acquisition development and implementation at the facility. As discussed in the last report, the QMRPs do not appear to have the time or expertise to write SAPs that will meet the standards of the Settlement Agreement. Additionally, the QMRP assistant interviewed was responsible to monitor the implementation of 700 SAPs a month. It does not appear that she could maintain the level of quality monitoring required in this provision when she is responsible for that	

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		number of SAPs a month. 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.	
	(b) Include to the degree practicable training opportunities in community settings.	Many individuals at LSSLC enjoyed various recreational activities in the community. The facility had begun to make progress in providing and documenting the occurrence of training in the community. This process had recently begun and could not be fully evaluated at the time of the onsite review, and therefore this item was rated as being in noncompliance. The facility's newly enacted community integration tracking report recorded training activities in the community. These activities included training specific SAPs (e.g., Individual #111 paying a cashier for items chosen with verbal prompts). It is recommended that these training activities in community be centrally tracked across home and individual so that community training trends could be better tracked, and increased across the facility. At the time of the review, four individuals at LSSLC worked in the community. This was consistent with the number reported during the last onsite review. The monitoring team was encouraged by the facility's progress on this provision item and look forward to seeing continued progress at the next review.	Noncompliance

Recommendations:

1. It is recommended that the facility consistently document SAPs are based on individual needs and preference.
2. All skill acquisition plans should contain all of the training components demonstrated to be necessary for learning and skill development.
3. The facility should expand its training methodology to other procedures shown to be effective in developing new behavioral repertoires.
4. It is recommended that the facility expand its training methodology to other procedures shown to be effective in developing new behavioral repertoires.
5. Replacement behavior training procedures, like those for the desensitization plans, should be incorporated into the general training methodology, and conform to the standards of all skill acquisition programs.
6. 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.

7. Ensure that decisions concerning the continuation, discontinuation, or modification of SAPs are data-based.

8. The facility should ensure that SAPs are consistently practical and functional.

9. It is recommended that a plan be developed to collect and graph integrity data to ensure that SAPs are conducted as written.

10. It is recommended that these training activities in community be centrally tracked across home and individual so that community training trends could be better tracked, and increased across the facility.

11. Form a work group for educational services: create standing agenda, review data, collaborate with three other SSLCs, and so forth.

12. Address the three items listed at the end of the Educational Services subsection of section S1 above (carryover, commensurate school day, extended school year).

The following are offered as additional suggestions to the facility:

13. In order to ensure that individual SAPS are based on needs and preferences, include the reason/rationale for the selection of each new skill on the SAP training instructions.

14. In order to increase the likelihood that SAP plans include all of the components of an effective training plan, include a section on each training instructions sheet that describes:
    - the use of relevant discriminative stimuli
    - specific consequences for correct responses
    - a plan for maintenance and generalization of skills.

15. Consider a reorganization and simplification of how skill acquisition programming is organized, implemented, and monitored at the facility.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.1, updated 3/31/10, and attachments (exhibits) o DRAFT revised DADS SSLC Policy: Most Integrated Setting Practices, and attachments o DADS Obstacles Report for SSLCs, October 2010 o Organizational chart, undated o LSSLC policy lists, 3/17/11 o List of typical meetings that occurred at LSSLC o LSSLC POI, 4/4/11 o LSSLC Admissions and Placement Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 4/18/11 o Community Placement Report, through 4/7/11 o LSSLC Weekly Admission, Inquiries, and Referrals Update, 4/19/11 o List of individuals who were referred for placement and had been placed since last onsite review (nine individuals, however, two were readmitted) o List of individuals who were referred for placement and had not yet been placed (20 individuals) o List of individuals who requested placement, but weren't referred, 3/11/11 (six individuals, though one had since been referred) o List of individuals who requested placement, but weren't referred solely due to LAR preference, 3/11/11 (three individuals) o List of individuals discharged under alternate discharge procedures (one individual) o Documentation regarding individual discharged under alternate discharge procedures o List of alleged offenders (three individuals) o Description of how facility assessed an individual for placement o List of all individuals at the facility, indicating that all had been assessed for placement, 3/18/11 o Checklist tool used by APC regarding assessment submissions for CLDP, completed for: • Individual #283, Individual #398, Individual #538 o List of all post move monitoring visits, including individuals placed by LSSLC (six individuals) and individuals placed by other facilities and monitored by LSSLC (five individuals), 3/11/11 o APC monthly reviews of each individual who requested placement but was not referred (other than those for whom LAR preference was the sole reason), 2/16/11, 3/21/11, 4/15/11 o Various emails and documents regarding the referral status of: • Individual #61, Individual #166 o Documentation of QMRP training on the Placement Appeal Policy (23 attendees) o List of trainings related to most integrated setting practices, 3/11/11

	o Various documents regarding the 3/21/11 provider fair o Documents regarding the 10/12/10 MRA inservice, the 1/19/11 Every Child inservice, and the 4/1/11 CLOIP and CLDP inservice o Documents regarding statewide APC and PMM trainings, activities, and conference calls o CLOIP and Permanency Plan tracking sheets through March 2011 o List of information regarding individuals' visits to community group homes and day programs o Various documents regarding the re-admissions of Individual #340 and Individual #256, and the possible re-admission of Individual #464 o List of rescinded referrals (four individuals) o Completed self-monitoring forms related to most integrated setting practices done by the post move monitor and the QA department o PSPs for: • Individual #144, Individual #410, Individual #45, Individual #600, Individual #538, Individual #24, Individual #587, Individual #221, Individual #27, Individual #164 o CLDPs for: • Individual #219, Individual #378, Individual #398, Individual #283, Individual #260, Individual #538 o Post move monitoring checklists conducted since last onsite review for: • Individual #538: 7-day • Individual #398: 7-day, 45-day • Individual #283: 7-day • Individual #378: 7-day, 45-day, 90-day • Individual #219: 7-day, 45-day, 90-day • Individual #260: 7-day, 45-day, 90-day • Individual #260: 7-day, 45-day, 90-day • Individual #340: 7-day, 45-day, re-admission info • Individual #256: 7-day, 45-day, re-admission info • Individual #350, Individual #113: forms completed by another SSLC <u>Interviews and Meetings Held</u>: o Lisa Pounds Heath, Admissions and Placement Coordinator o Glenda Pierce, Post Move Monitor o Stephen Webb, QA program monitor o Gale Wasson, Facility Director o John Moore, Regional Director, D&S Services, Longview, TX 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 #253, Individual #476, Individual #162

	o CLDP meeting for: • Individual #534 o Community group home visit for: • Individual #283 o Many residences and day programs at LSSLC
	Facility Self-Assessment: The facility's self-assessment, its POI, was revised and simplified compared to the POI presented during the previous onsite review. This was an improvement and should provide the admissions and placement department with guidance and direction. The POI was dated 4/4/11, two weeks before the onsite review. The monitoring team recommends that the department use the information provided in this section of the report to revise the content of this POI. Many comments, feedback, recommendations, and suggestions are provided below. It would make sense for the APC to use this report to guide her in setting forth a set of actions to work towards achieving substantial compliance with this provision. The POI indicated a self-rating of substantial compliance with five provision items. The monitoring team agreed with four of these ratings. In addition, the monitoring team rated two provisions as being in substantial compliance that LSSLC self-rated as being in noncompliance. First, there was agreement on substantial compliance for provision items T1c2 (CLDP timeframes), T1c3 (CLDP approvals), T1h (community placement report), and T2b (observation of post move monitoring). The monitoring team did not agree with LSSLC's self-rating of substantial compliance with provision item T1g (quality assurance) because a facility-wide assessment of obstacles had not been conducted. Although a draft report was issued as noted below in T1g, it was not in completed form. The monitoring team, however, rated T1d as being in substantial compliance because all assessments were collected prior to the each individual's move and because the APC maintained a sufficient monitoring checklist of these assessments. The monitoring team also rated T2a as being in substantial compliance due to the post move monitor's thorough completion of the post move monitoring activities. The monitoring team also rated T4 as being in substantial compliance. T4, however, was not included in the POI at all. With the APC and PMM, the monitoring team reviewed the department's presentation book. It was well prepared, organized, and contained a great deal of relevant information, including actions related to each provision item, and actions related to each recommendation from the previous monitoring report. 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 continued to engage in many activities to encourage and assist individuals to move to the most

	integrated setting. The specific numbers of individuals who were in the referral and placement process, however, remained very low, given the size of the facility (i.e., 20 out of 400, that is, 5%). • Nine individuals were placed in the community since the last onsite review • Two of these nine were readmitted after failed community placements. • 20 individuals were on the active referral list. • The referrals of four individuals were rescinded since the last review. The monitoring team recommends that the department's data (including, but not limited to the above list) be summarized and graphed every six months, and that the data be incorporated into the facility's QA program. The two failed placements, four rescinded referrals, and the re-admission inquiries of one individual who was placed two years ago, raised some important issues for the facility. Six of these seven cases were due to behavioral and psychiatric reasons. Given that two of the nine placements failed (22%), and four of 24 referrals (17%) were rescinded, each of these cases should receive a thorough review. Given that placement is the most important activity of this department, these should be considered the equivalent of sentinel events by the APC. A thorough review (e.g., root cause analysis) of the actions taken by the facility may help to determine what led to the failed placement, what might be done when the individual is referred again sometime in the future, and possible recommendations for the overall referral and placement processes at LSSLC. It appeared to the monitoring team that the opinions of the professionals on the PST were often not adequately incorporated into discussion, documentation, and decision-making as required (this was what was noted in the previous monitoring report). Professionals need to provide their opinions regarding community placement and these opinions need to be explicit in the written PSP document. The new policy and procedures will require a more structured living options discussion to occur during the meeting and to be documented in the written PSP. This will require that the APC and her staff work closely with the QMRP coordinator and the QMRPs to ensure this get implemented correctly. Obstacles to referral and placement were not adequately identified or addressed in the PSPs in any type of consistent manner across the facility. A plan to address the obstacle via an action plan as a service objective or training objective was not explicitly noted in most cases. PSTs may need to describe obstacles to referral separately from obstacles to making a placement happen (e.g., provider capability). The annual provider fair was more organized than before. Outcome data were collected and participants were surveyed for their evaluation of the fair. The facility opened a small home on campus for up to four individuals as a transition home. This was for individuals who were on the referral list and provided an opportunity for them to live in a small home. The home can provide another opportunity for individuals and LARs to visit a community-like site. Further, the experiences of the individuals and managers at this home might provide ideas to the PSTs regarding the types of skills and activities they might target doing for

	many of the individuals on the main part of campus. Self-advocacy activities need to be improved, especially if these activities are to be used as a possible forum to learn about and discuss community living. The lists of supports in the CLDPs were improved from the last onsite review, but remained inadequate and indicated problems in the planning of this aspect of each individual's transition. Problems in identifying essential and nonessential supports were identified in the baseline monitoring report and again the previous monitoring report. The lists of essential and nonessential supports contained requirements for staff inservicing in PBSPs, PNMPs, and safety issues. Although this was very important, requiring only the documentation of the inservicing of staff is insufficient. The required supports should list out those actions that the provider must take to satisfy the post move monitor that these supports are being provided. There were few supports that were directly related to actions that were to occur day to day for each individual. The PSTs (under the guidance of the APC and PMM) really need to consider the most important aspects of the individual's life, that is, his or her preferences, support needs, and safety concerns. It appeared to the monitoring team that important aspects of each individual's life were not included in the list of essential and nonessential supports. Examples are provided in section T1e below. DADS had developed three self-monitoring tools for the SSLCs to use to self-monitor performance related to most integrated setting practices. As this develops, the APC and QA department need to ensure that they are looking at quality of the items on their tool, not just their presence (see Facility Self-Assessment above). Post move monitoring was done well and was rated as being in substantial compliance. Post move monitoring was completed within the required timelines, and followed the requirements of Appendix C of the Settlement Agreement. Her reports were thoroughly completed, detailed, and done in a manner that made it easy for the reader to understand the individual's transition into his or her new home. The post move monitor was assertive in ensuring that all needed supports were in place. She worked with providers, MRA staff, and each individual's LSSLC PST. She demonstrated additional effort to try and support the two failed placements that occurred during this period. The monitoring team's observation of an actual post move monitoring visit concurred with the quality and contents of the written documents that were reviewed.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for	LSSLC continued to engage in many activities to encourage and assist individuals to move to the most integrated setting. These activities were, as required, not opposed by the	Noncompliance

