United States v. State of Texas

Monitoring Team Report

Lufkin State Supported Living Center

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Table of Contents

Background 3
Methodology 4
Organization of Report 5

Executive Summary 6

Status of Compliance with Settlement Agreement
- Section C: Protection from Harm – Restraints 19
- Section D: Protection from Harm – Abuse, Neglect, and Incident Management 34
- Section E: Quality Assurance 62
- Section F: Integrated Protections, Services, Treatment, and Support 73
- Section G: Integrated Clinical Services 96
- Section H: Minimum Common Elements of Clinical Care 100
- Section I: At-Risk Individuals 106
- Section J: Psychiatric Care and Services 115
- Section K: Psychological Care and Services 148
- Section L: Medical Care 167
- Section M: Nursing Care 184
- Section N: Pharmacy Services and Safe Medication Practices 212
- Section O: Minimum Common Elements of Physical and Nutritional Management 229
- Section P: Physical and Occupational Therapy 242
- Section Q: Dental Services 257
- Section R: Communication 264
- Section S: Habilitation, Training, Education, and Skill Acquisition Programs 275
- Section T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs 287
- Section U: Consent 310
- Section V: Recordkeeping and General Plan Implementation 314

List of Acronyms 322

Background

In 2009, the State of Texas and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with developmental disabilities in state-operated facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. The Settlement Agreement covers 12 State Supported Living Centers (SSLCs), including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) component of Rio Grande State Center.

Pursuant to the Settlement Agreement, the parties submitted to the Court their selection of three Monitors responsible for monitoring the facilities' compliance with the Settlement. Each of the Monitors was assigned responsibility to conduct reviews of an assigned group of the facilities every six months, and to detail findings as well as recommendations in written reports that are submitted to the parties.

In order to conduct reviews of each of the areas of the Settlement Agreement, each Monitor has engaged an expert team. These teams generally include consultants with expertise in psychiatry and medical care, nursing, psychology, habilitation, protection from harm, individual planning, physical and nutritional supports, occupational and physical therapy, communication, placement of individuals in the most integrated setting, consent, and recordkeeping.

Although team members are assigned primary responsibility for specific areas of the Settlement Agreement, the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members share information routinely and contribute to multiple sections of the report.

The Monitor's role is to assess and report on the State and the facilities' progress regarding compliance with provisions of the Settlement Agreement. Part of the Monitor's role is to make recommendations that the Monitoring Team believes can help the facilities achieve compliance. It is important to understand that the Monitor's recommendations are suggestions, not requirements. The State and facilities are free to respond in any way they choose to the recommendations, and to use other methods to achieve compliance with the Settlement Agreement.

Methodology

In order to assess the facility's status with regard to compliance with the Settlement Agreement and Health Care Guidelines, the Monitoring Team undertook a number of activities, including:

(a) **Onsite review** – During the week of the review, 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.
Review of documents – Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. The Monitoring Team made additional requests for documents while on site. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the facility. In other instances, particularly when the facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures.

(b) **Observations** – While on site, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. However, the following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, Personal Support Team (PST) meetings, discipline meetings, incident management meetings, and shift change.

(c) **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.

Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement, as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement. The report addresses each of the requirements regarding the Monitors' reports that the Settlement Agreement sets forth in Section III.I, and includes some additional components that the Monitoring Panel believes will facilitate understanding and assist the facilities to achieve compliance as quickly as possible. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the Settlement Agreement. This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report;
c) **Summary of Monitor's Assessment:** Although not required by the Settlement Agreement, a summary of the Facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the Facility has with regard to compliance with the particular section;
d) **Assessment of Status:** A determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement, and detailed descriptions of the Facility's status with regard to particular components of the Settlement Agreement, including, for example, evidence of compliance or noncompliance, steps that have been taken by the facility to move toward compliance, obstacles that appear to be impeding the facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;
e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; and
f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the Settlement Agreement. It is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement.
g) **Individual Numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers (for example, as Individual #45, Individual #101, and so on.) The Monitors are using this methodology in response to a request form the parties to protect the confidentiality of each individual.

Executive Summary

First, once again, the monitoring team wishes to 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. The facility director, Gale Wasson, was again extremely supportive of the monitoring team's activities throughout the week of the onsite review. She was readily available whenever needed, and receptive to all questions.

The Settlement Agreement Coordinator, Sherry Roark, was assigned primary responsibility for coordination of document preparation and coordination of activities during the onsite review. Ms. Roark did a great job of assisting the monitoring team throughout the onsite week (as well as in the weeks prior to, and following, the onsite week) with all requests, information or documents, scheduling, and anything else needed to help the monitoring team conduct this review. She was assisted by Rita Inman, Ms. Roark's assistant, who was also very professional and helpful.

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. 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, as detailed in the full report and as the reader will see, 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 comments on a few general topics regarding service operations at the facility.

- Reviews of serious events: This was noted in the previous monitoring report and continued to be a need at LSSLC. That is, that some events that occurred at LSSLC should receive a more in depth review (e.g., a root cause analysis), such as repetitive and/or serious injuries, serious medication errors, and failed community placements. Treating these, and perhaps other, serious events with a thorough review is more in line with generally accepted professional standards of care and will, most likely, result in improved service provision. For example, four cases that should have drawn the attention of the facility's clinical and management staff, and perhaps prompted an all-out internal review, came to the attention of the monitoring team during the course of this review (Individual #285, Individual #447, Individual #368, and Individual #552).

- Facility-wide activities: A facility-wide approach will be necessary to address these two topics:
  - PNM, positioning, and related participation in programming
  - Engagement, things to do, activities in natural environments and in the community

- Child specialization: LSSLC was recently designated as a child facility, that is, the facility will only accept for admission individuals under 18 years old. As a result, the facility director should examine whether the facility needs to obtain additional training or specialized clinicians regarding aspects of service that are specific to children, such as pediatric medicine, child psychiatry, and special education.

- Facility self-assessment: LSSLC provided its facility self-assessment, called the POI. The development of a useful POI has been an ongoing project for all of the SSLCs. Future revisions will be done in collaboration with DADS central office. In each of the sections of this report, the Monitor comments on the POI. Overall, the LSSLC POI described actions the facility had taken that, in its opinion, were moving the facility towards substantial compliance, and actions it planned to take in the future. While this information was useful to the monitoring team, the POI should describe
  - The activities the facility engaged in to conduct the self-assessment of the provision. This might include sampling, observations, implementation of their self-assessment tools, etc.
  - How the facility used the findings from these activities to determine substantial compliance or noncompliance.
  - A self-rating of substantial compliance or noncompliance.
  - Action steps/activities the facility planned to engage in to work towards substantial compliance.

- Statewide self-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). At LSSLC, these tools were being taken very seriously, that is, they were being used regularly and data were reviewed regularly. As the facility moves forward with this process, the monitoring recommends the following considerations (also see section E below):
  - Make sure the content of each tool is appropriate and correct. Revisions are needed. Some items in each tool will need to be reworded, others deleted, and others added. This activity will need to occur along with DADS central office.
  - There should be correspondence with the monitoring team's ratings. That is, high ratings should correspond with substantial compliance, and low ratings should correspond with noncompliance.

- Scores on these tools should also have some face validity with department leadership's more subjective opinions.
- Create two graphic presentations of the data, one that shows a single data point for each month's total, and a second presentation that presents the data for each item of the tool for only the current month.
- Be thoughtful about the assessment of reliability such that it is being used to ensure interobserver agreement and to set the occasion for training and collaboration.
- Address the data entry problems raised by QA department staff.

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

<u>Restraints</u>

- Over the past six months, 93 restraints occurred. Of these 93, 27 (29%) were emergency restraints; and 66 (71%) were programmatic. Of these 93, 91 (98%) were physical restraints and 2 (2%) were chemical restraints. Nineteen individuals were the subject of restraints. Seven individuals had been restrained more than three times during the reporting period.
- These numbers showed a reduction in the use of restraints since the last monitoring visit. The facility, particularly the psychology department, had implemented a number of new procedures to monitor and reduce the number of restraint incidents:
  - A workgroup was formed to formally address section C provisions of the POI.
  - The Restraint Reduction Committee expanded to include campus coordinators and psychology assistants.
  - A dental desensitization workgroup was established to reduce or eliminate the need for pretreatment dental sedation.
  - The supervising psychologist with the most expertise in restraint use techniques had begun providing competency based training on intervention and redirection techniques, approved restraint techniques, and adequate supervision of individuals in restraints.
  - The facility began completing restraint audits using the state developed Section C- Restraints audit tool.
- Staff, however, did not document what activity individuals were engaged in prior to behavioral incidents leading to restraint in most instances, therefore, it was difficult to ascertain whether or not restraints were used in the absence of adequate programming. As noted throughout section C, there continued to be some problems with accurate documentation and monitoring of restraints.

Abuse, Neglect, and Incident Management

- Investigation of 61 allegation of abuse, neglect, or exploitation were conducted by DFPS at the facility in the past six months. Of these 61 allegations, 8 (13%) were confirmed allegations by DFPS (including one allegation of physical abuse, two allegations of emotional/verbal abuse, and five allegations of neglect), 39 (64%) were unconfirmed allegations, 10 (16%) were inconclusive, and four (7%) were referred back to the facility because they did not meet the DFPS definition of abuse or neglect.
- This was a significant decrease in the number of allegations reported in the six months prior to the monitoring visit in April 2011. Moreover, there was a decrease in the number of confirmed allegations during this period, from 16 to 8.
- There were an additional 19 serious incidents at the facility that did not involve allegations of abuse or neglect investigated by the facility. Four of these were deaths and 15 were serious injuries.
- There were a total of 1441 injuries reported between 5/1/11 and 9/31/11. These 1441 injuries included 15 serious injuries resulting in fractures or sutures. The facility needs to aggressively address trends in injuries and implement protections to reduce the number of incidents and injuries.
- During observation of residential and day programs, it was noted that many individuals spent a majority of their day not engaged in meaningful activities. This appeared to contribute to the high incidence of both self abusive behavior and aggression towards others. It remains a concern of the monitoring team that individuals at the facility are at high risk for harm in their current environment.

Quality Assurance

- LSSLC again made little progress towards establishing a comprehensive quality assurance program. A new QA director was appointed in September 2011 and she was just getting started on addressing the items of this provision at the time of this onsite review.
- QA policy was not yet developed. The QA director, however, had written a QA manual that might be used as a QA plan. Further, she had create an initial QA report. Much work will be needed, but these activities indicated that progress could be expected by the time of the next onsite review.
- Progress was evident in one area: the creation and implementation of performance improvement teams (also called work groups) to address any concerns identified by the QAQI Council. Seven PITs were created since the last onsite review.
- A system of managing corrective actions was not yet in place.

Integrated Protections, Services, Treatment, and Support

- The facility was considering how to best implement the person centered planning process and ensure consistent implementation and monitoring of services. All staff had also been trained on the new risk identification process and the new process had just been implemented for some individuals at the facility.
- DADS had recently initiated a thorough review of the PSP process and hired a set of consultants to help the SSLCs move forward in PSP development and the meeting of this provision's requirements. The monitoring team met with one of the consultants during the week of the onsite review. The consultant's work had recently begun at LSSLC. The facility was in the beginning stages of revising the PSP process.
- Seven annual PSP meetings were observed by the monitoring team. In meetings observed, the QDDPs were attempting to encourage team participation and ensuring that all necessary information was covered during the PST meeting. While the process was still understandably awkward to the teams, they were having a more integrated discussion at the team meetings and time was better spent on developing plans and talking about needed supports. Team meetings were well attended and it was noted that there was positive movement towards integrating supports throughout each individual's plan.
- There was, however, 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. During observation of residential and day programs, it was noted that many individuals spent a majority of their day not engaged in meaningful activities.
- Quality assurance activities with regards to PSPs were in the initial stages of development. The facility had begun to use state developed audit tools to review both meeting facilitation and the PSP development process.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- LSSLC continued to make progress with this important provision. The facility director was the lead for this provision and was aware of its importance. Evidence of integration efforts on the part of numerous disciplines was presented to the monitoring team during the conduct of this review.
- The daily medical meeting was expanded to include all clinical disciplines and PCP attendance at the annual PSPs improved. Collaboration between psychology and psychiatry was observed to have improved significantly during clinics. Moreover, a multidisciplinary workgroup was formed to develop plans that would assist in overcoming barriers to dental treatment.
- Most areas required additional work to ensure that integration resulted in the desired clinical outcomes for the individuals. This will likely occur as the processes are refined and the facility fully embraces a culture consistent with the provision of integrated services. The strategic move to appoint the facility director as the lead for this provision should foster a greater sense of collaboration and accountability among the various disciplines.
- LSSLC is in need of further guidance from state policy. Further, a valid and reliable monitoring tool is needed.

At-Risk Individuals

- The state had taken a number of steps to support positive results in the area of risk management, such as instituting changes in state policy and forms, developing new risk guidelines, and an initiative to address aspiration pneumonia.
- 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.
- LSSLC had taken steps towards compliance with this provision including ensuring that all individuals had PST meetings to address their risks utilizing the new At Risk Process, creating a data base to track pneumonia, conducting training sessions for all PST members, and developing action plans to address risk categories for individuals identified as being at medium or high risk.
- PSTs, however, were not accurately identifying risk for individuals, even with the new process.

Psychiatric Care and Services

- The 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 admitted to the hospital or 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.
- Psychiatry was interacting with psychology on some levels. The psychiatric clinic had been expanded to include representatives from all disciplines. This was beneficial, given that psychiatrists were not available to regularly attend PST meetings. Given the lack of clinical resources, the facility will have to be creative with regard to the use of psychiatry resources in order to achieve integration.
- Psychiatry had made some gains in the area of informed consent. Psychiatrists were responsible for revised documentation regarding the risks, benefits, side effects, and alternatives to treatment with a particular medication. They were also responsible for contact with or attempts to contact the individual's legally authorized representative with regard to informed consent.
- 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 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.

Psychological Care and Services

- There were several improvements since the last onsite review. These included the establishment of external peer review, the use of more informative graphs, the beginning of the collection of replacement behaviors, the establishment of the collection of Inter-Observer Agreement (IOA) data, the establishment of treatment integrity data, and improvements in the quality of PBSPs.
- The areas that LSSLC should work on for the next review are to collect data reliability, establish goals, and pilot a method to ensure that they are achieved and maintained in at least one home; establish treatment integrity goals, and pilot a method to ensure that they are collected and recorded, and maintained in at least one home; ensure that all direct functional assessments include observations of target behaviors, and provide additional information about the antecedents and consequences potentially affecting the target behavior; and ensure that all Positive Behavior Support Plans (PBSPs) are based on the hypothesized function of the target behavior.

Medical Care

- There was evidence that basic health care services were provided as individuals received the appropriate immunizations and basic preventive services. Completion of other screenings appeared more problematic. There was some increase in neurology hours provided through off site services. The on-campus clinic remained limited to two hours.
- Overall, the medical staff responded to the needs of the individuals, but there were lapses noted in follow-up of acute issues as well as chronic issues. There were numerous instances in which clinic follow-ups did not occur as needed as well.
- External reviews were completed and corrective actions implemented. All of the efforts targeted processes as the review included no clinical outcome indicators. The third audit showed no significant improvement in overall compliance rates. Compliance in the essential elements was consistently far below the required 100%. With one exception, most primary providers failed to fully correct problems that were amenable to correction.
- Mortality reviews were completed by the facility. During a meeting with the chief nurse executive, QA nurse, and medical director, it was quite evident that there was conflict among the participants of the clinical review committee relative to the effectiveness of the process. What was very evident to the monitoring team was that there was no objective physician review of the cases to address the standards of medical care provided to the individual.
- There was no development of a medical quality program and efforts initiated six months earlier appeared to have been abandoned as there was no continuation or follow-up related to the issues. No clinical guidelines were developed.

Nursing Care

- LSSLC was addressing many of the problems noted during the prior review. For example, in response to a failure to ensure complete assessments in the presence of acute illness/injury, the Nurse Educator and nurse managers provided re-training to some nurses and initial training to all direct care staff members.
- During the monitoring team's attendance at PSPAs, which were held to address the health needs of individuals, the nurses were knowledgeable of the individuals' immediate problems and relevant history, significantly contributed to the discussions, and were responsive with recommendations and interventions to meet the individuals needs.
- There were, however, areas where progress was delayed or not made since the prior review. For example, a top priority of the Nursing Department was to improve nursing care. However, during the conduct of this review, a number of observations indicated the need for much more work to be done in this area. For example, individuals had plans in place to reduce their health risks related to aspiration, blood clots, and inactivity and immobility that were not carried out. Thus, individuals were observed lying flat on their backs after meals, sitting/lying in the same positions for prolonged periods of time, and, for those individuals who had capacity to engage in moderate forms of physical and mental activity, not engaged.
- Direct care staff members' lack of knowledge of the most basic health needs of individuals, even as they occurred in the setting of the infirmary, was striking. This problem was significantly more evident and pervasive on other units where the direct care staff members were unable to speak beyond whether or not the individual was a "check and change."
- During the review, it was consistently noted and observed that effective collaboration and coordination between the Nursing Department and other departments, such as Quality Assurance, Habilitation, and Psychology had not been achieved and needed improvement in order to meet the many and multidisciplinary needs of the individuals who reside at LSSLC.

Pharmacy Services and Safe Medication Practices

- The facility's current software system required that a series of checks occur prior to dispensing medication. Documentation of communication with medical providers related to the prospective review was not clearly evident. The vast majority of SPIs were retrospective. The notes extracts did not contain any information that indicated what provider was contacted or what the response was to the concern.
- There was improvement in the quality of the QDRRs, but it was very disconcerting to find that the recommendations were essentially being disregarded with a series of repetitive responses of "no action required." Similarly, the MOSES and DISCUS evaluations were completed, but very often the provider did not provide a response as required.

- ADRs were reported, but based on the facility's definition of an ADR, the size of the facility and the number of medications administered, the reporting of 10 ADRS (some duplicate) over a six-month period likely represented under-reporting. One DUE was completed each quarter and information was shared with the medical staff during the Pharmacy and Therapeutics Committee meeting.
- The facility maintained a system for reporting medication variances. Pharmacy and nursing maintained separate data streams. A significant concern was the fact that medication errors were reported as events and not occurrences. This introduced the ability to significantly diminish the actual medication error rate. This was disconcerting because actual error rates often are used as a quality indicator. Moreover, it was not clear that the true error rate was accurate because the facility only reported omissions related to pill medications.

Physical and Nutritional Management

- The PNMT at LSSLC consisted of only one dedicated team member (nurse) at the time of this review. While a number of meetings had been held since the previous review, the team had initiated an assessment for only one individual. Attendance by all core team members was inconsistent and will ultimately impact the effectiveness of this team. The facility was significantly behind in the development of this team.
- The PNMPs were of a consistent format and each was current within the last 12 months. LSSLC had incorporated instructions related to bathing, oral hygiene, and medication administration for most individuals. Implementation of these plans, while improved, continued to be problematic and staff did not understand the rationale for the strategies they were instructed to apply. In addition, there was no evidence that a strong skills-based competency training for elements of the plans was provided.
- Positioning and transfers continued to be a concern. Supervisors and monitors were not recognizing the problems and/or were not taking sufficient corrective actions to address them. PNMPCs did not consistently identify ongoing problems and admitted to not persisting with reporting issues when they were not attended to previously. PNMP monitoring must also address the question of whether interventions are effective. Implementation of a system to routinely evaluate efficacy of PNMPs and other interventions will be key.
- As described in detail in Section P below there were several cases that did not reflect an effective, appropriate and timely team approach to the delivery of PNM supports and services. While these failures to address the needs of Individual #447, Individual #16, Individual #518, and Individual #77 were not directly a function of the PNMT itself, they were a clear reflection of the status of PNM services at LSSLC. Resolution to ensure a more effective team approach to these supports system-wide is critical to the achievement of compliance with this provision.

Physical and Occupational Therapy

- Services provided to Individual #447 exemplified the facility's performance for this provision. He came to the monitoring team's attention early in the week of the onsite visit because he was on extended bed rest since 9/25/11 due to the fact that he did not have an appropriate wheelchair. Over the course of that week, it was clear that he had not been provided with appropriate assessment, interventions and supports, training for staff, and monitoring; all resulting in injury and subsequently denying him access to active treatment and other favorite activities. The monitoring team observed, listened, and participated in the development of an action plan to address these issues. Habilitation therapists, among other team members, failed to provide him with appropriate and timely supports and services, ensure his safety and well being, promote opportunities to work and engage in activities that he enjoyed, and failed to serve as an advocate for him.
- As it turned out, this was not an isolated case. Individual #16 had been on extended bed rest due to delays in the provision of a new seating system. Individual #518 was on extended bed rest with delays in the provision of a new seating system. Individual #77 had experienced a significant change in her health and functional status (it was verbally reported that a stroke was suspected, though this was not confirmed in her record), so that her move to the community was postponed indefinitely.

Dental Services

- The dental department continued to make progress. The loss of the full time dental director in August 2011 was a significant setback for the department because it reduced the number of available clinic hours. Services continued to be provided as the part time dentist continued and the oral hygiene program continued.
- Individuals received frequent dental care and oral hygiene ratings appeared to be improving. The home oral hygiene maintenance program expanded and all individuals had undergone evaluation.
- The use of chemical restraints continued, but a significant achievement for the facility was the implementation of a multidisciplinary workgroup, which was charged with developing a formal desensitization strategy for the facility. Since the last onsite review, eight plans were developed.

Communication

- There was a long list of individuals who required a comprehensive communication assessment, including Individual #16 who had significant potential to benefit from communication supports. Per the Master Plan, only 20 assessments had been completed to date.
- There were a number of individuals with communication systems (82). This represented 33% of those individuals (250) identified as nonverbal. The communication systems observed were intended to be functional and many were portable for use across a variety of settings. They appeared to be individualized and potentially meaningful to the individual.