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	individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	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. Funding did not appear to be an obstacle to any individual's transition. There were no reported instances of a placement being delayed or prevented due to lack of funding and there were reported to be plenty of slots available to individuals at LSSLC. The facility had made a lot progress in meeting this provision item, however, as noted below, much work was still needed in order to achieve substantial compliance. Referral and placement activities continued to be overseen by Lisa Pounds Heath, the Admissions and Placement Coordinator (APC). She was experienced and very knowledgeable, including knowing important details about every one of the individuals on the facility's referral list. She continued to be assisted by Glenda Pierce, the Post Move Monitor (PMM). Ms. Pierce was committed to conducting post move monitoring in the most effective way possible. The specific numbers of individuals who were in the referral and placement process remained low, given the size of the facility (i.e., 20 out of 400, that is, 5%). • 9 individuals were placed in the community since the last onsite review (however, 2 were re-admitted to LSSLC within two months of placement). This compared with 8 who had been placed at the time of the last review, and 5 at the time of the baseline review. • 20 individuals were on the active referral list. This compared with 25 individuals who had been referred at the time of the last review, and 17 at the time of the baseline review. • 6 individuals were described as having requested placement, but were not referred. This compared with 9 individuals at the time of the previous review. o Various emails from the past few months showed that the facility took important actions for those individuals in this group who did not have an LAR. Specifically, the Placement Appeals Policy was implemented more thoroughly than it had been, including convening the Placement Review Team and requiring monthly documentation from the APC on the "APC Review and Status Update." The most recent (4/15/11) indicated that of the six individuals, three had now been referred, two were having another living options discussion meeting scheduled, and one had come under new guardianship and his LAR's preference was to remain at LSSLC. The monitoring team liked the attention paid to these individuals. For instance, numerous emails indicated thoughtful consideration of whether Individual #61 had indicated a preference, how her preference might be determined, and how her refusals to visit	

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		any group homes were interpreted by the PST. • 3 individuals were describe as having requested placement, but were not referred due solely to LAR preference. This compared to 17 at the time of the previous review. o The data for this topic need to be defined more clearly. This should be a list of individuals who would have been referred for placement but were not, solely due to LAR preference. This list should include not only those individuals who themselves requested referral, but those individuals who were not able to express themselves. This is a different list than the one described in the bullet immediately above, however, some names might appear on both lists. • 2 individuals were re-admitted to the facility after failed community placements. • The referrals of 4 individuals were rescinded since the last review. o One was for behavioral/psychiatric reasons, one was the individual's choice, and two were listed as "other reason." The above data should be summarized and graphed every six months. Each of the above six bullets should be graphed separately. The monitoring team recommends creating simple line graphs with one data point representing six months of data (preferably to coincide with the onsite reviews, that is, October-March and April-September). These data should be submitted and included as part of the facility's QA program (see sections E above and T1f below). The monitoring team is available to help the facility create this graphic presentation prior to the next onsite review. The two failed placements, four rescinded referrals, and the re-admission inquiries of a one individual who was placed two years ago, raised some important issues for the facility. Six of these seven cases were due to behavioral and psychiatric reasons. Given that two of the nine placements failed (22%), and four of 24 referrals (17%) were rescinded, each of these cases should receive a thorough review. Given that placement is the most important activity of this department, these should be considered the equivalent of sentinel events by the APC. A thorough review (e.g., root cause analysis) of the actions taken by the facility may help to determine what led to the failed placement, what might be done when the individual is referred again sometime in the future, and possible recommendations for the overall referral and placement processes at LSSLC. This should be viewed as a way to improve processes, not as a way to find fault. For example, a review of a variety of documents regarding the two failed placements demonstrated that the APC and PMM worked hard to make the placements work by consulting with the PSTs, making recommendations, communicating regularly with the MRA service coordinator, and holding meetings and site visits. Further, the LAR for one	

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		of the individuals did not allow the facility to implement its typical (and required) referral and placement processes (i.e., the processes of this section of the Settlement Agreement), thereby contributing to the failure of the placement. Moreover, it is possible that a root cause analysis may highlight that a particular community provider may be incapable of properly supporting individuals who have challenging behaviors and who are diagnosed with psychiatric disorders, however, many individuals with challenging behaviors are being supported successfully in community placements. In addition, the APC should do a review of every rescinded referral. Three of the four recent rescinded referrals may have been due to problems during tours and pre-placement visits (Individual #434, Individual #294, Individual #142). Perhaps a thorough review might lead to changes in these processes for all, or some, individuals at LSSLC. The APC continued to maintain a weekly update of her department's activities. She did so by updating a weekly written report and by making a weekly presentation to the senior management team. These were great actions, should be continued, and might be used by other SSLCs, too. In this way, all of her data were up to date and senior management was well informed. <u>Determinations of professionals</u> This provision item requires that actions to encourage and assist individuals to move to the most integrated settings are consistent with the determinations of professionals that community placement is appropriate. This is an activity that should occur during the annual PSP meeting. It appeared to the monitoring team that the opinions of the professionals on the PST were often not adequately incorporated into discussion, documentation, and decision-making as required (this was what was noted in the previous monitoring report). This was based on a review of PSP documents that included little about the opinions of PST professionals. In most PSPs, a statement at the end of the PSP narrative attempted to present the PST's decision regarding most integrated setting and referral. These were typically one or two sentences that provided insufficient detail regarding the opinions of professionals, and led the monitoring team to assume that the professionals did not provide their opinion on this important matter. Professionals need to provide their opinions regarding community placement and these opinions need to be explicit in the written PSP document. Examples of what was found in a sample of recent LSSLC PSP documents are presented below and are representative of the statements in all of the facility's PSPs. • Individual #144's PST determined that the most integrated setting at the current time was to continue to live at LSSLC. The PSP did not indicate why the PST	

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		arrived at this conclusion. • The PSP for Individual #410 noted that his PST determined that the most integrated setting for him was his current residence at LSSLC. It did not, however, indicate why they made this determination. • The wording in the PSP for Individual #45 was identical as to that of the individual described immediately above, that is, that the most integrated setting was her current home at LSSLC. No reason was provided. • Individual #600's PSP indicated that the PST referred her to San Angelo SSLC. Although this may be a reasonable action for the PST to take, the PSP needs to explicitly indicate the opinions of the professionals of the PST. • Individual #538's PSP indicated that he was referred for placement with a family. Even so, the PSP did not indicate the determinations or opinions of professional members of his PST. Perhaps the new style PSP and the upcoming proposed revisions to the DADS policy on most integrated settings practices and the living options discussion will set the occasion for the incorporation of professional's determinations. The facility should ensure that professional determinations are explicitly included in the PSP meeting, and that these professional determinations are clearly indicated in the PSP document. This provision item allows (and calls for) professional determination as separate from both the preference of the LAR and the opinion of the PST as a whole. <u>Preferences of individuals</u> LSSLC appeared to work to honor the preferences of individuals. <u>Preferences of LARs and family members</u> LSSLC attempted to obtain the preferences of LARs and family members and to take these preferences into consideration. <u>Senior management</u> As noted above, senior management were regularly informed of the status of referrals and placements. Again, all of the data discussed throughout section T of this report should be incorporated into the facility's QA program.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review,	The monitoring team looked to see if policies and procedures had been developed to encourage individuals to move to the most integrated settings. The state policy regarding most integrated setting practices was numbered 018.1 and was dated 3/31/10.	Noncompliance

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	revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	A revised state policy was in draft format. The Monitoring Panel had the opportunity to review this draft revised policy and submitted a set of comments to DADS separately from this report. In addition, the APC and PMM reported that they had the opportunity to also provide comments to state office. The new policy contained improvements from the previous version as well as more detail for PSTs. Once finalized and disseminated, LSSLC will need to incorporate these revised policies, practices, and forms into its facility-specific policies. The two facility-specific policies described in the previous report were in the process of revision. The APC was awaiting finalization of the state policy because that would help to guide her in the development of the facility-specific policy or policies. Thus, these will be reviewed during the next onsite review. Implementation of the new state policy and the updating of facility policies to make them in line with the new state policy will lead LSSLC towards substantial compliance with this provision item.	
	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. The new statewide PSP policies and procedures were being implemented at LSSLC. These policies and procedures were recently taught to the facility's PSP coordinators and the new procedures were put into place in late 2010. Six of the annual PSP meetings held during the week of the onsite review were observed by the monitoring team. At LSSLC, PSP meetings were facilitated by QMRPs. In addition to attending PSP meetings, 10 recently completed PSP documents were reviewed (listed above in the Documents Reviewed list). The total sample included individuals representing different levels of referral for placement, ages, need for extensive supports, language abilities, medical needs, and family involvement. Across this sample of PSPs, there was variety in the depth of information provided. The monitoring team has some comments regarding this set of PSPs. First, Individual #144's PSP was one of the more detailed and included a lot of relevant information. Moreover, this was the only PSP that included any information about an optimistic living vision.	Noncompliance

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		Further, his PSP had information on his family, trust fund, dental desensitization, and pre-meeting questionnaires. Second, the PSPs at LSSLC had a 20- to 30-page attachment that had important and relevant detail about each of the assessments prepared for the PSP. This was helpful to the reader. This attachment, however, was not needed in all locations where the PSP was used (e.g., the individual notebook) because the attachment's information was further summarized in the PSP itself. Third, many of the PSPs included a short paragraph briefly describing the individual's history at LSSLC and other placements. This was also very helpful to the reader. Fourth, the action plans contained objectives, either service or training. Typically, instead of having a single training objective for a skill, the PSP included multiple objectives for the same skill. The multiple objectives indicated different steps in a task analysis, or the fading of prompts over time. This is more appropriate for inclusion in the written skill acquisition plan than in the PSP. This should be corrected in future PSPs. The new policy and procedures will require a more structured living options discussion to occur during the meeting and to be documented in the written PSP. This will require that the APC and her staff work closely with the QMRP coordinator and the QMRPs to ensure this get implemented correctly. <u>Protections, Services, and Supports</u> 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." Again, the revised (but not yet finalized or disseminated) state policy included a more structured way of addressing the living options discussion (LOD) portion of the PSP meeting, both in the meeting and in the written document. Further, it separated the discussion of addressing the individual's preferences (which were derived from the PFW and discussed earlier at the PSP meeting) and the individual's needed supports and services (which were derived from assessments and discussed later at the PSP meeting during the LOD). The revised LOD will help ensure that the PST properly and fully considers an (a) optimistic living vision, (b) all aspects of supports and services, and (c) preferences. LSSLC was making progress towards achieving substantial compliance with this aspect of this provision item. For example, the PSPs of Individual #587, Individual #221, and	