- Of the 36 individuals monitored who had one or more AAC systems, 10 were reported to have systems that were broken, five individuals had systems reported to be missing and nine did not use the system at all or rarely. Consistent use and integration across settings continued
- 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 group.

Habilitation, Training, Education, and Skill Acquisition Programs

- 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 the SAP format to include a rationale for SAP selection and the inclusion of several necessary components for learning, the addition of a new position to oversee the SAP process, an increased use of data based decisions of the continuation, modification, or discontinuation of SAPs, and the development of a data system to track and improve training of individuals in the community
- The facility focus on expanding the new SAP format to all SAPs written at LSSLC ensuring that the rationale for each SAP clearly states how acquiring this skill is related to each individual's needs/preferences, and ensuring that all of the components necessary for learning new skills are included in each SAP. In addition, LSSLC should continue to expand the methodology used to teach SAPs, collect and track SAP integrity measures and ensure that individual engagement is monitored and improved on evenings and weekends.

Most Integrated Setting Practices

- The number of individuals referred and placed remained low, given the size of the facility, however, there was an increasing trend in placement activity since the baseline review in April 2010. Since the last onsite review, 13 individuals were placed, including four who were both referred and placed within the past six months. Individuals involved in the referral and placement process were of all ages and level of disability.
- The APC had made progress in summarizing and graphing some of her department's data. This effort should be continued and expanded. More work should be done on failed placement activity, such as a root cause analysis for rescinded referrals, post placement psychiatric hospitalizations or deaths, and returns the facility. These did not happen very often, but each occurrence should be evaluated for possible future improvements in the placement process.

- A new PSP process was being developed by DADS. It planned to address some continued inadequacies, such as including the opinions of the professionals on the PST, identifying needed supports and services, and identifying obstacles to referral and placement.
- PSTs were becoming more involved in the referral process and in the selection of providers. LSSLC had good working relationships with the local MRAs and local providers.
- CLDPs were recently initiated at the time of referral. Further, there continued to be serious problems with the facility's ability to develop an adequate list of essential and nonessential supports in the CLDP. Instead, most focused primarily on the provision of inservices, the scheduling of appointments, and the presence of items and plans rather than their use and implementation. There were few supports that were directly related to actions that were to occur day to day for each individual, such as implementation of preferred activities,. 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.
- Post move monitoring continued to be in substantial compliance. This was particularly noteworthy given that a new post move monitor had been hired mid-way through the past six month period.

Consent

- Some positive steps that the facility had taken in regards to consent and guardianship issues included approval of a policy addressing guardianship, designation of a Guardianship Coordinator, and updating of a list of individuals and their guardianship status.
- Even though the facility maintained a list of individuals needing an LAR, PSTs were not adequately addressing the need for a LAR or advocate.
- While the facility was pursuing guardianship for a number of individuals at the facility, the efforts did not appear to be related to those individuals determined by the facility to have the greatest prioritized need.
- The facility had a Human Rights Committee (HRC) in place to review restrictions requested by the PST. At the HRC meeting observed, committee members did not engage in thorough discussion regarding the need for the proposed restrictions prior to giving approval. The PSTs observed were also holding minimal discussions around the need for guardians in reference to the capacity for individuals to make decisions and give consent.

Recordkeeping Practices

- The active records were neat and organized. Attention was needed to address problems with use of the individual notebooks. The facility should consider forming a performance improvement team regarding individual notebooks. LSSLC had recently begun to create new master records for each individual. The new master records were a great improvement from the previous format.

- The URCs conducted reviews of all three components of the unified record each month, but had not yet met the requirement to have at least five done each month. Overall, the reviews that were completed were done so in a consistent manner. Two forms were completed for each review. One was the statewide monitoring tool. The other was the table of contents for the active record and individual notebook. There was a consistency in the issues and problems identified by the URCs. Many items were marked "N/A." A brief explanation is needed in future reviews, especially for those items that are not asterisked to indicate optional.
- All needed corrections were entered into a table called the Audit Tracking Tool. The URCs used this listing to follow-up on all of the corrections. It was a reasonable way to manage the status of corrections, however, had only been implemented for less than two months.
- The URCs had begun to summarize and graph data from some of their activities. These data were now submitted to the QA department.

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.

II. 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 Policy: Use of Restraint Policy 7/25/11 o Training Curriculum: Use of Restraint in a Behavioral Crisis o PMAB Training Curriculum o LSSLC Plan of Improvement o Training transcripts for 24 LSSLC employees o A list of restraint related injuries for the past six months o List of all restraints used for crisis intervention for the past six months o List of all chemical restraints for the past six months o List of all medical restraints for the past six months o List of all dental restraints for the past six months o List of individuals restrained off the grounds of the facility (1) o LSSLC Restraint Trend Analysis for FY11 o List of individuals with dental desensitization plans o Dental desensitization plans for Individual #294, and Individual #360. o Restraint Reduction Committee meeting minutes since 3/1/11 o List of all individuals who had a Safety Plan o Training transcripts for 24 LSSLC employees o Sample of Daily Incident Review Team Meeting Minutes o PSPs, Positive Behavior Support Plans (PBSPs), PSPAs, and Safety Plans (if applicable) for: • Individual #166, Individual #170, Individual #410, Individual #252, and Individual #176 o PSPA, Dental Assessments, Dental Desensitization Plan for Individual #360 and Individual #294 o To monitor item C7: PBSPs, safety plans, functional assessments, and personal support plan addendums (PSPAs) for Individual #170, Individual #166, and Individual #410 o A sample of restraint documentation (#C.1) for behavioral intervention including: • Physical restraints ▪ Individual #166 dated 7/28/11, 6/24/11, 6/22/11, and 5/27/11 ▪ Individual #170 dated 9/21/11, 5/14/11, and 4/10/11 ▪ Individual #380 dated 5/2/11 ▪ Individual #114 dated 5/4/11 ▪ Individual #300 dated 5/15/11 ▪ Individual #252 dated 5/22/11 ▪ Individual #51 dated 5/30/11 ▪ Individual #410 dated 5/31/11

	▪ Individual #587 dated 6/3/11 • Chemical restraints ▪ Individual #490 dated 5/27/11 ▪ Individual #176 dated 9/1/11 <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Kendra Carroll, Director of Competency Training and Development o Luz Carver, QDDP Coordinator o Jason Peters, Human Rights Officer o Royce Garrett, Director Consumer and Family Relations o Stacie Cearley, Quality Assurance Director o Mike Ramsey, Facility Investigator o Kelli Sliga, Incident Management Coordinator o Sylvia Middlebrook, Chief Psychologist o Lisa Curington, Director of Day Programs <u>Observations Conducted</u>: o Observations at residences and day programs o Oak Hill Morning Unit Meeting 11/1/11 o Incident Management Review Team Meeting 10/31/11 and 11/3/11 o Annual PSP meetings for Individual #116, Individual #321, and Individual #50 o Personal Focus Meeting for Individual #560 o Human Rights Committee Meeting 11/2/11 o Self Advocacy Meeting
	Facility Self-Assessment: LSSLC submitted its self-assessment, called the POI. It was updated on 10/17/11. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, the comments section of each item of the provision included a statement regarding what tasks had been completed or were pending. The facility's Plan of Improvement for section C indicated that the facility had implemented several new processes to address deficiencies noted in the last monitoring report. These processes are discussed below. The POI for C1, C3, and C8 indicated how the findings from activities of self-assessment were used to determine the self-rating of each provision item. Other sections of the POI listed activities completed with the intention to address substantial compliance.

	The facility was aware of problems with monitoring and documentation of restraints, and was in the beginning stages of addressing those issues. The facility rated itself as being in substantial compliance with items C1, C2, and C3. The monitoring team agreed with the facility's self assessment rating of substantial compliance for item C2. Other provisions of Section C were found to be out of compliance. Positive steps taken to address noncompliance by the facility are noted in the summary section. The facility needs to continue identify and address trends or systemic issues in regards to restraint application, monitoring, and documentation.
	Summary of Monitor's Assessment: Based on information provided by the facility in a list of all restraints used for crisis intervention, between 3/1/11 and 8/31/11: • 93 restraints occurred; • 27 (29%) were emergency restraints; and • 66 (71%) were programmatic. • 91 (98%) were physical restraints; and • 2 (2%) were chemical restraints. • 19 individuals were the subject of restraints. • Seven individuals had been restrained more than three times during the reporting period. There had been a significant reduction in the use of restraints since the last monitoring visit. The facility, particularly the psychology department, had implemented a number of new procedures to monitor and reduce the number of restraint incidents. According to the facility POI, action taken by the facility to address compliance with section C since the last monitoring visit included: • A workgroup was formed to formally address section C provisions of the POI. • The Restraint Reduction Committee had been expanded to include Campus Coordinators and Psychological Assistants. • A dental desensitization workgroup was established to discuss strategies to reduce or eliminate the need for pretreatment dental sedation. • Supervising psychologist with the most expertise in restraint use techniques had begun providing competency based training on intervention and redirection techniques, approved restraint techniques, and adequate supervision of individuals in restraints. • The facility had begun completing restraint audits using the state developed Section C- Restraints audit tool. During observation of residential and day programs, it was noted that many individuals spent a majority of their day not engaged in meaningful activities. This appeared to contribute to the high incidence of both self abusive behavior and aggression towards others. Staff did not document what activity individuals

	were engaged in prior to behavioral incidents leading to restraint in most instances, therefore, it was difficult to ascertain whether or not restraints were used in the absence of adequate programming. As noted throughout section C, there continued to be some problems with accurate documentation and monitoring of restraints.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	<u>Prone Restraint</u> Based on facility policy review, prone restraint was prohibited. Employees were trained during New Employee Orientation and annual PMAB training that 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 for review of restraints resulting from behavioral incidents. Sample #C.1 was a random sample of restraints for the three individuals with the greatest number of restraints and eight other individuals (randomly chosen). These 11 individuals accounted for 58% of all individuals who were the subject of restraints in the six-month reporting period. The individuals in this sample were Individual #166, Individual #170, Individual #410, Individual #380, Individual #114, Individual #252, Individual #51, Individual #490, Individual #176, Individual #587, and Individual #300. • Individual #166 had the greatest number of restraints, accounting for 15 restraint incidents since 3/1/11. • Individual #170 had the second greatest number with 13 of the restraints. • Individual #410 had 9 restraints during the reporting period. Based on a review of 16 restraint records for individuals in Sample #C.1 involving nine 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, 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 16 restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: • In 16 of the 16 records (100%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• For the 16 restraint records in the sample, a review was completed of the description of events leading to behavior that resulted in restraint. The checklists reviewed described the individual's behavior prior to the restraint, but only seven (44%) restraint checklists in the sample indicated either what activity the individual was involved in at the time of the restraint or what was occurring in the environment that might have triggered the behavior leading to restraint. These included the following: Individual #587 dated 6/3/11, Individual #51 dated 5/30/11, Individual #252 dated 5/22/11, Individual #114 dated 5/4/11, Individual #490 dated 5/27/11, and Individual #170 dated 4/10/11 and 5/14/11. Some examples where events leading to restraint were not adequately documented included: o In the area for the description of events on the restraint checklist for Individual #166 on 5/27/11, staff documented "started displaying SIB." o On the restraint checklist for Individual #170 dated 9/1/11 the description of events leading to the behavior noted "destroying property, biting and hitting self." Staff did not document in what activity the individual was involved prior to the incident. • In all 16 of the records (100%), 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. 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 not evident that restraints were not used in the absence of, or as an alternative to, appropriate programming and treatment. As noted above, documentation did not always indicate what activities individuals were involved in prior to restraint. Based on observations in the homes and day program building, engaging individuals in more individualized and meaningful programming of interest would likely significantly reduce behavioral incidence leading to restraints. Facility policies identified a list of approved restraints techniques. Based on the review of documentation for 16 restraints, 16 (100%) were documented as approved restraints techniques. Dental/Medical Restraint The facility provided a list of medical pretreatment sedation/ medical restraints between	

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		5/1/11 and 9/31/11: • 46 individuals were the subject of restraints, • 62 incidents of restraint occurred. The dental clinic was gathering data on restraints used for dental procedures and had begun to develop desensitization plans to address dental restraints. A similar action towards identifying medical restraints was not in place. 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 all interventions attempted prior to restraint. Further, 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 11 individuals in Sample #C.1 were reviewed. Of these, four of the individuals had a Safety Plan for Crisis Intervention (SPCI) that gave direction for the use of restraint. A sample of restraint documentation for 14 physical restraints was reviewed to determine if the restraint was terminated as soon as the individual was no longer a danger to him/herself or others. Fourteen (100%) restraints reviewed indicated that the individual was released immediately when no longer a danger. Restraints in the sample lasted from less than one minute to 53 minutes in duration. • The restraint for Individual #410 dated 5/31/11 lasted 53 minutes in duration. The action/release section of the restraint checklist indicated that release was not attempted prior to the time of release. The state restraint policy mandates that the maximum time in restraint prior to an attempt to release is 30 minutes. The facility POI indicated that the Psychology Director was reviewing restraint documentation for compliance with this provision. The facility self-rated C2 as being in substantial compliance. The monitoring team agreed.	Substantial Compliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints	Review of the facility's training curricula revealed that it included adequate training and competency-based measures in the following areas: • Policies governing the use of restraint, • Approved verbal and redirection techniques, • Approved restraint techniques, and • Adequate supervision of any individual in restraint. A sample of 24 current employees was selected from a current list of staff. A review of	Noncompliance

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	and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	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 (100%) had current training in RES0105 Restraint Prevention and Rules. • Twenty (83%) employees with current training completed the RES0105 refresher training within 12 months of the previous training. • Twenty-four (100%) had completed PMAB training within the past twelve months. • Nineteen (79%) completed PMAB refresher training within 12 months of previous restraint training. All staff were required to sign an acknowledgement form stating that failure to complete refresher training as required could result in disciplinary action. The facility is not in substantial compliance with this provision item. Employees will need to complete training annually as required by the facility policy to gain substantial compliance.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	Based on a review of 16 restraint records (Sample #C.1), 16 (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. The facility had not developed medical desensitization plans for all individuals who required the use of restraint for routine medical care. According to a list provided to the monitoring team, dental desensitization programs had been developed for 114 individuals who needed pretreatment sedation or restraint to have work completed. Further clarification of this list indicated that not all plans were yet developed or implemented. A sample of 10 plans that had been implemented was requested by the monitoring team for review. The facility submitted two desensitization plans. • The plans for Individual #294 and Individual #360 were good examples of desensitization plans that included individualized strategies. The dentist for the facility indicated that informal desensitization strategies were being used with a majority of the individuals requiring dental restraints. These strategies need to be documented in a formalized plan in order to ensure consistent implementation and evaluate progress towards desensitization. The facility did not maintain a "Do Not Restrain" list. The facility had a Physician	Noncompliance

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		Assessment for Identifying Potential Health Risks for Restraint Checklist that was to be completed annually and when the individual's medical condition significantly changed. It was not clear where this information could be found in the individual's record or how staff knew when an individual should not be restrained. This information was not included in any of the PSPs reviewed. PSTs should discuss the need for restraints during medical and dental procedures, and desensitization plans should be developed that include individual specific strategies to try to reduce or eliminate the need for restraint. The facility should maintain a "Do Not Restrain" list based on the decision of the PSTs. The facility is not in compliance with this provision.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may 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	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 16 restraint records (Sample #C.1), a face-to-face assessment was conducted as follows: • In 16 incidents of restraint (100%), there was assessment by a restraint monitor. • In 16 instances of restraint (100%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. • In 16 instances (100%), the documentation showed that an assessment was completed of the application of the restraint. • In 16 instances (100%), the documentation showed that an assessment was completed of the circumstances of the restraint. Based on a review of 16 behavioral restraint records for restraints that occurred at the facility, there was documentation that a licensed health care professional: • A nursing assessment was completed for individuals involved in all restraints. However, the assessment was not completed within 30 minutes from the initiation of the restraint in five (31%) of the instances of restraint. Exceptions were: o Individual #176 dated 9/1/11 o Individual #587 dated 6/3/11 o Individual #170 dated 9/2/11 o Individual #114 dated 5/4/11 o Individual #410 dated 5/31/11 • Monitored and documented vital signs in 16 (100%). • Monitored and documented mental status in 16 (100%). Based on a review of 10 restraint records for medical restraints that occurred at the	Noncompliance

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	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.	facility there was documentation that: • A nursing assessment was completed for individuals involved in all restraints. However, the assessment was not completed within 30 minutes from the initiation of the restraint or at the frequency required by policy in six (60%) of the instances of restraint. Exceptions were: o Individual #479 dated 8/10/11 o Individual #88 dated 8/8/11 o Individual #401 dated 8/3/11 o Individual #285 dated 9/13/11 o Individual #387 dated 9/1/11 o Individual #99 dated 9/8/11 The facility needs to ensure that a licensed health care professional monitors and documents vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint. The facility was not in compliance with this 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 16 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 15 (94%), continuous one-to-one supervision was indicated as having been provided. o The restraint checklist for Individual #114 dated 5/4/11 did not indicate the level of supervision while restrained. • In 16 (100%), the date and time restraint was begun were indicated. • In 16 (100%), the location of the restraint was indicated. • In seven (44%), information about what happened before, including the change in the behavior that led to the use of restraint, was indicated. Seven indicated what events were occurring that might have led to the behavior (see section C1 for a list of exceptions). • In 16 (100%), the specific reasons for the use of the restraint were indicated. • In 16 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. • In 16 (100%), the names of staff who applied/administered the restraint was recorded. • In 14 (100%) of 14 observations of the individual and actions taken by staff while the individual was in restraint for physical restraints were recorded. • In 14 (100%) of 14 physical restraint incidents, the date and time the individual was released from restraint were indicated. • In 16 (100%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health	Noncompliance

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		effects were recorded. • Restraint documentation reviewed did not indicate that restraints interfered with mealtimes or that individuals were denied the opportunity to use the toilet. The longest restraint in the sample was 53 minutes in duration. In a sample of 16 records (Sample #C.1), restraint debriefing forms had been completed for 16 (100%). The facility's self assessment indicated that the facility was not in compliance with section C6. The monitoring team agrees with this finding. There had been significant improvement in documentation regarding the monitoring of restraints. Circumstances leading up to restraints should be documented to provide clear indication that a restraint was used as a last resort measure and not in the absence of adequate treatment or programming. 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 five individuals were placed in restraint more than three times in a rolling thirty-day period. This compares to the six individuals placed in restraint more than three times in a rolling thirty-day period reported during the last (April 2011) review. Three of these individuals (i.e., Individual #170, Individual #166, and Individual #410) were reviewed (60%) to determine if the requirements of the Settlement Agreement were met. PBSPs, safety plans, functional assessments, and personal support plan addendums (PSPAs) were reviewed for all three individuals. Although all of the items in C7 below have been rated as noncompliance, the facility planned to train staff in the use of a new form to ensure that each of the issues below are discussed and documented in each PSPA meeting following more than four restraints in a 30-day period. Additionally, the facility had recently begun to collect integrity measures. Accordingly, the monitoring team anticipates substantial compliance in many of these	Noncompliance

#	Provision	Assessment of Status	Compliance
		items in the next review. In order to achieve substantial compliance with this item C7a, 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. All three of the PSPA minutes reviewed reflected a discussion of the individuals' psychiatric diagnosis. None of these discussions, however, reflected a plan or discussion of how the Individual's psychiatric diagnosis affected the target behaviors provoking restraint, and how this psychiatric issue would (or could) be addressed. Therefore, this item was rated as noncompliance. Simply listing diagnoses is not likely to be useful in better understanding, and ultimately decreasing the behaviors provoking restraint. The purpose of this item is to discuss potential adaptive skills, and biological, medical, and/or psychosocial factors hypothesized to be affecting these dangerous behaviors. If any of these variables are hypothesized to affect the behavior provoking restraint, an action plan to decrease the likelihood of these behaviors in the future should also be reflected in the PSPA minutes. An example of a PSPA that would achieve substantial compliance with item would be one that documents a discussion of how an individual's recent medication changes are hypothesized to increase dangerous behavior. Additionally, the minutes would reflect a plan to adjust the medications (e.g., referral to the Psychiatrist).	
	(b) review possibly contributing environmental conditions;	All PSPAs should reflect a discussion of potential contributing environmental factors (e.g., noisy or crowded environments, etc.) and if any are hypothesized to potentially affect dangerous behavior, suggestions for modifying them to prevent the future probability of restraint. One of the three PSPAs reviewed (i.e., Individual #170) 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) was apparent in the PSPA reviewed. In order to achieve substantial compliance with this provision item, all PSPAs should reflect a discussion of possible contributing environmental factors, and suggestions for modifying potential factors to prevent the future probability of restraint (if environmental conditions are identified).	Noncompliance

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	(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. One PSPA (i.e., Individual 170) indicated that the team identified no antecedents to restraint. 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 and did not believe that it is relevant to better understanding why an individual was restrained is preferable to simply putting N/A. The other two PSPAs reviewed identified potential antecedents to restraint, but no action to attempt to eliminate or reduce these antecedents to dangerous behavior was evident in the PSPA minutes. For example, an antecedent to the dangerous behavior that provoked restraint for Individual #410 was that he was told he could not sit in the front seat of the van. No action to address this antecedent in the future was discussed. Potential actions, for example, could include pre-training prior to trips, and/or allowing Individual #410 choice of seats in the back of the van, etc. 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
	(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. In order to achieve substantial compliance, 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 minimize that physical aggression results in escape should be reflected in the PSPA minutes. All three of the PSPA minutes reviewed indicated that a potential function of the behavior provoking restraint was gaining staff attention. No discussion, however, of how attention associated with target behaviors could be minimized (e.g., avoid eye contact, maintain flat affect, etc.) was reflected in the discussion. Therefore, this item was rated as 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	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	Noncompliance