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		Individual #144 included narratives regarding a number of different support areas as per the template of the PSP. The PSPs will need to include the full range of characteristics of an optimistic ideal setting for the individual. The QA department and the APC and her staff conducted occasional monitoring of the annual PSP meeting. Monitoring of the PSP meeting can be a very valuable activity that may best be accomplished with the collaborative efforts of the QA department, the APC, and the PSP coordinators. As noted below in T1f, it may be necessary to revise the tool used to monitor the new style of the PSP meetings. <u>Obstacles to Movement</u> There continued to be no coordinated plan or approach to identify and address obstacles to movement to the most integrated setting across the facility (also see T1g below). Obstacles to referral and placement were not adequately identified or addressed in the PSPs in any type of consistent manner across the facility. A plan to address the obstacle via an action plan as a service objective or training objective was not explicitly noted in most cases. As indicated in T1g below, the state will be requiring the PST to specifically identify obstacles to placement by choosing from 12 different categories. It may be that use of this list will help PSTs at LSSLC to be more successful in identifying and addressing obstacles. Further, as evident by reading the following list, PSTs may need to describe obstacles to referral separately from obstacles to making a placement happen (e.g., provider capability). The state's new system for determining and categorizing obstacles is likely to be helpful to PSTs. The new system should help PSTs to separate the defining of the supports and services the individual needs from the identification of obstacles that are preventing the individual receiving those supports and services in the most integrated setting. The below list of obstacles from this set of PSPs indicated that all types of characteristics, situations, and conditions were given as obstacles. Some reflected preferences, others reflected conditions of individuals, and others reflected the perceived capacity and competence of community providers. • Guardian and individual did not want placement (Individual #144) • Aggression, serious dangerous behaviors, and psychiatric conditions (Individual #600) • Behavior (Individual #410) • No obstacles, the family was satisfied at LSSLC (Individual #45) • Need for 24 hour nursing and a wheelchair van (Individual #24)	

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		• No legal status as a citizen (Individual #587) • Fear of driving in a vehicle (Individual #221) • Uncontrolled seizures (Individual #27) • Medical and equipment needs, including wheelchair, g-tube, mechanical lift hospital bed, and bathing slab (Individual #164) As PSTs begin to define what supports are necessary to meet these needs, the discussion will likely become more centered upon what it is that the providers of community services will need to provide in order for the individual's placement to be successful, fulfilling, and long-term. Please also see section F1e above for additional detailed discussion regarding assessment of preferences and needs, the optimistic living component of the PSP, skill training related to community living, obstacles, and referrals.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	LSSLC continued to engage in activities to educate individuals and their families or guardians to make informed choices. The facility had engaged in each of the activities listed in the DADS policy. The facility had only just begun to address education of individuals and their families on an individual basis. This was due to the PSP template requiring a comment about the education of the individual and LAR, however, as exemplified in the list below, the PSP provided very little information and no details. The next step is for the PST to specifically report on (a) the activities of the previous year and (b) make a plan for the upcoming year. At this point, the PSPs varied in their description of the activities related to this provision item for each individual. • Individual #45's PSP indicated that she would continue to be educated about community options. • The guardian of Individual #24 was to continue to receive information. • Individual #27 was to continue to be educated. • The guardian of Individual #164 was to continue to be informed of living options on an annual basis. • Individual #410 was not aware of community options, but his parent gave permission for him to go on group home tours. • Individual #144 had received information from the MRA and had visited two group homes. • Individual #600 was aware of community options. Her PST recommended that no further information be given. The APC and the facility made many improvements to the annual provider fair, in part, in	Noncompliance

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		response to comments from the previous monitoring report. For example, a planning committee of five senior managers was created. Their planning included preparing the gym, scheduling different times for each of the units to attend, preparing a list of questions for individuals and staff to use when speaking with providers, and conducting a short evaluative survey. One outcome was attendance. A goal of having 45% of the individuals attend was set, and was achieved. Their data showed that 179 individuals, 169 staff, and three family members attended. Further, the data showed detail regarding the 169 staff (e.g., unit, type of position, department). The evaluative survey was summarized with results from 54 staff, 27 individuals, three family members, 14 providers, and three MRA staff. Many participants provided comments, including a number of very good suggestions for future provider fairs. There were numerous trainings over the past six months regarding most integrated setting practices. One was conducted in January 2011 and was done along with a statewide nonprofit agency that assists in placing children in foster care families. The agency, Every Child, Inc., conducted the session along with the APC. There were 17 LSSLC attendees. This appeared to be the beginning of a good relationship for LSSLC, especially given that the facility will only be accepting child admissions and will need to work creatively to develop appropriate placements. In April 2011, the DADS central office continuity of care coordinator, Donnie Wilson, conducted a three-hour session for 40 LSSLC staff, including all the QMRPs, regarding the living options discussion, PSP, referral processes, and transition activities. The updated PSP and LOD components were reviewed in detail. Also in April 2011, a statewide three-day meeting for all APCs and PMMs was held in Austin. It appeared that relevant topics were reviewed. A Community Living Options Information Process (CLOIP) or Permanency Planning Process (for individuals under age 22) continued to be 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 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. The online family survey can also provide information for the facility regarding family/LAR knowledge and satisfaction with the information they've received. The survey was new, however, there were already more than 50 respondents at this time. The facility took individuals on visits to community providers. The facility had made progress in organizing its system of planning, documenting, and reporting. The facility	

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		reported that 39 individuals and 40 staff had gone on tours since the previous onsite review, compared with 30 individuals who had gone on tours during the six months prior to the previous onsite review. The APC submitted two community tour lists called reports. Report #13 listed all of the individuals, staff, and destination for each tour. Report #11 provided additional information, including whether the tour was appropriate for the individuals and comments regarding their responses. This was good to see and indicated a lot of efforts by the facility to make the system of tours more organized. The next step would be to summarize this information and ensure that all individuals who should go on tours have the opportunity to do so. The APC should incorporate data on tours into the admission and placement department's data, and include these data in the facility's overall QA data system, such as number of individuals who have gone on tours, number of providers visited, number of direct care staff who have gone on tour, and so forth (see section E above). A new program at LSSLC might provide another way to educate individuals and their LARs about community placement. The facility opened a small home on campus for up to four individuals as a transition home. This was for individuals who were on the referral list and provided an opportunity for them to live in a small home, rather than in the large residence. Further, just like in a community home, the individuals and staff did their own cooking, shopping, laundry, transportation, and activity planning. The home had opened only four weeks before the onsite review. The home can provide another opportunity for individuals and LARs to visit a community-like site. Further, the experiences of the individuals and managers at this home might provide ideas to the PSTs regarding the types of skills and activities they might target doing for many of the individuals on the main part of campus. Finally, although not solely related to education about community placements and providers, the self-advocacy activities at LSSLC can be another venue to educate individuals about community placement and the community placement process. This was noted in the previous report and it appeared that LSSLC was being responsive to this comment because, during the onsite review, the self-advocacy meeting included a speaker from the local MRA who spoke about HCS and ICFMR community options. Although it was good to see that LSSLC was making this attempt, the overall organization of the self-advocacy group meeting was terrible. The meeting was in the large gym, the speaker could not be heard, there were no photos or pictures of community homes, and the level of the information was higher than almost every individual in the audience could comprehend. Overall, it was a waste of everyone's time. If this was an indication of the self-advocacy activities at LSSLC (which the monitoring team was led to believe), it	

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		needs to be fixed if it is to be in any way meaningful to the individuals.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	This provision item required the facility to assess individuals for placement. The facility reported that the living options discussion of the annual PSP was the way this was accomplished. The facility's written response was: "LSSLC assesses an individual for placement during the LOD, at the initial PSP meeting as well as the annual PSP meeting. Also, living option discussions and determinations can occur anytime, at the request of the person, their legally authorized representative/guardian, personal support team or family member/correspondent. The QMRP addresses the following living options topics during the discussion to help ascertain whether a person should be referred for community placement: (a) efforts are made to understand the person's awareness of community living options as well as the LAR's awareness of living options, (b) identification of all supports and services the person needs to reside in the community, (c) identification of barriers to placement, (d) development of an action plan to address identified barriers, (c) MRA input, and (f) the optimistic vision for the person." 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 previous monitoring report, the facility will need guidance from DADS regarding this provision item. If the position of the facility is that the PST goes into the annual meeting with the concept that all individuals can be supported in the community (with very few exceptions), the PSP meeting and PSP document will need to clearly show discussion of the supports the individual needs wherever he or she will be living, obstacles to community placement, and methods to address these with action plans. It is possible that a combination of a document review (of PSP) and an observation review (of PST meetings) could show that the facility did an assessment of the individual for placement. Further, the PSP might include an explicit statement, such as "The PST assessed (the individual) for placement by doing the following:"	Noncompliance
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	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. The monitoring team had the opportunity to review this new CLDP form a few months ago. These comments were presented in previous monitoring reports for other SSLCs.	Noncompliance

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	coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	DADS has taken these comments into consideration, however, none of these suggestions were yet reflected in the revised CLDP. This was perhaps due to the state office waiting to incorporate feedback from APCs and PMMs in addition to that received from the monitoring teams. Some of the suggestions are repeated below from previous reports. • 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. o The monitoring team recommends that consideration be given to all items that are standard across all placements. By reviewing a set of CLDPs, the state may find that there are other items that could be added to this list. • 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 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 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. 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.	
	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	The DADS policy on most integrated setting practices 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.	Noncompliance

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	coordinating the community living discharge plan with provider staff.	The monitoring team reviewed five of the most recently completed CLDPs (listed above under Documents Reviewed). The five that were reviewed were done in the new style CLDP format. This provision item addresses the assignment of responsibilities for implementation of the CLDP. This was primarily indicated in the CLDP in sections III (Community Living Data), VI (essential and nonessential supports), and VII (monitoring activities) and was standard in all CLDPs. The five CLDPs were surprising similar, if not identical, in many aspects. The lack of individualization, especially in the listing of essential and nonessential supports was problematic and is described in more detail in T1e below. During the time of the previous onsite review, it did not appear that DADS central office had conducted any reviews of CLDPs at LSSLC as it had done at other SSLCs. This appeared to be the case at the time of this onsite review, too. It would be helpful to LSSLC; the APC and PMM would benefit from having their CLDPs reviewed.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDP clearly indicated the staff responsible for certain actions and activities.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	The CLDP contained evidence of individual and LAR review. This was also evident during observations of PSP and CLDP meetings.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	In preparation for the CLDP meeting, assessments were to be updated and summarized. Therefore, the CLDP document was to contain these updated/summarized assessments, rather than full assessments. This appeared to be an adequate process. These assessment updates were included with all five of the five CLDPs reviewed by the monitoring team. In addition, the APC created a new checklist in February 2011 to keep track of all required assessments. Three of these were reviewed and appeared to indicate that this was a now a typical part of the APC's CLDP management activities.	Substantial Compliance