#	Provision	Assessment of Status	Compliance
	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;	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. Two of the three PBSPs (66%) that were designed to weaken or reduce the behaviors that provoked restraint, however, were determined to be inadequate (i.e., Individual #170, and Individual #166) because they 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 only one (i.e., Individual #170) of the safety plans reviewed (33%), was the maximum duration of restraint authorized 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. In order to achieve substantial compliance with this provision item, PBSPs should be based on the results of the functional assessment, and safety plans will need to include the maximum duration of restraint authorized.	
	(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%) was 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 that the PBSPs for any of the individuals reviewed included a discussion of the effectiveness of the current PBSP (including possible modification when necessary) to decrease the future probability of requiring restraint. In order to achieve compliance with this item of the Settlement Agreement, PSPAs will	Noncompliance

#	Provision	Assessment of Status	Compliance
		need to reflect a discussion of the effectiveness of the PBSP and a plan to modify the plan (or retrain staff) if it is determined to be ineffective.	
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, Incident Management Review Team Meeting (IMRT) meetings, Daily Unit meetings, and Human Rights Committee (HRC) meetings. Restraint incidents were also referred to the PST for follow-up. PSTs met following restraint incidents to review restraints. See C7 for comments on review by the PST. A sample of Face-to-Face Debriefing and Review Forms related to 16 incidents of non-medical restraint 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. • 15 of 16 (94%) were reviewed by the Unit Director and/or the Chief Psychologist. Fourteen (88%) were reviewed within three days of the restraint. o The signature page was not included in the documentation for Individual #587. o The restraint documentation for Individual #380 was not reviewed until over a week after the incident occurred. The Chief Psychologist was completing a review of each restraint incident. Additionally, a sample of restraints was being reviewed monthly using the state developed audit tool for Section C. Findings from these audits were similar to the findings of the monitoring team. The Restraint Reduction Committee had begun reviewing audit findings and making recommendations for corrective action. 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.	Noncompliance

Recommendations:

1. 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 (C1).

2. Circumstances leading up to restraints should be documented to provide clear indication that a restraint was used as a last resort measure and not in the absence of adequate treatment or programming (C1, C2, C6).

3. Employees will need to complete retraining annually as required by the facility policy (C3).

4. PSTs should discuss the need for restraints during medical and dental procedures and desensitization plans should be developed to try to reduce or eliminate the need for restraint (C4).

5. The facility needs to develop and maintain a "Do Not Restrain" list based on recommendations of each individual's PST (C1).

6. The facility needs to ensure that a licensed health care professional monitors and documents vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint (C5).

7. 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 deficiencies noted in the review of restraints. Continue to monitor restraints and retrain staff as necessary (C8).

8. 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 (C8).

9. Complete the following to address provision item C7:
    a. Each individual's PSPA (following more than three restraints in 30 days) 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 (C7 a).
    b. All PSPAs (following more than three restraints in 30 days) should reflect a discussion of potential contributing environmental factors (e.g., noisy or crowded environments, etc.) and if any are hypothesized to potentially affect dangerous behavior, suggestions for modifying them to prevent the future probability of restraint (C7 b).
    c. All PSPAs (following more than three restraints in 30 days) should reflect a discussion of potential antecedents to the behaviors provoking restraint (e.g., placing demands, etc.), and if any are hypothesized to potentially affect dangerous behavior, suggestions for modifying them to prevent the future probability of restraint (C7 c).
    d. All PSPAs (following more than three restraints in 30 days) should reflect a discussion of the variables hypothesized to be maintaining the behaviors provoking restraint (e.g., attaining attention, escaping demands, etc.), and if any are hypothesized to potentially affect dangerous behavior, suggestions for modifying them to prevent the future probability of restraint (C7 d).
    e. PBSPs should be based on the results of the functional assessment, and safety plans need to include the maximum duration of restraint authorized (C7 e).
    f. Each PBSP should include integrity data to ensure that it has been implemented as written (C7 f).
    g. All PSPAs (following more than three restraints in 30 days) will need to reflect a discussion of the effectiveness of the PBSP and a plan to modify the plan (or retrain staff) if it is determined to be ineffective (C7 g).

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 Section D Presentation Book o DADS Policy: Incident Management #002.2,dated 6/18/10 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021 dated 6/18/10 o LSSLC Policy: Client Management- Investigation of Client Abuse/Neglect/Exploitation 11/2/10 o LSSLC Policy: Client Management – Reporting, Documenting, and Review of Unusual Incidents dated 11/05/10 o LSSLC Policy: Client Management – Injuries to Individuals dated 8/15/11 o MH&MR Investigations Handbook Commencement Policy Effective 8/1/11 o Information used to educate individuals and their LAR on identifying and reporting unusual incidents. o Incident Management Committee meeting minutes for each Monday of the past six months o Sample of Unit Level Meeting minutes o LSSLC Plan of Improvement o Three most recent five-day status reports o Training transcripts 24 randomly selected employees o Training Curriculum: Abuse and Neglect – Identification, Reporting, and Prevention o Training Curriculum: Comprehensive Investigator Training o Acknowledgement to report abuse for 24 randomly selected employees o Acknowledgement to report abuse for all employees hired in the past two months (67) o List of staff who failed to report abuse, neglect, or exploitation o Training and background checks for the last three employees hired o Training transcripts for facility investigators (13) o Training transcripts for DFPS investigators assigned to complete investigations at LSSLC (5) o Abuse/Neglect/Exploitation Trend Reports FY11 o Injury Trend Reports FY11 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 terminated based on background checks o A sample of acknowledgement to self report criminal activity for 24 current employees o PSPs for Individual #43, Individual #Individual #102, Individual #540, and Individual #132 o For Individual #368 – PSP, PSPAs, injury reports for the past three months o Injury reports for three most recent incidents of peer-to-peer aggression incidents o BSP and PSPA related to the last three incidents of peer-to-peer aggression o List of all serious injuries for the past six months

- List of all A/N/E allegations since 4/1/11 including case disposition
- List of all confirmed allegations of abuse and neglect
- List of employees reassigned due to ANE allegations
- A sample of completed audits for abuse and neglect concerns or unusual incidents
- Documentation of employee disciplinary action taken regarding UII #238, UII #248, and UII #246
- Client Injury reports for serious injuries for Individual #502 dated 8/1/11, Individual #141 dated 4/13/11, Individual #361 dated 9/13/11, Individual #524 dated 5/18/11, Individual #354 dated 6/11/11, and Individual #480 dated 5/23/11.

- Documentation from the following completed investigations, including follow-up:

Sample D.1	**Allegation**	**Disposition**	**Date/Time of APS Notification**	**Initial Contact**	**Date Completed**
#39186853	Neglect (5) Physical Abuse	Confirmed (4) Unconfirmed (1) Unconfirmed	4/28/11 2:23 am	4/28/11 8:20 pm	8/8/11
#39757067	Physical Abuse	Unconfirmed	6/10/11 8:07 pm	6/13/11 3:00 pm	6/20/11
#39832468	Neglect	Unconfirmed	6/16/11 6:37 pm	6/17/11 3:00 pm	6/27/11
#39916347	Neglect (2) Sexual Abuse (1)	Unconfirmed (1) Other (1) Unconfirmed	6/23/11 1:23 pm	6/24/11 1:00 pm	6/30/11
#40215399	Physical Abuse	Unconfirmed	7/26/11 2:40 pm	7/28/11 2:00 pm	8/3/11
#40216139	Emotional/verbal Abuse	Confirmed	7/27/11 8:45 am	7/27/11 4:10 pm	8/4/11
#40221764	Neglect	Confirmed	8/1/11 3:08 pm	8/1/11 5:40 pm	8/10/11
#40223328	Physical Abuse	Unconfirmed	8/2/11 3:30 pm	8/3/11 10:00 am	8/10/11
#40237265	Physical Abuse Sexual Abuse	Unconfirmed Unconfirmed	8/15/11 10:22 am	8/16/11 11:15 am	8/23/11
#40258735	Physical Abuse	Confirmed	8/31/11 3:10 pm	9/1/11 12:30 pm	9/10/11
Sample D.2	**Type of Incident**	**DFPS Disposition**	**Date of DFPS Referral**	**Began Investigation**	**Closed Investigation**
#39762627	Neglect (3)	Referred Back Rights Issue	6/13/11	Unknown	7/18/11

#39782369	Neglect	Referred Back Admin Issue	6/20/11	6/23/11	7/7/11
#40221320	Neglect	Referred Back	8/1/11	Unknown	8/3/11
#40231144	Neglect	Referred Back	8/10/11	Unknown	9/12/11
Sample D.3	**Type of Incident**	**Date/Time of Incident**	**Director Notification**		
#242	Serious Injury	8/7/11 2:30 pm	8/8/11 3:20 pm		
#236	Serious Injury	7/31/11 1:55 pm	7/31/11 2:55 pm		
#235	Serious Injury	7/27/11 4:30 pm	7/27/11 4:30 pm		
#22	Serious Injury	9/18/11 9:15 pm	9/19/11 1:37 am		
#35	Serious Injury	10/6/11 6:35 pm	10/6/11 8:00 pm		
#43	Serious Injury	10/20/11 4:40 pm	10/20/11 4:40 pm		

Interviews and Meetings Held:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs;
- Kendra Carroll, Director of Competency Training and Development
- Luz Carver, QDDP Coordinator
- Jason Peters, Human Rights Officer
- Royce Garrett, Director Consumer and Family Relations
- Stacie Cearley, Quality Assurance Director
- Mike Ramsey, Facility Investigator
- Kelli Sliga, Incident Management Coordinator
- Sylvia Middlebrook, Chief Psychologist
- Lisa Curington, Director of Day Programs

Observations Conducted:

- Observations at residences and day programs
- Oak Hill Morning Unit Meeting 11/1/11
- Incident Management Review Team Meeting 10/31/11 and 11/3/11
- Annual PSP meetings for Individual #116, Individual #321, and Individual #50
- Personal Focus Meeting for Individual #560
- Human Rights Committee Meeting 11/2/11
- Self Advocacy Meeting

	Facility Self-Assessment: LSSLC submitted its self-assessment, called the POI. The facility's POI for section D indicated that several new policies and processes had been implemented to address problems noted in the last monitoring report. The POI indicated that the facility had implemented several new audit systems to address compliance with section D. The POI indicated that the findings from this new audit process were used to determine the self-rating of each provision item. The facility POI indicated that LSSLC was in substantial compliance with all sections D of the Settlement Agreement. The monitoring team found that 14 out of 22 areas of section D were in substantial compliance. As discussed below, the monitoring team did not find evidence to support substantial compliance with provisions D2a, D2b, D2i, D3b, D3e, D3f, D3i, and D4. The facility POI noted processes that were in place to address provisions, but did not indicate if those processes were audited for effectiveness. On some items found to be out of compliance (for example, D2a and D3b) the POI stated that processes in place continue to be followed. Effective monitoring, however, was not in place to determine if the processes were ensuring substantial compliance. The facility did not appear to have a quality improvement process in place to address issues identified through the self audit system. The facility was holding daily unit meetings to review all incidents and injuries. It was not evident that the facility had a process in place to look at systemic issues contributing to incidents and injuries. The facility will need to implement a process to address incident and injury trends.
	Summary of Monitor's Assessment: According to information provided to the monitoring team, investigation of 61 allegation of abuse, neglect, or exploitation were conducted by DFPS at the facility in the past six months. Of these 61 allegations, 8 (13%) were confirmed allegations by DFPS (including one allegation of physical abuse, two allegations of emotional/verbal abuse, and five allegations of neglect), 39 (64%) were unconfirmed allegations, 10 (16%) were inconclusive, and four (7%) were referred back to the facility because they did not meet the DFPS definition of abuse or neglect. This was a significant decrease in the number of allegations reported in the six months prior to the monitoring visit in April 2011. Moreover, there was a decrease in the number of confirmed allegations during this period, from 16 to 8. A list of all serious incidents investigated by the facility during the previous six months was requested by the monitoring team. According to a list provided by the facility, there were an additional 19 serious incidents at the facility that did not involve allegations of abuse or neglect investigated by the facility. Four of these were deaths and 15 were serious injuries. Not all serious incidents were included on the list provided to the monitoring team. Other incidents found in documentation but not included on this list:

- Individual #189 had a serious injury on 6/17/11 requiring five staples to close a head laceration.
- Individual #238 fell hitting his head on a table on 9/14/11. Dermabond was used to close a laceration on his forehead.
- A sexual incident between two individuals was investigated by the facility on 5/12/11.