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		The APC reported that she reviewed all assessments and all assessment updates/summaries in order to ensure that all recommendations were reviewed and considered by the PST during the CLDP meeting. The outcome of this, however, as indicated below in T1e, was inadequate because many important supports did not make it to the list of essential/nonessential supports for most individuals.	
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.	This provision item requires the identification of a set of individualized important supports that the PST determines are critical for the individual's success in his or her new placement. These are labeled as either essential supports (those that must be in place prior to the individual's move) or nonessential supports (those that must be put in place, but aren't required to be in place on the day of the move). The development of these lists of supports is one of the most important aspects of planning for each individual's move. The creation of the list of essential and nonessential supports provides the PST with the opportunity to ensure that the new provider provides the individual with all of the aspects of service and support that the PST deems necessary. PST members should never lose sight of their responsibility and opportunity, that is, that this is their chance to ensure that the individual gets what he or she needs and wants. Many PST members have, for many years, cared for, and cared deeply about, the individuals who are transitioning. They should not squander this opportunity to increase the likelihood of their individual's success at his or her new home. The lists of supports in the CLDPs were improved from the last onsite review, but remained inadequate and indicated problems in the planning of this aspect of each individual's transition. Problems in identifying essential and nonessential supports were identified in the baseline monitoring report and again the previous monitoring report. There are three components to a proper list of essential and nonessential supports. • First, the CLDP needs to include supports from a wide range of possible supports. This should come from the o individual's personal preferences and interests, o family members and LARs, o written assessments and updates from PST members, o other documents, such as the PSP and PSPAs, and o discussion at PST meetings, with attendance as required. • Second, supports, both essential and nonessential, need to be described in adequate detail, using observable, measureable, and verifiable terminology. The wording must provide the facility, the receiving provider, and the post move monitor with adequate guidance regarding the provision and monitoring of each	Noncompliance

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		support. • Third, the way in which provision of the support is to be verified must be provided. The CLDP needs to specify what should be observed by the post move monitor (e.g., paperwork, items, interactions with staff) and at what criterion (e.g., twice per week). The facility might also note that it remains available, perhaps even on an on-call basis, for any questions the provider might have regarding any support. The monitoring team reviewed five CLDPs. Below are comments regarding these CLDPs. • Conducting a PST meeting after each post move monitoring visit was a great addition to the CLDP process. In most cases, no action was needed, but in the few cases when it was, the APC and PMM ensured that relevant information was shared back and forth between the PST and the community provider (e.g., Individual #538, Individual #283, Individual #378). • It appeared that the PSTs thought they could ask for no more than two training objectives to be included in the list of nonessential supports. This is not the case; the PST should include as many training objectives as it determines are necessary for the individual. • The lists of essential and nonessential supports was overly filled with the scheduling of appointments and the arrangement for services. o For Individual #538, 11 of 18 (61%) nonessential supports were about scheduling appointments or services. o For Individual #283, 12 of 20 (60%) nonessential supports were about scheduling appointments or services. o For Individual #398, 10 of 16 (63%) nonessential supports were about scheduling appointments or services. o For Individual #378, 10 of 15 (67%) nonessential supports were about scheduling appointments or services. o For Individual #219, 11 of 17 (65%) nonessential supports were about scheduling appointments or services. • The lists of essential and nonessential supports contained requirements for staff inservicing in PBSPs, PNMPs, and safety issues. Although this was very important, requiring only the documentation of the inservicing of staff is insufficient. The required supports should list out those actions that the provider must take to satisfy the post move monitor that these supports are being provided. o For Individual #538, 7 of 18 (39%) nonessential supports were about inservicing staff. o For Individual #283, 4 of 20 (20%) nonessential supports were about inservicing staff.	

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		o For Individual #398, 3 of 16 (19%) nonessential supports were about inservicing staff. o For Individual #378, 4 of 15 (27%) nonessential supports were about inservicing staff. o For Individual #219, 2 of 17 (12%) nonessential supports were about inservicing staff. Thus, there were few supports that were directly related to actions that were to occur day to day for each individual. The PSTs (under the guidance of the APC and PMM) really need to consider the most important aspects of the individual's life, that is, his or her preferences, support needs, and safety concerns. It appeared to the monitoring team that important aspects of each individual's life were not included in the list of essential and nonessential supports. Below are examples: • Individual #538: o Having bite-sized food seemed important because it was mentioned throughout his set of assessments, yet it wasn't addressed as a needed support. o The problem behavior of running away (i.e., flight) was a very important issue for him and his PST. Moreover, an occurrence of this behavior happened only a few weeks prior, on 2/17/11. There should be a support specifically addressing this behavior that required an indication that staff, for example, implemented his reinforcement program and provided proper supervision. o Similarly, for his BSP and PNMP, the PMM will want to know more than just that staff were trained. She will want to know that they followed the behavior plan and the PNMP each day and/or each shift. o Recreational activities were important. The support needed a criterion, such as specifying the minimum number of outings and range of variety. o The required evidence for training objectives should be more detailed and include, for example, required frequency of implementation and regular review of progress. • Individual #283: o Weight and diet were one of the most important aspects of her support needs. More details were needed regarding what specifically was required to be done to address her weight, diet, and exercise activities. o More attention should have been paid to the relationship between her obesity and her medications. Zyprexa is well known for having weight gain as a side effect, yet her assessments stated that she was having no observed side effects. This medication may have played a role in her weight gain, increased appetite, and difficulty in losing weight. Obesity	

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		placed her at risk for other health problems, including hypertension and diabetes: she was already diagnosed with hypertension and receiving medication for it. Her obesity should probably have been considered an adverse drug reaction (ADR, see section N above) and perhaps it could have been addressed in a more comprehensive manner. o She had a history of challenging behaviors, including a previous failed placement. Even though this was many years ago, the implementation of her BSP was very important, but did not have a support specified for it. o More detail regarding the criterion for community activities, searching for a job, and family contact should have been included. • Individual #398: o The three supports related to his day to day activities should have had more detail regarding the activities and criterion of occurrence instead of only requiring for there to be a log of activities. This applied to vocational/day, leisure, and daily living skills. o Not too long ago, he was readmitted to LSSLC from a community placement due to serious behaviors. It was insufficient to merely say that all that was required was for staff to be inserviced on his behavior plan. There must be some actions that can be documented to having occurred each day to support appropriate behaviors and absence of problem behaviors. o Diet and weight were important to his success, yet there was nothing specific in his list of support. o His assessments noted that he had two falls over the past year, including one that resulted in a broken rib. There was nothing in his list of supports to alert staff and to address this so that it would be unlikely to occur again. • Individual #378: o Having his food in cut up pieces was important, but the only requirement was for there to be a staff inservice. o A number of safety-related items were included within nonessential support #1, however, the only requirement was that staff received an inservice. The PST, APC, and PMM should ensure that specific actions are documented to indicate that safety activities occurred. • Individual #219: o Social activities were described throughout the CLDP and assessments as <u>the most</u> important aspect of his life. Yet, it was included as a poorly written support, with no definition, direction to the provider, or criterion for occurrence.	

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		o He had a failed community placement, and although 15 years ago, there was nothing listed to specifically reduce the likelihood of behavioral occurrences that might threaten the success of this new placement. Some additional positive comments about the LSSLC placement process, however, are warranted. First, LSSLC continued to place individuals, and placement was a desired outcome for many individuals at the facility. Second, individuals were placed from all units at the facility, representing all ages and functioning levels. Third, individuals had opportunities to select from different providers, visit different homes, and go on overnight visits. Fourth, for many individuals, there were multiple PSPA meetings leading up to their final CLDP prior to move. Fifth, the CLDPs contained a good description of the individual's history of placement and activities that led to this placement. These were all important and positive characteristics of the LSSLC placement process. Further, the monitoring team had the opportunity to attend the CLDP meeting for Individual #534. The poor quality of the speakerphone was an impediment to family participation. The facility must get a better speakerphone arrangement. More and more placements will be occurring and, therefore, more and more meetings will include participants via speakerphone so that a wide range of people can participate. The APC led the meeting and it was, overall, a productive discussion of his history, the choice of provider, his support needs, and details of his upcoming transition. The PST, MRA, parent, and provider appeared to have a good working relationship. The comments above regarding appointments, inservicing, training objectives, and the need for more explicit outcomes were evident in this meeting, too. In particular, examples of providing more detail regarding Individual #534's use of his communication device (e.g., training objective for teaching and learning, check-off sheet for use throughout the day), wearing of orthotics (e.g., check-off sheet for daily monitoring), and being supervised to have bite size food pieces were discussed, with participation by the monitoring team.	
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	DADS had developed three self-monitoring tools for the SSLCs to use to self-monitor performance related to most integrated setting practices. These reviewed the living options discussion at the annual PSP meeting, the CLDP document, and the post move monitoring documents. Completed forms were submitted from February 2011 and April 2011. Some were done by the PMM, others by the QA department. There were one or two for each of the three	Noncompliance

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	responsible, consistent with the provisions of this Section T.	new statewide self-monitoring formats. This was good to see and both the PMM and the QA staff member were serious about doing this correctly and making it a valuable exercise. It is expected that the forms will be updated, but more importantly, the PMM and QA staff should work together to ensure they are scoring items in a consistent and reliable manner. Further, they will need to ensure that the contents of their tool, and the definitions they use to determine presence are consistent with that of the soon-to-be-disseminated revised state policy and with that of the monitoring team. In addition to the implementation of self-monitoring, data from the referral and placement activities at LSSLC should be submitted to and incorporated into the QA program at the facility (see section E above). Certainly, a variety of data can be collected and reported by the APC that would be of interest to the facility's QA department and to its senior management team. Examples include: • Individuals placed • Individuals referred • Obstacles to placement • Action plans related to obstacles • Educational activities • Number of providers, quality of providers	
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	At the facility level, LSSLC was not in compliance with this provision item. LSSLC was not gathering relevant information regarding obstacles across the facility. LSSLC was not analyzing information related to identified obstacles to individuals' movement to more integrated settings. 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 state level, 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.	Noncompliance

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	resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	Some obstacles might be able to be resolved at the facility-level, while others will need state intervention. The data that will be used were being entered into the system as each individual planning session transpired. This was to occur beginning 9/1/10, however, no data were submitted to the monitoring team. If implemented, this appeared to be a reasonable approach to reaching substantial compliance with the requirements of this provision item. The monitoring team recommends that further information be collected regarding one type of obstacle, that is, LAR preference for the individual to remain at the SSLC. Rather than solely listing this as an obstacle, the report should indicate the reasons for the LAR's preference (i.e., reluctance to support referral). This information will be helpful to DADS and to each facility.	
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	The monitoring team was given a document titled "Community Placement Report." It was updated 4/7/11 (i.e., the week prior to the onsite review). This provision item was found to be in substantial compliance given the current contents as well as the facility and state's intention to include, in future Community Placement Reports, a list of those individuals who would be referred by the PST except for the objection of the LAR, whether or not the individual himself or herself has expressed, or is capable of expressing, a preference for referral. As noted above with regard to provision T1a, professionals on individuals' teams need to make independent recommendations regarding the appropriateness of an individual for community placement. The state indicated that at this time, its data system did not include this information, but it was working toward being able to produce these data in the near future.	Substantial Compliance

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	facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool 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.	LSSLC was implementing the post move monitoring process. Post move monitoring was conducted by the post-move monitor, Glenda Pierce. A recent change in state policy and practice required each SSLC to post move monitor all of its own placements. This was a very good change, as noted below, however, the facility will need to examine the travel and time requirements to determine whether more than one PMM will be needed, especially given that more placements are likely to occur once the facility becomes one of the only SSLCs to accept individuals under age 18. There were many positive aspects to the post move monitoring as evidenced by discussions with the APC and PMM, and a detailed review of completed post move monitoring forms and associated attachments as listed above in Documents Reviewed. • The PMM completed all post move monitoring within the required timelines. • The PMM used a standard assessment tool that was consistent with the sample tool at Appendix C of the Settlement Agreement. • The post move monitoring forms were completed in a cumulative manner. That is, the PMM added commentary and findings to each successive post move monitoring form such that, by the completion of the 90-day post move monitoring, all three post move monitorings were described in a single completed form. This made it extremely easy for the reader to see the set of reviews, the progress of support provision over the three months, and the manner in which problems were addressed and solved. • The narrative paragraphs were very well written. They were descriptive, including both directly observable items and the PMM's subjective opinions. The monitoring team appreciated the clear writing style of the PMM. • Information from the PMM's pre-move site review was included in the post move monitoring (primarily the essential supports). This was another way that the post move monitoring form, as completed at LSSLC, adequately described, from pre-move through 90-day review, the transition and experience of each these individual.	Substantial Compliance

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		• In many of the forms, the PMM clearly indicated when a nonessential support was not yet required to be completed (e.g., "not required at 7-day"). • Narrative summary comments at the end of the post move monitoring form were very informative and helped the reader to understand the overall context of the details in the preceding pages. The monitoring team recommends that this be a standard part of all post move monitoring forms. • Requiring that the individual's LSSLC PST meet after each post move monitoring visit was another great idea and had already born positive outcomes. For example, Individual #283's PST was very concerned about the provider's need to do more to address her weight, eating at restaurants, and making good food choices. The PST's concerns were brought back to the provider by the PMM. She then followed up on these to completion. • LSSLC was now post move monitoring all of its own placements. This was another good improvement. It provided better continuity for the placed individual because the PMM and PST that knew, and had placed, the individual, were now more involved in the post placement activities. This was evident in a review of Individual #378's set of post move monitoring forms. LSSLC took over this post move monitoring for the final (90-day) review from another facility. The detail, depth, and individualization of the 90-day review far exceeded that done by the other facility. This was further evident in the monitoring team's review of two individuals placed by LSSLC, but post move monitored by another facility (Individual #350, Individual #113). The quality of their post move monitoring forms paled in comparison to that of the individual's monitored by LSSLC's PMM. The PMM demonstrated good follow up on a number of incomplete items. She was assertive and did not hesitate to directly contact providers and MRA staff, involve the individual's LSSLC PST and PST members, and seek assistance from the APC when needed. For example: • Individual #538: the PMM ensured that the provider addressed and corrected an apparent overuse of constipation medication. • Individual #398: the PMM required that the provider fix the broken backyard fence, repair the deck, and remove the carpeting in his bedroom. All of these were related to essential supports identified in the CLDP. The PMM then required a full site review before approving the individual's move. This was great to see. • Individual #283's PST wanted the provider to do more to address her weight, eating high calorie foods at restaurants, and making good food choices throughout her day. The PMM followed up on this. • At the 90-day post move monitoring, the LSSLC PMM found that Individual	

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		#378's provider had not adequately implemented a number of required essential and nonessential supports (unfortunately, this had not been identified by the other facility's PMM). For example, the provider had not provided the required psychological services as per the nonessential support in his CLDP. As a result, she involved the PST and required an additional post move monitoring visit. • The PMM found that Individual #219 was homesick for LSSLC. Specifically, he missed seeing his friends and members of his PST. The PMM brought this information back to the PST and they quickly arranged to visit him and have him visit them. Further, the PMM ensured that two supports were implemented to acceptable completion: church attendance (one of his preferences), and getting him his TV. It appeared to the monitoring team that without the LSSLC PMM's involvement, neither of these actions would have occurred. This was an example of the importance of the PMM being active and assertive throughout the post move monitoring process. • Although Individual #260's provider brought her to an ophthalmology appointment, as required by the CLDP, the PMM was extremely concerned that the ophthalmology results were lackadaisical, given Individual #260's history and needs, and the PMM's knowledge of the individual. As a result, the PMM obtained PST input, required the provider to see the ophthalmologist again, required the provider to implement additional vision supports for Individual #260, and conducted an additional post move monitoring visit after the 90-day review. • Although Individual #340's placement eventually failed, the PMM and APC conducted two interim post move monitoring visits, for a total of five. As a result, additional staff training occurred and the LSSLC psychologist conducted a site visit with provider staff. As noted above, LSSLC should treat every failed placement as a "sentinel event" for their department and, thereby, subject it to intense review and scrutiny. Some aspects of the post move monitoring process, however, require improvement if the facility is to maintain substantial compliance. • The previous form had a column for the PMM to indicate yes/no/na for each support. The new form did not contain this column, but should. • In at least one instance (Individual #398), the provider did not meet the 45-day requirement for him to have an appointment with a new psychiatrist. This was due, perhaps in part, to the difficulty many providers have in locating a psychiatrist who will accept the individual's health insurance. PSTs should consider requiring these types of appointments to be set prior to the individual's move, that is, the setting of an appointment can be considered to be an essential	

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		support. • The inclusion of a column to indicate the evidence that the PST determined would be required to be present to indicate presence of the support was an excellent and needed addition to the post move monitoring process. Making this type of determination should not be the PMM's responsibility; instead it should be done by the PST, most preferably, during the CLDP meeting. Thus, the PST, at the CLDP meeting, needs to identify, for every essential and nonessential support: o what evidence should be present, and o the criterion for this evidence. Even though there were many problems in each individual's CLDP regarding the proper definition and description of evidence, the monitoring team based its finding of substantial compliance with this provision item on the PMM's professional, consistent, and tenacious efforts at post move monitoring. As the definition of supports and the description of evidence improves, her post move monitoring will become even more effective.	
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 PMM on a visit to the group home of Individual #283 for her 45-day post move monitoring visit. 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 nonessential supports. The monitoring team wishes to thank the PMM and the community agency for making arrangements for this visit to occur. Also attending this visit were the APC and the facility's QA staff member who was assigned to most integrated setting practices. The home was operated by D&S Services. The regional director, John Moore, was also present for this visit. Four individuals lived at the home, including Individual #260. Overall, it was a clean, simply furnished home in a nice residential neighborhood and appeared to be a nice place to live. All of the women seemed to be happy. Individual #283 talked with the post move monitor and the monitoring team. She expressed herself very clearly. For example, she said, "I like it here, I don't want to move no more. This is the best home" and, "I love my home, I got good staff." She was referring to an option the provider was making available, as per her CLDP, for her to move to a new home in another town once it was opened. In particular, the individual was very	Substantial Compliance

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		proud of her success in losing weight over the past few weeks. The PMM was professional and personable with the individual and with the staff and regional director. The PMM used the post monitoring form and went through each support one by one. As was not surprising (given the problems noted above), many of the supports were not defined in a way that clearly indicated how the PMM was to determine its presence. The monitoring team took the opportunity to explain ways in which each support could have been defined more adequately and the types of evidence a PMM could, and should, ask to see. Examples were related to supports that called for there to be staff inservices without calling for the monitoring of implementation of those supports (see T2a 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 item does not receive a rating.	
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency	One individual was discharged properly as per the requirements of this provision item as evidence by documents submitted to the monitoring team. The individual and the reason for discharge are below: • Individual #563: declining health and need for respiratory nursing care.	Substantial Compliance

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

Recommendations:

1. Do additional follow up post move monitoring with Individual #283 to ensure that any medication-related weight issues are thoroughly explored by her new provider and new treating clinicians.

2. Implement updated DADS policy on most integrated setting practices, when it is disseminated.

3. Revise facility policies to be in line with the updated DADS policy.

4. Implement the updated version of the living options discussion as per the updated DADS policy.

5. Update the facility's tool for monitoring the PSP meeting so that it is in line with the new style PSP meeting and so that it contains monitoring of the discussion of the most integrated setting/optimistic living vision. Also, update the other two self-monitoring tools (CLDPs, post move monitoring).

6. Ensure that the opinions of professionals regarding referral are obtained and explicitly documented, separate from the preferences of the LAR and the team as a whole.

7. Identify and address the obstacles to each individual's movement to the most integrated setting within the PSP for each individual.

8. The PSP document should include an explicit statement regarding how the individual was assessed for placement.

9. Identify, for each individual, the plan for the upcoming year to educate the individual and his or her LAR regarding community options. Include a description of what was conducted over the previous year. This could be included in the PSP document.

10. Don't make multiple separate objectives in the PSP action plans for a single skills' steps in a task analysis or for the systematic fading of prompts. These are good teaching techniques and should be included in the skill acquisition plan.

11. Graph and track departmental data. See suggestions in T1a and T1f.

12. Include department data in the facility's QA program.

13. Create a correct and thorough lists of individuals who would be referred except for the preference of the individual's LAR. This list should be for individuals who can, as well as those who cannot, express a preference.

14. Identify and address obstacles to referral and placement across all individuals at the facility by conducting a comprehensive assessment and analyzing the information as required by provision item T1g. Include a review and analysis of the fluctuating numbers of placements and referrals.

15. Determine desired outcomes and assess the effectiveness of the CLOIP process and community tours.

16. Improve the way important essential and nonessential supports are included in the CLDP:
    a. Ensure that a wide range of all important supports are directly taken from professional assessments and recommendations, discussions at relevant PST meetings, and the individual's records.
    b. Define each support in observable and measureable terms, and define the manner in which the presence of each support will be verified.
    c. Include a criterion along with the evidence required for each support.

17. Review all failed placements by doing a comprehensive review (e.g., root cause analysis).

18. Review all rescinded referrals by doing a comprehensive review (e.g., root cause analysis).

19. Consider further revising the new CLDP form as per the bullet points presented in T1c.

20. Consider revising the post move monitoring form as per the comments in T2a.

21. Get a working and high quality speakerphone for the department.

The following are offered as additional suggestions to the facility:

22. DADS should provide feedback and suggestions on the facility's CLDPs to the APC. In addition, 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 eventually being necessary.