There were a total of 1441 injuries reported between 5/1/11 and 9/31/11. These 1441 injuries included 15 serious injuries resulting in fractures or sutures. It was not evident that the facility was adequately addressing the high number of injuries documented at the facility with preventative actions. Documentation indicated that a significant number of injuries were resulting from behavioral issues including peer-to-peer aggression. The following is a list of incidents documented during a typical eight day period for two residential units. The facility needs to aggressively address trends in injuries and implement protections to reduce the number of incidents and injuries.

DATE	INDIVIDUAL	INCIDENT	CAUSE
9/1/11	#43	Bite to left and right arm	Self inflicted
	#146	Hit in back	Peer to peer aggression
	#562	Pushed	Peer to peer aggression
	#479	Hit on left leg	Peer to peer aggression
	#114	Hit on right arm	Peer to peer aggression
	#504	Hit in back	Peer to peer aggression
	#407	Hit in middle of back	Peer to peer aggression
	#23	Hit in back	Peer to peer aggression
	#157	Hit on right arm	Peer to peer aggression
	#57	Scratch on knuckle	Hit door with fist
	#494	Bite on forearm	Peer to peer aggression
	#411	Slapped on cheek	Peer to peer aggression
9/2/11	#524	Hit in head	Peer to peer aggression
	#74	Bruise on eyelid	Hit head on toilet when vomiting
9/3/11	#407	Hit left side of head and arm	Peer to peer aggression
	#491	Skin tear finger	SIB
	#477	Hit right shoulder	Peer to peer aggression
	#145	Hit right arm	Peer to peer aggression
	#562	Slapped on arm	Peer to peer aggression
	#166	Pinched	Peer to peer aggression
	#145	Slapped	Peer to peer aggression
	#457	Hit	Peer to peer aggression
9/4/11	#423	Abrasions to wrist an forearm	SIB/hitting wrist-arm on shower wall
	#162	Redness and abrasions to forehead, forearm, shoulder, and back	SIB/rolling around on sidewalk, hitting head on ground

	#60	Scratch to shoulder	Peer to peer aggression
	#157	Bite wound to forearm	Peer to peer aggression
	#145	Hit on right side of neck	Peer to peer aggression
	#482	Pulled hair	Peer to peer aggression
	#169	Hit	Peer to peer aggression
	#477	Hit	Peer to peer aggression
	#145	Hit	Peer to peer aggression
	#169	Hit	Peer to peer aggression
	#491	Hit	Peer to peer aggression
	#263	Hit on shoulder	Peer to peer aggression
	#407	Pushed down	Peer to peer aggression
	#317	Slapped	Peer to peer aggression
	#51	Hit	Peer to peer aggression
	#426	Hit on face	Peer to peer aggression
	#494	Bite or inner bicep	Peer to peer aggression
9/5/11	#336	Bruise and swelling of toe	Stumping toe on chair
	#252	Scratch to face	Peer to peer aggression
	#57	Pushed	Peer to peer aggression
	#592	Pushed down	Peer to peer aggression
9/6/11	#333	Bruise to shoulder	Slapping self, throwing chairs, slamming doors, spitting at staff. Probably got bruise at this time.
	#60	Redness to face	Digging in trashcan, probably scratched face
	#249	Bruise to upper arm	Showing disruptive behavior
	#4	Swelling to ankle	Fell over carpet in workshop
	#475	Cut on left hand	Hitting wall
	#256	Scratches on hand and arm	SIB – upset after meeting
	#97	Multiple abrasions to knee	SIB
9/7/11	#558	Laceration to left eyebrow	Peer to peer aggression
	#317	Abrasion to chin	Fall
	#500	Scratches to neck	SIB
	#423	Abrasion/scratches to finger	Hit nurse – hit finger on her ring
	#116	Abrasion to elbow	Dropping to floor
	#469	Slapped in back	Peer to peer aggression
	#569	Discoloration to both forearms	Probably from catching herself on edge of table due to unsteadiness
	#305	Cut to middle of forehead	Had seizure, fell hit head on doorknob
9/8/11	#336	Bite to shoulder	Peer to peer aggression
	#60	Slapped on face	Peer to peer aggression

	#114	Slapped on back of neck	Peer to peer aggression
	#261	Hit 5 times in back	Peer to peer aggression

While a number of steps had been taken to ensure incidents and injuries were appropriately investigated and corrective action was documented, there had not been a focused effort on addressing systemic issues that placed individuals at risk for abuse, neglect, and injury. The facility needs to further explore trends of incidents and 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. Consideration should be given to factors that generally contribute to injuries and incidents at a large facility, such as crowded living areas, inappropriate levels of supervision, poorly trained staff, and lack of meaningful activities. The QA department might also be part of this effort.

During observation of residential and day programs, it was noted that many individuals spent a majority of their day not engaged in meaningful activities. This appeared to contribute to the high incidence of both self abusive behavior and aggression towards others. It remains a concern of the monitoring team that individuals at the facility are at high risk for harm in their current environment. As the facility moves forward, all departments will need to take an integrated, aggressive approach to restructuring the environment, supports, and programming to address these issues.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The facility's policies and procedures did: • Include a commitment that abuse and neglect of individuals will not be tolerated, • 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. The facility policy stated that failure of an employee to report an allegation of abuse, neglect, or exploitation to DFPS within the allotted time period without sufficient justification was considered a violation of the agency's policy and made the employee subject to disciplinary action and possible criminal prosecution. 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 with both information on identifying abuse and neglect and steps to be taken if abuse or neglect was either suspected or witnessed. • 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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		or neglect, all staff consistently stated that they would report the incident to DFPS by calling the 800#. All staff wore badges that contained reporting information on the back. • Employees at LSSLC were required to sign a form titled Acknowledgement of Responsibility for Reporting Abuse/Neglect Incident(s) form during pre-service training and every 12 months thereafter. Completed forms were requested by the monitoring team for a random sample of 24 employees. All (100%) had signed a form acknowledging responsibility to report abuse and neglect within the past 12 months. Additionally, signed forms were provided for all employees hired within the past two months. The facility provided a copy of the signed acknowledgement for 67 new employees. • 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. • A review of cases reported to DFPS indicated that staff routinely reported cases of suspected abuse and neglect to DFPS for investigation. In DFPS case #40215399, the facility required two employees to complete a refresher course in Reporting Abuse and Neglect after failing to report suspected abuse in a timely manner. Documentation of disciplinary action was reviewed for two cases in which DFPS substantiated an allegation of abuse or neglect. In both cases, timely disciplinary action was taken for all employees involved in confirmed allegations. • For DFPS case #40216139, DFPS confirmed an allegation of emotional/verbal abuse by an employee. The employee was terminated. • For DFPS case #40221764, an employee was terminated following a confirmation of neglect. In this case, staff failed to provide appropriate support when transferring an individual resulting in a fractured leg. The facility found evidence that four employees had not reported suspected abuse and/or neglect as required by policy. All four employees were required to complete a refresher course in reporting abuse and neglect.	
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,		

#	Provision	Assessment of Status	Compliance
	procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	According to DADS 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 addressing Incident Management required that all serious incidents be reported to the facility director or designee within one hour, reported to DFPS immediately if abuse or neglect was suspected. This policy was consistent with the requirements of the Settlement Agreement. According to a list of abuse, neglect, and exploitation investigations provided to the monitoring team, investigation of 61 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility since the last monitoring visit. From these 61 allegations, there were: • 24 allegations of physical abuse, o 1 was substantiated, o 22 were unsubstantiated, and o 1 was inconclusive. • 11 allegation of verbal/emotional abuse, o 2 were substantiated, o 8 were unsubstantiated, and o 1 was inconclusive. • 3 allegations of sexual abuse o 3 were unsubstantiated. • 23 allegations of neglect, o 5 were substantiated, o 6 were unsubstantiated, o 8 were inconclusive, o 4 were referred back to the facility for investigation. • There were no allegations of exploitation investigated. According to a list provided to the monitoring team, the facility investigators conducted investigations for 19 additional serious incidents since the previous monitoring visit. The incidents were: • Serious Injuries, peer to peer aggression – 2 • Serious Injuries, determined cause – 13 • Deaths – 4	Noncompliance

#	Provision	Assessment of Status	Compliance
		Based on an interview of eight staff responsible for the provision of supports to individuals, seven (88%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation and other serious incidents. One staff person stated that he would report suspected abuse or neglect to his supervisor. All staff wore name badges with reporting procedures on the back of the badge. From the 80 investigations since 4/1/11 reported by the facility, 20 investigations were selected for review. The 20 comprised three samples of investigations: • Sample #D.1 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 included a sample of facility investigations that had been referred to the facility by DFPS for further investigation. • Sample #D.3 included investigations the facility completed related to serious incidents not reportable to DFPS. Based on a review of the 10 investigative reports included in Sample #D.1: • 9 of 10 (90 %) reports in the sample indicated that DFPS was notified within one hour of the incident or discovery of the incident. o DFPS Case #40216139 was reported to DFPS on 7/26/11 by a staff member who witnessed the incident on 7/23/11. • Ten (100%) indicated that the facility director or designee was notified within one hour. • Seven (100%) indicated that OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. • Two of 10 (20%) indicated that the state office was notified as required. In reviewing Sample D.3 (serious incidents), five of six (83%) were reported immediately (within one hour) to the facility director/designee. The facility director was not notified within one hour in the following incident: • A serious injury for Individual #405 on 10/6/11 was not reported to the facility director designee within an hour of the incident. The facility had a standardized reporting format. The facility used the Unusual Incident Report Form (UIR) designated by DADS for reporting unusual incidents. This form was adequate for recording information on the incident, follow-up, and review. A standardized UIR which contained information about notifications was included in: • 10 out of 10 (100%) investigation files in Sample #D.1. • 10 of 10 (100%) investigation files in Sample #D.2 and Sample #D.3.	