23. Improve the self-advocacy program at the facility.

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o List of individuals for whom an LAR had been obtained since 10/1/10 o DRAFT DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o Personal Support Plans for: • Individual #538, Individual #560, Individual #144, Individual #170, Individual #45, Individual #267, Individual #258, Individual #300, Individual #256, Individual #349, Individual #166, Individual #203, Individual #573, Individual #593, Individual #146, Individual #29, Individual #470, Individual #498, Individual #290, Individual #504, and Individual #475. Interviews and Meetings Held: • Informal interviews with various individuals and direct support professionals • Luz Carver, QMRP Coordinator • Stacie Cearley, Incident Management Coordinator • Royce Garrett, Consumer and Family Relations Director Observations Conducted: • Observations at residences and day programs • Castle Pines Morning Unit Meeting 4/19/11 • Human Rights Committee Meeting 4/20/11 • Annual PSP meetings for Individual #593 and Individual #162
	Facility Self-Assessment: The facility's POI indicated that the facility had assigned a rating of noncompliance to both items in this provision and were waiting on the new state policy to address consent and guardianship issues. The monitoring team agreed with the finding of noncompliance for this provision.
	Summary of Monitor's Assessment: Since LSSLC did not indicate it was in compliance with any of the provisions of this section, and particularly, since it indicated it was waiting on the final statewide policy and training before taking most actions, the monitoring team reviewed a small sample of documents in order to be able to assess progress, if any, from the previous review and provide any additional recommendations that may be helpful to the facility when it does undertake action in these provisions. Comments are as follows:

	• Provision item U1 was determined to be in noncompliance. The facility did maintain a prioritized list of individuals needing an LAR. Not all individuals at the facility were included on the list and not all PSTs were adequately addressing the need for an LAR or advocate. • Provision item U2 was determined to be in noncompliance. The facility had pursued guardianship for a small number of individuals at LSSLC. Compliance with this provision item will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a prerequisite.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The facility had a Director of Individual and Family Relations who was responsible for the development of a process to address this provision item. LSSLC did not have a policy in place for developing and maintaining 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. They were still waiting on the state policy regarding this provision. The state developed a draft policy to address this provision, but had not yet released it to the SSLCs for implementation. The facility's POI indicated that it plans to take action in these areas once the policy was finalized. 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, continued to maintain a Priority Listing for Adults Without Guardians that prioritized need for guardianship based on: • Individuals without 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. At the last review, 227 individuals (58%) had been ranked for need of guardianship. The rankings were as follows: Level 5 (highest priority) – 5 individuals Level 4 – 31 individuals Level 3 – 72 individuals	Noncompliance

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		Level 2 – 69 individuals Level 1 – 38 individuals Not a priority – 12 individuals As of 3/15/11, 228 individuals (58%) had been ranked for need of guardianship. The rankings were as follows: Level 5 – 21 Level 4 – 76 Level 3 – 79 Level 2 – 44 Level 1 - 8 . While the facility was not in substantial compliance with this provision item, staff were taking positive steps to put procedures in place to do so. In 21 PSPs reviewed, there were 10 individuals (48%) who did not have guardians. There was at least minimal discussion of the individualized need for an LAR in nine (90%) of these 10 PSPs. Examples included: • Individual #504 did not have an LAR. His PSP indicated that a guardianship packet had been mailed to his father on 11/30/10 and he planned to pursue guardianship. The PSP indicated that The Human Rights Committee had approved restrictions to his money and restraint use for medical and dental procedures. He was listed as a Priority 4 for guardianship. • Individual #290 did not have a guardian, but his sister served as an advocate for him. His PSP indicated that a guardianship packet had been mailed to his sister on 11/20/10. The HRC had approved restrictions on his spending money and sedation for dental appointments. He was listed as a Priority 4 for guardianship. • Individual #498's PSP indicated that she did not have an LAR, but her mother served as an advocate for him. The PSP documented that his sister had been given information on guardianship. There was no discussion regarding her ability to give informed consent in the PSP. Her PSP indicated that she had restrictions on her spending money and the use of restraints for medical appointments had been approved by the HRC. • Individual #29 did not have an LAR or an advocate. She had no contact with her family. Her PSP indicated that she demonstrated no comprehension of the value or concept of money and she is unable to make a clear and informed reference as to where and with whom she would like to live. There was no discussion regarding the need for a guardian at her annual PST meeting. She was listed as a Priority 4 for guardianship. • Individual #146 did not have an LAR or advocate. The PST determined that she	

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		would benefit from having a guardian to assist her with decision making. An action referral was forwarded to the Community and Family Relations Department to be placed on the list for guardianship. She was listed as a Priority 2 for guardianship. • Individual #470 did not have an LAR. Her sister was listed as her advocate. She was at high risk for a number of significant medical issues. Her PSP noted that she had very little if any ability to understand her living options. The team determined that she was not able to give or withdraw consent. The team determined that she was in need of a guardian. Her sister expressed interest in pursuing guardianship, but indicated that she did not have to funds to do so right now. She was listed as a Priority 2 for guardianship. • Individual #593 did not have an LAR. His PSP indicated that his cousin served as his advocate. His cousin told the social worker that she might seek guardianship but she would wait until he absolutely needed one. He was listed as a Priority 3 for guardianship. There was no discussion regarding his ability to make informed decisions. • Individual #573 did not have an LAR. His PSP indicated that his mother served as an advocate for him. The PST determined that he should be referred for a guardian. He was listed as a Priority 3 for guardianship. • Individual #203 did not have a guardian. His sister was his correspondent, but had not seen him in 13 years. Information was mailed to her regarding guardianship on 8/6/10. He was listed as a Priority 3 for guardianship. • Individual #166 did not have a guardian. Her PSP indicated that she had a number of restrictions approved by the HRC. Her ability to make an informed decision was not discussed. She had consistently requested community placement, but her team determined that it was not appropriate for her, so they had not referred her for community placement. The team agreed that she should be referred to the guardianship coordinator to pursue guardianship on her behalf. She was listed as a Priority 3 for guardianship.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting	LSSLC did not have policy or procedure established to implement this provision item. It reported it was awaiting the final version of the statewide Policy Number: 019 Rights and Protection (including Consent & Guardianship) before developing facility-specific documents. The facility continued to make efforts to obtain LARs for individuals through contact and education with family members. According to documentation provided to the monitoring team, there were five individuals at the facility who had obtained a guardian since 10/1/10.	Noncompliance

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	and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	The facility did have some rights protections in place including an assistant independent ombudsman housed at the facility and a rights officer employed by the facility. There was a Human Rights Committee (HRC) at the facility that met to review all emergency restraints or restrictions, all behavior support plans and safety plans, and any other restriction of rights for individuals at LSSLC. The monitoring team observed the HRC meeting held the week of the monitoring visit. The committee, unfortunately, did not effectively review and discuss rights restrictions. Only very basic information was presented to the committee and restrictions were approved with little appropriate discussion. The monitoring team encourages the facility to continue to explore new ways to support the rights of individuals while working through the guardianship process. Some other options outside of guardianship that the facility should explore are active advocates for individuals and health care proxy/medical power of attorney for individuals.	

Recommendations:

1. Ensure all teams are discussing and documenting each individual's ability to make informed decisions and need for an LAR.
2. Continue to provide information to primary correspondents/families of individuals in need of an LAR regarding local resources and the process of becoming an LAR.
3. 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.
4. Continue to explore new ways to support the rights of individuals while working through the guardianship process. Some other options outside of guardianship that the facility should explore are active advocates for individuals and health care proxy/medical power of attorney for individuals.
5. Ensure that any restriction of rights for an individual is approved through the Human Rights Committee approval process.
6. Improve the operation of the HRC so that it meets the intent for which it was designed.

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, updated 3/11/11 o Organizational chart, undated o LSSLC policy lists, 3/17/11 o List of typical meetings that occurred at LSSLC o LSSLC POI, 4/4/11 o LSSLC Recordkeeping Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 4/18/11 o New state-provided tables of contents active records and individual notebooks, 4/12/11 o Table of contents for the master record, dated 3/8/11 o List of all staff responsible for management of unified records o Description of how documents flowed from completion to filing in records o Description of the record auditing procedures o Two spreadsheets that tracked the status of state and facility policies for each provision of the Settlement Agreement o Email regarding state office expectations for facility-specific policies, from central office SSLC director of operations, Donna Jesse, 3/15/11 o List of individuals whose unified records were audited each month, 11/10 through 4/11 o 10 Completed audits for December 2010 (two), January 2011 (five), and February 2011 (three): • active records (two forms), • individual notebooks, • master records, • list of items that needed to be corrected, and • follow-up notations as to whether these items were corrected. • responses from some PST members to question from URC regarding their use of the records o Email regarding individual notebooks from Becky McPherson to the SSLCs, 12/9/10 o State draft questionnaire on use of records (for V4) o Active records of many individuals who lived at LSSLC during observations in residences o Review of active records and/or individual notebooks of: • Individual #542, Individual #156, Individual #267, Individual #160, Individual #476, Individual #534, Individual #191, Individual #118, Individual #449 o Review of master records of: • Individual #279, Individual #444

	Interviews and Meetings Held: o Stacie Cearley, Client Records and Incident Management Coordinator o Sheila Thacker and Stormy Tullos, Unified Records Coordinators o Sherry Roark, Settlement Agreement Coordinator o Becky McPherson, Program Compliance Coordinator o Numerous staff and clinicians during observations in residences Observations Conducted: o Records storage areas in residences o Master records storage area in administrative building
	Facility Self-Assessment: The facility's self-assessment, called the POI, was submitted to the monitoring team. The POI was revised since the last onsite review. The new version was shorter and more likely to be useful to the facility. It listed the four provision items, what the facility did or planned to do for each provision item, and actions it had taken towards addressing five of the recommendations made in the previous monitoring report. LSSLC self-rated all four provisions as being in noncompliance. The monitoring was in agreement with these self-ratings. Even given these ratings, the facility had made a lot of progress in its recordkeeping practices and in its work towards achieving substantial compliance with this provision. The monitoring team wishes to acknowledge these efforts.
	Summary of Monitor's Assessment: Overall, LSSLC had made a lot of progress towards achieving substantial compliance with the items of this provision. Moreover, the two unified records coordinators were responsive to many of the recommendations and suggestions made in the previous monitoring report. 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. The new set of records followed the state's policy. A facility-specific policy was written and DADS central office had provided feedback requiring some editing before approval would be given. The active records and individual notebooks were organized according to the required format. Overall, the new records were neat, entries were made as required, and most required documents were contained in the record. The nursing section, however, was very large and consideration should be given to either reducing the size or subdividing so that it is more manageable for all staff. Further, It would be helpful for there to be information as to what consents are appropriate and required for each individual, and an indication of what medical consultations should be in each individual's record.

	Individual notebooks were also in place for each individual. There were mixed reports from staff, managers, and clinicians regarding the usefulness, and occasional counter-therapeutic nature, of the individual notebooks. A determination will need to be made as to whether the individual notebooks can be eliminated. If so, the facility will need to ensure that the original intentions for creating the individual notebooks are met via other processes. The master records were being organized according to a newly revised table of contents. The LSSLC master records, however, contained a great number of documents, many of which appeared to be unnecessary to include in a master record (e.g., recent psychiatric consultation, ARD/IEP form). A complete set of state and facility policies had continued to grow since the last onsite review, but was not yet complete and comprehensive as required by provision V2. Two new spreadsheets were being used to manage and track the existence and development of both the state and the facility policies for each provision of the Settlement Agreement. State central office had recently taken a much more hands on approach in managing, directing, and supporting the facilities to have appropriate facility-specific policies for all Settlement Agreement provisions. The conduct of quality assurance reviews of the unified record was another area where continued improvement occurred since the last review. Thorough reviews of all three components of the unified record were conducted by the unified records coordinators. Items needing correction were listed, the relevant manager or clinician was notified via email, and follow up was done one week later. Based on numerous filing errors and missing documents, the URCs provided nighttime training to overnight staff and overnight supervisors. LSSLC had taken some first steps towards ways to determine whether and how the unified records were used in making treatment decisions as specified in provision V4. The one activity occurring at LSSLC was that the URCs asked one or two PST members how they used the records. More work will need to be done and assistance from central office will be required. The recordkeeping department was not, but now should be, collecting data on its own performance and submitting those data to QA to be part of the facility's QA program.