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		An additional sample of seven client injury reports was reviewed for serious discovered injuries in the past six months to determine if injuries were reported for investigation. This included injury reports for Individual #502 dated 8/1/11, Individual #141 dated 4/13/11, Individual #361 dated 9/13/11, Individual #524 dated 5/18/11, Individual #354 dated 6/11/11, Individual #368 dated 10/6/11, and Individual #480 dated 5/23/11. Only two of the seven (29%) were reported to DFPS for further investigation when evidence did not support a probable cause for the injury. See details in section D.2.i. New employees were required to sign an acknowledgement form regarding their obligations to report abuse and neglect. All employees signed an acknowledgement form annually. A sample of this form was requested for 67 new employees hired in the past two months and for a random sample of 24 other employees at the facility. All employees (100%) in the sample had signed this form. The facility was not in substantial compliance with this provision based on evidence that not all serious injuries were reported for investigation when a probable cause could not be established during a preliminary investigation.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	The facility policy regarding injuries unusual incidents was updated on 11/5/10. The policy required that staff take immediate action in response to incidents to ensure individual's safety and well being. This may include: • Heighten supervision; • Interview individuals; • Medical exam/treatment; • Physical separation of individuals; • Change of supervision requirements • Counseling; • Staff training; • Reassignment of staff; and/or • Environmental changes. . The facility did have a system in place for assuring that alleged perpetrators were removed from regular duty until notification was made by the facility Incident Management Coordinator. The facility maintained a log of all alleged perpetrators reassigned with information about the status of employment. Based on a review of 10 investigation reports included in Sample D.1, in every instance where an alleged perpetrator (AP) was known, the AP was immediately placed in no contact status. Additionally, the monitoring team was provided with a log of employees	Noncompliance

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		who had been reassigned since 5/1/11. The log included the applicable investigation case number, the date of the incident and the date the employee was returned to work if the employee was not discharged or had resigned. In eight out of 10 cases (80%) the employee was not returned to client contact prior to the completion of the investigation. The exceptions were: • For DFPS case #39757067, information on the reassignment log conflicted with information included in the investigation file regarding when the AP was released to return to work. The log indicated that the employee returned to work on 6/17/11, three days prior to completion of the case by DFPS. A letter to the employee included in the investigation file indicated that the AP was notified that she was cleared to return to work on 7/13/11. • For DFPS case 39916347 reported on 6/23/11, the facility reassignment list indicated that the APs were cleared on 6/24/11. According to the DFPS investigation, the APs were not interviewed until 6/28/11. The facility UIR included a section for documenting immediate corrective action taken by the facility (Section 10 of the UIR). Based on a review of the 20 investigation files in Sample D.1, D.2, and D.3, this section was not sufficiently completed in all instances to provide clear determination that adequate additional action was taken to protect individuals in each case. Additional actions that should have been documented were any changes in level of supervision, repairs to physical property, or additional medical monitoring. • For UIR #238, the facility did not document all immediate action taken in Section 10 of the UIR including medical care to address the injury, changes in level of supervision, or removal of the AP from direct client contact. • For UIR #174, the facility did not document medical care sought to address the injury in Section 10 of the UIR. • For UIR #237, an allegation of neglect was reported to DFPS. The neglect allegation involved staff's failure to ensure that his diet order was followed. It was not clear that measures were put into place following the incident to ensure that the individual continued to follow his prescribed diet. • Section 10 of UIR #242 did not address medical care and follow up action needed to continue to ensure the safety of Individual #354 following a fall that resulted in a head injury requiring seven staples for closure. It was noted in witness statement that he had been without his helmet for several weeks because it was broken. Someone should have been assigned follow up to ensure his helmet was repaired or replaced in a timely manner. In order to achieve substantial compliance with this item, the facility will need to ensure that APs are not returned to direct care positions until at least a well- supported,	

#	Provision	Assessment of Status	Compliance
		preliminary assessment determines that the employee poses no risk to individuals or the integrity of the investigation. The facility should document all immediate action taken in the designated area of the UIR, so that facility management can easily determine that adequate protections were put into place following incidents. Trends of injuries should be reviewed and adequate action taken to reduce the occurrence of similar incidents. As noted in the summary section, a high number of injuries were occurring routinely at the facility. It was not evident that adequate protections were in place to reduce incidents.	
	(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. • 24 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 18 (95%) of 19 employees (employed over one year) with current training completed this training within 12 months of the date of previous training. • 24 (100%) employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • Five (26%) of the 19 employees (employed over one year) with current training completed this training within 12 months of the date of previous training. Based on interviews with eight direct support staff in various homes and day programs: • Seven (88%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. The following procedures had been put into place to ensure all staff received timely training on recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. • All staff were required to sign an acknowledgement form stating that failure to complete refresher training as required could result in disciplinary action. • The Competency, Training, and Development Department sent a memo to all employees notifying them of training due and reminding them that disciplinary action could be taken if training was not completed on time. • A list of employees with training due or delinquent was sent to each department head monthly. • Any staff member failing to attend or successfully complete training was deemed no longer meeting the qualifications for his/her position and referred to the department director for appropriate action, including removal from his/her position until training was completed.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The facility provided evidence that these actions were occurring. The facility was rated as being in compliance with this provision.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	According to facility policy, all staff were required to sign a statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation to DFPS immediately during pre-service and every 12 months thereafter. A sample of this form was requested for 67 new employees hired in the past two months and for a random sample of 24 other employees at the facility. All employees (100%) in the sample had signed this form. 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 sample of DFPS reports included one example where an employee failed to report abuse and the facility took action. In DFPS case #40216139 an employee was required to complete refresher training for failing to report abuse.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide 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.	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. In the previous report, the monitoring team faulted the facility for not including documentation that information on reporting abuse and neglect had been shared with individuals and their LARs during the last review. A sample of four PSPs developed after 8/1/11 was reviewed for compliance with this provision. The sample included PSPs for Individual #43, Individual #Individual #102, Individual #540, and Individual #132 • All four (100%) documented that this information was shared with individuals and/or their LARs at the annual PST meetings. In informal interviews with individuals at the facility indicated that all individuals questioned during the review were able to describe what they would do if someone hurt them, or they had a problem with which they needed help. Since incidents of abuse, neglect, and exploitation were reported anonymously, it was	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		difficult to determine how well individuals were being assisted to report. However, in the context of the sample of investigative reports, there were at least two instances where facility staff reported allegations on behalf of individuals to DFPS based on allegations made by individuals.	
	(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 of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. There was a human rights officer at the facility. Information was posted around campus identifying the rights officer with his name, picture, and contact information. The rights officer was known by individuals at the facility and was involved in meetings regarding abuse, neglect, and rights issues. The facility safety officer was responsible for making rounds monthly to ensure posters were displayed in all residences and day programs.	Substantial Compliance
	(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. Based on a review of 10 allegation investigations completed by DFPS (Sample #D.1), DFPS had notified law enforcement and OIG of the allegation in nine (100%) when appropriate. Not all allegations referred were necessarily reportable to OIG. OIG completed investigations in three of the cases referred. The facility had a process in place to verify that law enforcement had been notified when appropriate. Facility UIRs documented notification to law enforcement and the outcome of the investigation if an investigation was completed by OIG.	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	The following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: • LSSLC facility-specific 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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	this it occurred. The facility was asked for a list of staff against whom disciplinary action had been taken due to their involvement in retaliatory action against another employee who in good faith had reported an allegation of abuse/neglect/exploitation. No names were provided. Based on a review of investigation records (Sample #D.1), there were no concerns noted related to potential retaliation for reporting. It was evident based on the sample reviewed; staff routinely reported incidents when abuse or neglect was suspected.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The facility had implemented an audit process to review a sample of individual records, including nursing notes, observation notes, and progress notes to identify annotations that should have resulted in an injury report. These audits were being completed on a sample of individuals monthly. A sample of audits completed in June 2011 was reviewed. None of the audits were completed for individuals who had a significant number of injuries during the review period. The facility needs to also complete the audit process on individuals where trends for injuries have been identified. As evidenced in the examples referenced below, the audit process was not adequate for identifying instances where investigations were not being completed for significant resident injuries. Sample #D.3 included investigations completed on a sample of serious injuries. All six (100%) of the investigations were thorough and completed using a standardized UII. Additionally, a sample of seven injury reports was reviewed for serious discovered (not witnessed) injuries in the past six months. This included injury reports for Individual #502 dated 8/1/11, Individual #141 dated 4/13/11, Individual #361 dated 9/13/11, Individual #524 dated 5/18/11, Individual #354 dated 6/11/11, Individual #368 dated 10/6/11, and Individual #480 dated 5/23/11. Evidence included in the seven injury reports did not support findings for probable cause in any of the investigations. Only two (29%) of the seven investigations were appropriately referred for further review. The following is a summary of that review. • The facility completed a preliminary investigation when it was discovered that Individual #502 had fractured her femur. The facility appropriately reported the injury to DFPS when a probably cause of the fracture could not be determined. An allegation of neglect was confirmed by DFPS. • The facility investigated a serious injury resulting in a fracture for Individual #141. An Unusual Incident Investigation (UII) form was not completed. A statement by the unit director indicated that the injury that was discovered on 4/13/11 probably occurred during a hospital stay more than two weeks earlier.	Noncompliance

#	Provision	Assessment of Status	Compliance
		This determination was based on a sitter's observation while he was hospitalized regarding swelling to his left foot on 3/29/11. There was not enough information gathered by the facility to determine a cause of the injury or to rule out the possibility of abuse or neglect. If in fact, the unit director thought that the evidence clearly pointed to an incident that occurred more than two weeks prior to medical care being sought, the facility should have looked at neglect in seeking medical care in a timely manner. • A discovered fracture for Individual #361 was appropriately reported to DFPS for investigation when the facility was unable to determine the cause of the injury. • Home staff completed an injury investigation for Individual #524 following a laceration to his head requiring three staples. The investigation concluded that the injury possibly could have happened while he was sliding through the bars on the gate. There was no evidence to support this finding and the case was not referred for further investigation. • A serious injury to Individual #354 was also investigated by home staff. Probable cause was attributed to a broken CD found in his room. There was no evidence to support this finding and the case was not referred for further investigation. • A serious injury to Individual #480 was attributed to a fall after a seizure. Home staff made the determination of cause. It was not further investigated by staff not in the direct line of supervision of staff responsible for providing support. The documentation did not include his seizure history, so it was not evident that this was a reasonable cause. • Individual #368 was discovered with "eyes completely closed, swelling to his face, and ear, and bruising to his right finger with additional edema to his head" on 10/6/11. The injury was not considered serious though it was significant enough for the doctor to order a CT scan of the head. The campus coordinator completed an investigation with the finding that "he most likely realized he was sitting in urine and lost his balance hitting his right side of the face and used his middle finger to right hand to pull off helmet, causing his head to also bruise." There were no witness statements included in the investigation and no evidence to support this finding. A facility UII was not completed. Three of the investigations were completed by residential staff who were in the direct line of supervision of support staff and had not been trained on completing investigations. The facility was not completing adequate investigations on all significant injuries as required by state policy. When evidence did not support a probable cause, incidents were not referred for further investigation by trained investigative staff.	