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the	LSSLC had established, but had not yet maintained, a unified record for each individual consistent with the guidelines in Appendix D of the Settlement Agreement. Overall, the department had made a lot of progress since the last monitoring review. DADS had developed a policy on recordkeeping called Recordkeeping Practices. It was numbered 020.1, was dated 3/5/10, and was adopted in full by LSSLC. In addition,	Noncompliance

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	guidelines in Appendix D.	LSSLC had its own policy, called "Management of Protected Health Information." It was labeled Administrative-03 and was updated March 2011. The updated policy appeared to be in line with the state policy. It had been approved by the facility's internal policy approval process and had received feedback from the DADS central office. 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 URCs and the unit record clerks were now focusing on maintaining these records. The completed unified record consisted of the following, as required: • Active record • Individual notebook • Master record • Overflow files Tables of contents for the active records and individual notebooks were updated by DADS central office, coincidentally, during the week of the onsite review. The updates reflected the ongoing process of ensuring the tables of contents and thinning guidelines were meeting the needs of the facilities and their staff. In addition, LSSLC added items to the state's listing based on this facility's needs. All changes were clearly indicated on the table of contents. Recordkeeping activities continued to be managed primarily by the two experienced and dedicated Unified Records Coordinators. Since the last onsite review, they had modified the tables of contents to meet the needs of the facility, initiated record audits, collaborated with URCs at other SSLCs, and strengthened their relationships with the facility's many managers and clinicians. The monitoring team recommends that the recordkeeping department begin to collect data on its own performance. To do so, the URCs should list out the metrics that would be beneficial for their ongoing management of recordkeeping activities as well as be of interest to the facility. Examples include, but are not limited to: • Number of records reviewed per month • Average number of items that required correction per individual unified record • Number of incomplete corrections after a specified period of time (e.g., one month) These data should then be incorporated into the facility's QA program. While onsite, the monitoring team had the opportunity to speak at length with the DADS	

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		program compliance coordinator who is the DADS central office lead for recordkeeping activities. The monitoring team appreciated this opportunity and remains available for ongoing discussion. Discussion topics were relevant to all SSLCs and included the following: • potential future of individual notebooks • need for a table of contents/guidelines for the master record • plan for the master record to not contain unnecessary duplicative documents • determining what should be in the consents, habilitation, medical consultation, and SAP/SPO sections • activities regarding provision item V4, the determination of the facility's use of the unified records to make treatment and care decisions. <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 two or three three-inch binders. The active records were constructed following the order of sections from the state's table of contents. The active records were divided across the binders in the same way for all individuals across the facility. The active records were shelved on carousel-type rotating racks. These were new and provided an efficient way of storing the records. For example, in home 524, the active records were on this rotating rack providing easy access to the records. In home 557B, the rotating rack was a locking version because it had to placed in the living room area due to space restrictions in the office area). A review of observation notes and IPNs in the active records indicated that they appeared to be in good format, easy to read, and ordered correctly, though this was not always the case (e.g., gaps in IPNs). Note that this review of observation notes and IPNs refers to their format and appearance, not to their content; content is reviewed when applicable in the review of each provision of the Settlement Agreement in the other sections of this report). The active records of a number of individuals were reviewed in some detail (see list above under Documents Reviewed). Overall, they were well organized, neat, and consistent. Below are some general comments. • The three-volume active record for Individual #267was one of the best observed during the onsite review. Documents were filed correctly and neatly and it was easy to access all of the sections of the active record. • SAPs were separated by manila-colored dividers, this seemed to be a good system. The active record for Individual #156, however, used green stickie note	

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		tabs. This seemed to make it more difficult to easily find each SAP because the tabs were not at the first page of each SAP. • Individual #156's IPNs were in DAP format. The facility was planning to begin using SOAP format for IPNs. • The URCs reported that they had modified the way the active records were divided across binders to ensure that physician orders, IPNs, and nursing were in one binder. They reported that this was what the physicians wanted and they were being responsive to their request. This was good to see. • Since the previous review, the facility had clarified what documents needed to be in the habilitation section of the active record. They did so by adapting the table of contents to provide more detail (this was done statewide). Further, the new habilitation director provided the URCs with a list of what specific documents should be in the record for every individual. This was very helpful to the URCs. • At LSSLC, the overnight staff had responsibilities for some active record and individual notebook management, such as pulling documents from the individual notebook and putting them into the active record. The URCs reported that a lot of errors were occurring and documents were missing in both the active records and the individual notebooks. As a result they conducted inservices at 9 pm for some of the overnight staff and for all of the overnight managers. The effects of this training were not yet being assessed, but should be. For example, the audit findings could also be sorted by home and by type of correction needed. Some errors might be identified as being due to overnight staff mistakes. • More work still needed to be done to determine what consents should be in the consents section because not every individual was required to have the identical set of consents. • Similarly, the URCs were unable to determine what medical consultation documentation should be in each active record because these varied from individual to individual (e.g., cardiac, podiatry, vision). The monitoring team suggests that the URCs find out if the facility's medical department keeps a list of these consultations and, if so, whether a copy can be obtained every month for their use during record audits. • The nursing sections of the active records were very large. The facility should undertake a review of what is in the nursing section and determine if it can be reduced or perhaps subdivided. <u>Individual notebooks</u> Individual notebooks existed for each individual and were observed throughout the facility. For example, they were at each work area (called work lines) in the large	

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		workshop, out on tables in home 557B, and in the pouches on the back of wheelchairs (e.g., Individual #191). A notice from DADS central office in December 2010 allowed the SSLCs to do away with the individual notebooks, as long as they were able to meet a set of criteria, primarily centered around ensuring that information was readily available to direct care and clinical staff, and that a system was in place to allow accurate and reliable recording of pertinent data, such as the occurrence of problem behaviors, seizures, bowel movements, and performance on SAPs. The Settlement Agreement, however, specifically refers to the individual notebooks in Appendix D. The Monitoring Panel has recently had some initial discussions with DADS and DOJ regarding the individual notebooks and expects to be able to provide specific direction to the SSLCs in the next few months. Therefore, LSSLC should continue to maintain the individual notebooks until further direction is provided. The URCs reported that the individual notebooks were working fine at LSSLC. The monitoring team, however, heard a range of descriptions of the usefulness of the individual notebooks from staff, managers, and clinicians. For example, in home 524, a direct support professional commented that the home used to have one big book per group and that she liked that system better. The home supervisor, however, said the individual notebooks were more helpful than what they had before. Once the facility is provided with direction from central office, LSSLC should determine how best to proceed. Some comments regarding the onsite review of the individual notebooks are below: • The PSPs in the individual notebooks included attachments of all of the annual assessments. LSSLC should determine whether these attachments are necessary for inclusion in the individual notebook. • Data for PNMPs and PBSPs were recorded up to date in two out of two individual notebooks reviewed (Individual #118, Individual #449). • Individual #156's individual notebook was messy, papers were in the wrong places, and some were torn. • The SAP for Individual #118 to pick up his newspaper was not implemented because the newspaper was unavailable at the office. The SAP for Individual #449 to participate in community activities was not offered to him for two out of four opportunities. These were SAPs that required staff to be organized and plan ahead. The facility should see if this is a common problem or whether these were isolated cases. <u>Master records</u> The URCs had developed a table of contents for the master record since the last onsite	

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		review. As suggested by the monitoring team, they spoke with the URC at the San Antonio SSLC. As noted above, monitoring recommends that a standard table of contents across facilities be created that indicates what, at a minimum, should be in each master record. At LSSLC, however, it appeared that the master record contained much more than it needed to. The master record should be, primarily for important documents that do not exist elsewhere and/or are important to retain in a separate record, such as an original birth certificate, determination of disability, court orders, and guardianship papers. Moreover, unnecessary duplicating documents and storing them in the master record (e.g., recent PSPs, recent psychiatric notes) uses too much of the URCs' time, when it would be better spent working with the unit record clerks, conducting record audits, collecting and reporting data, and so forth. Two master records were reviewed, one for a more recent admission (Individual #279) and one for an individual who lived at LSSLC for many years (Individual #444). Examples of items that could probably be removed were the ARD/IEP for Individual #279 and the March 2011 psychiatric quarterly review for Individual #444. Furthermore, the master records sometimes contained very old information that was no longer relevant, but due to its age, recordkeeping staff did not want to remove any of it. For example, there was a note from a physician from 1950 regarding Individual #444. The facilities could use guidance from state office as to how to handle these types of documents and papers. <u>Overflow files</u> Purged items were stored in excess folders by the unit record clerks and then sent to the URCs for organizing and storage at their office space. After two years, purged items were boxed and sent to a commercial storage facility.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	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 recently created a spreadsheet for each facility that showed the status of the state policy and the status of any facility-specific policies for each provision of the Settlement Agreement. LSSLC created a second spreadsheet that provided additional details regarding their facility-specific policies. These were managed by the QA director. These spreadsheets appeared to be useful for the facility to easily track the latest version of each state policy as well as ensuring that management was aware of where the facility	Noncompliance

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		stood in terms of the development of its own policies for each provision. The monitoring team was very pleased to see the organized and systematic way that state office was going about managing facility-specific policies, that is, state office: • Required a facility-specific policy (or policies) for every Settlement Agreement provision • Required each facility-specific policy to be in line with the contents of the state policy • Required the facility to submit each facility-specific policy for approval • Provided feedback on the content of each facility-specific policy • Detailed these expectations in an email from the DADS SSLC director of operations, dated 3/15/11	
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.	The LSSLC URCs developed a system of reviewing the active records. Overall, the audit review system was going well and was likely to improve and become more consistent over the next few months. It consisted of: • Review of a sample of unified records by the URCs, with a goal of five per month. The review included all three components of the active record. This was good to see. • Listing all required corrections on the last page(s) of the review tool • Noting if/when the correction was completed on the review tool (the URCs check for correction one week after the review) • Surveying one or two PST members about their use of the records (see V4 below) QA department staff had not yet done any reliability checks of URC reviews. At this time, five audits were not being done consistently every month. They were November 2010 (four), December 2010 (four), January 2011 (five), February 2011 (three), March 2011 (none), and April 2011 (one). The audit reviews utilized two forms for the active records and individual notebooks: the statewide tool of characteristics, and a version of the table of contents. The combined use of these two tools was a good way to conduct the reviews. In addition, a simple one-page checklist was used for the reviews of the master records. Following each review, emails were sent to the relevant manager or clinician. Numerous emails were submitted to the monitoring team showing evidence of this correspondence. Typical examples included missing PNMPs, SAPs, and CLOIP worksheets. Many of the reviews indicated that there were gaps (empty lines) between entries in the active	Noncompliance

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		records. The URC wrote a clear one-page memo to the facility staff explaining the need to make this simple correction. The URCs need to create some way of tracking the needed corrections. For the moment, they were able to look back at each of the previous reviews to determine what corrections were still needed, but as the months proceed, this will be more difficult. The URCs at the Mexia SSLC were working on a way to do this, including developing a list of criteria for determining the length of time to do follow up for certain items. The LSSLC URCs might contact the Mexia SSLC URCs for more discussion and collaboration. In addition, LSSLC needs to do some sort of summarizing of the data from the reviews in both a graphic/tabular format and in a short narrative that describes the highlights of the data. Moreover, the information should be tracked and trended over time and included in the facility's QA program. The information should include, for example, number of reviews conducted, number of items that needed correction, and number of outstanding corrections (see V1 above). The monitoring recommends that state office share best practices across facilities and perhaps come up with a list of minimally required components of the overall quality assurance (audit) procedures.	
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.	DADS and LSSLC had taken some first steps towards addressing this provision item. Much more work will need to be done, however, to determine what activities the facility needs to engage in to demonstrate that records are being used as required by this provision item. The Monitoring Panel expects to work with DADS and DOJ over the next few months to delineate these activities. Further, as noted in V1 above, the monitoring team and the program compliance officer at state office had the opportunity to discuss this provision item at some length during the week of the onsite review. The one activity occurring at LSSLC was that the URCs asked one or two PST members how they used the records. Email responses were submitted to the monitoring team as evidence of this activity. The email responses should be summarized in some way for use by the facility. There were a number of interesting responses. Another possible activity to this end might be to ask QAQI Council members to describe how each of their departments uses the records as per the requirements of this provision item. The answers might provide some direction to the recordkeeping department. These activities, however, are just one or two of a number of actions that each facility will need to take towards meeting this provision.	Noncompliance

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		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. • Active records were at all of the PST meetings attended by the monitoring team: Individual #476, Individual #534, and Individual #253. • Primary providers were documenting consultation summaries and recommendations in the records. This was, however, very practitioner specific. • In all three observed psychiatric clinic encounters, the individuals record was available and the physician was actively reviewing documents. The psychiatric nurse and psychiatric assistant provided the physician with laboratory data and the most recent MOSES/DISCUS data for review during the encounter. • The psychiatric nurse was in the process of developing a tracking system for psychiatry clinic scheduling and laboratory data. Once this is completed, psychiatry will have the ability to schedule clinic independently and determine if necessary laboratory examinations have been completed and/or monitor the status of the results of these examinations. • Regarding the medical components of the records, the same areas as the 10/10 review required attention: o consistent documentation of the time of day using the 24-hour clock or am and pm was not consistently and completely implemented o IPNs often had multiple blank lines at the bottom of pages o lack of a date accompanying signatures of physician's on 180 day orders as well as for nurses noting the orders o recording the time an IPN was entered into the record o appropriately making late entries into the IPNs o correction of numbers entered in the chart and on forms that were filed in the chart without using established procedure to make the entries. Errors or mistakes are to have a single line drawn through them with initial, date, and time the error was made and the corrected information entered. Late entry procedure may be required. • Several homes we found the individual records locked in the med room (K4). Several of the more independent individuals were out at the gym, and their individual notebooks were left in the home. Several staff interviewed indicated the individual notebooks were not used as intended and not useful. • A number of the photographs intended to help staff implement the PNMP correctly were not current and did not reflect the existing equipment. Further, there were some inconsistencies in the written instructions that could lead to staff confusion and errors in implementation.	

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Recommendations:

1. Develop metrics (i.e., data, outcomes) for the recordkeeping department activities and regularly record these data.
2. Incorporate these recordkeeping department activities and data into the facility's QA program, including but not limited to the data collected by the recordkeeping staff during their record audits.
3. Once a determination is made regarding the individual notebooks, improve the quality of the individual notebooks, or create an alternate system that meets the intention of the individual notebook.
4. Complete task of determining what (a) consents and (b) medical consultation documentation should be in each active record.
5. Consider reducing the size of nursing section of the active record.
6. Reduce the amount of documentation routinely kept in the master records.
7. Track and summarize, perhaps by home, the performance of overnight staff in regards to their recordkeeping responsibilities.
8. Complete the development of policies as described in provision item V2.
9. Conduct the required number of quality assurance reviews (audits) per month (minimum of five).
10. Ensure records are used in making care, medical treatment, and training decisions. With guidance from DADS central office, determine what activities and actions the facility must engage in. Determine a way to assess whether or not these are occurring.

The following are offered as additional suggestions to the facility:

11. Consider whether or not to standardize the table of contents for the master records across SSLCs.
12. Coordinate the sharing of best practices in conducting quality assurance audit reviews across SSLCs.

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ACP	Acute Care Plan
ADA	Americans with Disabilities Act
ADL	Activities of Daily Living
ADR	Adverse Drug Reaction
AED	Anti Epileptic Drugs
AIMS	Abnormal Involuntary Movement Scale
ALT	Alanine Aminotransferase
AMA	Annual Medical Assessment
ANE	Abuse, Neglect, Exploitation
AP	Alleged Perpetrator
APC	Admissions and Placement Coordinator
APL	Active Problem List
APRN	Advance Practice Registered Nurse
APS	Adult Protective Services
ARD	Admissions, Review, and Dismissal
ASA	Aspirin
AST	Aspartate Aminotransferase
AT	Assistive Technology
ATP	Assistive Technology Practitioner
AUD	Audiology
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BID	Twice a Day
BMD	Bone Mass Density
BMI	Body Mass Index
BP	Blood Pressure
BS	Bachelor of Science
BSC	Behavior Support Committee
BSD	Basic Skills Development
BSP	Behavior Support Plan
BUN	Blood Urea Nitrogen
C&S	Culture and Sensitivity
CANRS	Client Abuse and Neglect Registry System
CAP	Corrective Action Plan
CBC	Criminal Background Check
CBC	Complete Blood Count

CC	Cubic Centimeter
CCC	Clinical Certificate of Competency
CDDN	Certified Developmental Disabilities Nurse
CFY	Clinical Fellowship Year
CKD	Chronic Kidney Disease
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CMP	Comprehensive Metabolic Panel
CMS	Centers for Medicare and Medicaid Services
CMS	Circulation, Movement, and Sensation
CNE	Chief Nurse Executive
CNS	Central Nervous System
COTA	Certified Occupational Therapy Assistant
CPK	Creatinine Kinase
CPR	Cardio Pulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
CTD	Competency Training and Development
CV	Curriculum Vitae
CXR	Chest X-ray
DADS	Texas Department of Aging and Disability Services
DAP	Data, Analysis, Plan
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
DME	Durable Medical Equipment
DNR	Do Not Resuscitate
DOJ	U.S. Department of Justice
DRR	Drug Regimen Review
DSM	Diagnostic and Statistical Manual
DUE	Drug Utilization Evaluation
e.g.	exempli gratia (for example)
EBWR	Estimated Body Weight Range
EES	erythromycin ethyl succinate
EKG	Electrocardiogram
EMR	Employee Misconduct Registry
EPS	Extra Pyramidal Syndrome
ER	Emergency Room
ER	Extended Release
FBI	Federal Bureau of Investigation

FBS	Fasting Blood Sugar
FDA	Food and Drug Administration
FOB	Fecal Occult Blood
FSPI	Facility Support Performance Indicators
FTE	Full Time Equivalent
FU	Follow Up
FY	Fiscal Year
G-tube	Gastrostomy Tube
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GM	Gram
H	Hour
HB/HCT	Hemoglobin/Hematocrit
HCG	Health Care Guidelines
HCL	Hydrochloric
HCS	Home and Community-Based Services
HCTZ	Hydrochlorothiazide
HDL	High Density Lipoprotein
HIV	Human immunodeficiency virus
HMP	Health Maintenance Plan
HOB	Head of Bed
HR	Heart Rate
HRC	Human Rights Committee
HST	Health Status Team
IAR	Integrated Active Record
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)
ILASD	Instructor Led Advanced Skills Development
ILSD	Instructor Led Skills Development
IM	Intra-Muscular
IMC	Incident Management Coordinator
IMT	Incident Management Team
IOA	Inter Observer Agreement
IPN	Integrated Progress Note
ISP	Individual Support Plan
IV	Intravenous
JD	
KCL	Potassium Chloride
L	Left

L	Liter
LAR	Legally Authorized Representative
LDL	Low Density Lipoprotein
LFT	Liver Function Test
LISD	Lufkin Independent School District
LOD	Living Options Discussion
LSSLC	Lufkin State Supported Living Center
LVN	Licensed Vocational Nurse
MA	Masters of Arts
MAR	Medication Administration Record
MBD	Mineral Bone Density
MBSS	Modified Barium Swallow Study
MD	Medical Doctor
MED	Masters, Education
MeqL	Milli-equivalent per liter
MERC	Medication Error Review Committee
MG	Milligrams
MH	Mental Health
MI	Simethicone Gas Relief
MOM	Milk of Magnesia
MOSES	Monitoring of Side Effects Scale
MOU	Memorandum of Understanding
MR	Mental Retardation
MRA	Mental Retardation Authority
MRA	Mental Retardation Associate
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphyloccus Aureus
MS	Master of Science
MSPT	Master of Science, Physical Therapy
MISYS	A System for Laboratory Inquiry
NA	Not Applicable
NAN	No Action Necessary
NANDA	North American Nursing Diagnosis Association
NAR	Nurse Aide Registry
NEO	New Employee Orientation
NMC	Nutritional Management Committee
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NPO	Nil Per Os (nothing by mouth)
O2SAT	Oxygen Saturation
OIG	Office of Inspector General
OT	Occupational Therapy

OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P	Pulse
P&T	Pharmacy and Therapeutics
PALS	Positive Adaptive Living Survey
PB	Phenobarbital
PBSP	Positive Behavior Support Plan
PCP	Primary Care Physician
PEG	Percutaneous Endoscopic Gastrostomy
PET	Performance Evaluation Team
PFW	Personal Focus Worksheet
Pharm.D.	Doctorate, Pharmacy
Ph.D.	Doctor, Philosophy
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
PO	By Mouth (per os)
POI	Plan of Improvement
POX	Pulse Oximetry
PPD	Purified Protein Derivative (Mantoux Text)
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
PTPTT	Prothrombin Time/Partial Prothrombin Time
QA	Quality Assurance
QAQI	Quality Assurance Quality Improvement
QDRR	Quarterly Drug Regimen Review
QMRP	Qualified Mental Retardation Professional
R	Respirations
R	Right
RD	Registered Dietician
RDH	Registered Dental Hygienist
RN	Registered Nurse
RNP	Registered Nurse Practitioner

RPH	Registered Pharmacist
RR	Respiratory Rate
SA	Settlement Agreement
SAC	Settlement Agreement Coordinator
SAM	Self-Administration of Medication
SAP	Skill Acquisition Plan
SIB	Self-injurious Behavior
SIG	Signature
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SSLC	State Supported Living Center
STAT	Immediately (statim)
STD	Sexually Transmitted disease
T	Temperature
TD	Tardive Dyskinesia
TCHOL	Total Cholesterol
TCN	Tetracycline
TID	Three times a day
TIVA	Total Intravenous Anesthesia
TSH	Thyroid Stimulating Hormone
UII	Unusual In
UIR	Unusual Incident Report
US	United States
URC	Unified Records Coordinator
UTI	Urinary Tract Infection
VIT	Vitamin
VNS	Vagus nerve stimulation
WBC	White Blood Count
WNL	Within Normal Limits