#	Provision	Assessment of Status	Compliance
		While a number of incidents deemed serious were investigated, it was not evident that the facility had a process in place to review trends or series of incidents that should have raised suspicion or at least warranted follow up investigation. For instance, Individual #368 had at least 15 documented injuries between 8/1/11 and 10/6/11 including: • 8/24/11 multiple bruises on body (according to nurse "too numerous to list") • 8/26/11 skin tear to elbow • 9/13/11 laceration to the back of head • 9/15/11 bruises and swelling to both hands and wrists and possible fractured clavicle • 9/17/11 bruised and abraded hips • 10/6/11 extensive bruises and swelling to head, face, ears, nose, arms and legs. Photographs were taken of injuries on 9/29/11, 9/30/11, 10/6/11, and 10/7/11. The photographs did not appear to correlate with brief descriptions of how he reportedly sustained the various injuries. Even when his physician noted on one occasion (8/25/11) that his bruises appeared to be "like finger marks" there was no evidence that an investigation of this trend of injuries was initiated for possible abuse or neglect. The physician and physical therapist even noted that he was no longer unsteady on his feet, he had a safe, steady gait, his ataxia had improved, and his use of a gait belt could be discontinued. Following this positive report from clinical staff on 8/12/11 and 8/13/11, he continued to suffer one injury after another with progressively increasing severity. On 10/6/11 he was discovered with multiple injuries to this head, face, eyes, nose, cheeks, ears, arms, and legs. He was so severely bruised and swollen that his pupils could not be checked because his eyes were swollen shut and he could not wear his helmet prescribed for protection due to the intense swelling of his head and face. Yet, this was not deemed a serious injury or investigated by the facility investigator or reported to DFPS. There was no evidence that the facility had investigated the trend of injuries for possible abuse and neglect. The facility failed to maintain substantial compliance with this item. Based on the sample of documentation reviewed, the facility's audit process was not adequate for ensuring that injuries were reported for investigation.	
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,		

#	Provision	Assessment of Status	Compliance
	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.	DFPS reported its investigators were 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 conducting investigations and working with people with developmental disabilities. Five DFPS investigators were assigned to complete investigations at LSSLC. The training records for DFPS investigators were reviewed with the following results: • Five investigators (100%) had completed the requirements for investigations training. • Five DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. LSSLC had 13 employees designated to complete investigations. This included the Quality Assurance Director, Incident Management Coordinator, Facility Investigator, six Campus Coordinators, and four Campus Administrators. The training records for those designated to complete investigations were reviewed with the following results: • 12 (92%) facility investigators had completed CIT0100 Comprehensive Investigator Training. o One campus coordinator had not completed this course. UIR #242, investigation of a serious injury, indicated that he was the preliminary investigator for the case. There was no indication who completed the investigation • 13 (100%) had completed UNU011 Unusual Incidents within the past 12 months; • Seven had completed Root Cause Analysis according to training transcripts reviewed. The Campus Coordinators had not completed this course; and • 13 (100%) had completed the requirements for training regarding individuals with developmental disabilities by completing the course MEN0300. Additionally, facility investigators did not have supervisory duties; therefore, they would not be within the direct line of supervision of the alleged perpetrator.	Substantial Compliance
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect,	Sample D.1 was reviewed for indication of cooperation by the facility with outside investigators. One of 10 (10%) investigations reviewed indicated that two facility employees had not cooperated with investigators.	Noncompliance

#	Provision	Assessment of Status	Compliance
	and exploitation.	A concern was noted regarding lack of cooperation with investigators by two LSSLC employees in regards to DFPS investigation #39186853. The investigation documented a concern that two collateral witnesses were unavailable for interview and did not respond at the contact numbers provided by the facility. The investigator stated "…each began two weeks vacation on 8/1/11, the second day of APS interviews at LSSLC. This was also the first business day after TDFPS was informed of these individuals' roles as collateral witnesses to a specific event that occurred during the alleged incident. TDFPS finds the circumstances of those coincidences highly suspect. This is a significant concern as the statements of one or both of these witnesses would likely have proved or disproved one of the specific allegations of this investigation." Documentation did not indicate that the facility had addressed this concern. The monitoring team did not find the facility in compliance with this item due to lack of action taken to address this significant concern.	
	(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 10 investigations completed by DFPS (Sample #D.1), nine had been referred to law enforcement agencies. In the investigations completed by both OIG and DFPS, it appeared that there was adequate coordination to ensure that there was no interference with law enforcement's investigations. • OIG completed investigations in three of the referred cases and did not find evidence of criminal activity in any cases in the sample. • There was no indication that the facility had interfered with any of the investigations by OIG in the sample reviewed. The facility POI indicated that quarterly meetings continued to be held with DFPS. OIG representatives were invited to these meetings, but chose not to attend.	Substantial Compliance
	(d) Provide for the safeguarding of	The LSSLC policy on Abuse and Neglect included Guidelines for Securing Evidence that	Substantial

#	Provision	Assessment of Status	Compliance
	evidence.	described steps to collect and secure physical evidence related to an allegation. Based on a review of the investigations completed by DFPS (Sample #D.1) and the facility (Sample #D.3): • There was no indication that evidence was not safeguarded during any of the investigations.	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.	DFPS had implemented a new commencement policy effective 8/1/11. Mandates in the new policy were described in the MH & MR Investigations Handbook published on 10/1/11. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.3) 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: • Ten (100%) of the investigations noted the date and time of initial contact with the alleged victim. • Nine of 10 (90%) were completed within 10 calendar days of the incident. o DFPS case #39832468 was completed on the 11th day. The reason for the delay was not documented and an extension was not filed. • All 10 (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 four of the 10 DFPS investigations reviewed (40%), concerns or recommendations for corrective action were included. Concerns were appropriate based on evidence gathered during the investigation in all four cases. <u>Facility Investigations</u> The following summarizes the results of the review of investigations completed by the facility from sample #D.3: • Three out of six (50%) of the UIRs reviewed indicated when the investigation commenced. o UIR #12-29, UIR #242, and #236 indicated when the incidents were reported and what action was taken by the investigator, but did not include a time and date for the action taken (e.g., the UIR did not note the time witness was interviewed).	Noncompliance

#	Provision	Assessment of Status	Compliance
		o UIR #12-22, #12-10, and #235 documented when the investigator began the investigation. • Three of six (50%) indicated that the investigator completed a report within 10 days of notification of the incident. The three facility investigations in the sample dated after 9/1/11 were completed in a new format. There was not a place on the UIR for the investigator to sign and date the completed report. All three were reviewed by the IMC and director within 10 days, so it can be assumed that the final report was submitted for review. • Six (100%) of the investigations completed in the sample indicated that the facility director and IMC had reviewed the report immediately upon completion. • All six investigations included appropriate recommendations for corrective action (100%). In two reports, the IMRT added additional recommendations following review. The facility needs to ensure that documentation reflects the time and date of investigative activities. This is a repeat finding from the previous monitoring report. The facility was not in compliance with this provision due to the need for this aspect of the facility's investigation system to improve.	
	(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	LSSLC Incident Management Policy required a UIR to 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.3) 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 the investigations in Sample #D.1, the report utilized a standardized format that set forth explicitly and separately, the following: o In 10 (100%), each serious incident or allegations of wrongdoing; o In 10 (100%), the name(s) of all witnesses; o In 10 (100%), the name(s) of all alleged victims and perpetrators (when known); o In 10 (100%), the names of all persons interviewed during the investigation; o In 10 (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 10 (100%), all documents reviewed during the investigation;	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	o In 10 (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. DFPS investigations now included a statement indicating that previous investigations were reviewed and either found relevant or not relevant to the case. o In 10 (100%), the investigator's findings; and o In 10 (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of six facility investigations included in sample #D.3 • The report utilized a standardized format that set forth explicitly and separately, the following: o In six (100%), each serious incident or allegations of wrongdoing; o In six (100%), the name(s) of all witnesses; o In six (100%), the name(s) of all alleged victims and perpetrators when known; o In six (100%), the names of all persons interviewed during the investigation; o In six (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 six (100%), all documents reviewed during the investigation; o In six (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. o In six (100%), the investigator's findings; and o In six (100%), the investigator's reasons for his/her conclusions. Additionally, injury reports completed for seven serious injuries that were discovered were reviewed to determine if the injuries were adequately investigated. As noted in the examples in D.2.i, not all serious injuries were adequately investigated by the facility when probable cause could not be determined based on evidence found. Significant injuries of undetermined cause or trends of injuries should be further investigated by the facility when a probable cause based on evidence cannot be determined.	
	(g) Require that the written report, together with any other relevant documentation, shall	To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.3) were reviewed. The results of these reviews are discussed in detail below, and the findings	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	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 10 DFPS investigations included in Sample #D.1: • In 10 investigative files reviewed (100%), there was evidence that the DFPS investigator's supervisor had reviewed and approved the investigation report prior to submission. • UIRs included a review/approval section to be signed by the Incident Management Coordinator (IMC) and director of facility. Ten (100%) DFPS investigations were reviewed by the facility director, and IMC following completion. o Zero (0%) UIRs were signed off on by the facility director and IMC within five days of receipt of the completed investigation. These should be signed even though other information showed that they were reviewed. o Eight (80%) of the investigation files include a review sheet that indicated review of the case by the facility director and IMC within five days. This review document was not included in documentation of DFPS #40258735. The review sheet for DFPS #40223328 indicated review by the facility director, but not by the IMC. o A methodological review was requested for one investigation in the sample following review of the completed report. o Three of the completed reviews included additional recommendations or comments by the facility director. Two IMRT meetings were observed during the monitoring team's visit to the facility. Completed investigations were reviewed at the daily IMRT meetings. These meetings were led by the facility director and attended by the IMC. Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility. <u>Facility Investigations</u> • In six of six (100%) UIRs from sample #D.3 reviewed for investigations completed by the facility, the form indicated that the facility director and IMC had reviewed the investigative report upon completion. • Four of six (67%) reviews were completed within five days of the completion date. The exceptions were UIR #12-29 and UIR #12-22. • Recommendations for follow up were made in six of the six (100%)	

#	Provision	Assessment of Status	Compliance
		investigations completed by the facility. Investigation documentation should indicate that all investigations were reviewed by staff supervising investigations to ensure that the investigation was thorough and complete and that the report was accurate, complete and coherent. The facility is in substantial 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 uniform UIR was completed for each unusual incident in the sample. A brief statement regarding review, recommendations, and follow-up was included on the review form. Evidence of follow up to recommendations was included in the investigation file.	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.	In order to determine compliance with this provision of the Settlement Agreement, a subsample of the investigations included was selected for review. This subsample was comprised of the following investigations: DFPS Case #40258735, DFPS Case #39832468, DFPS Case ##40231144, and DFPS Case #39762627. Documentation of follow-up action was included in three out of five investigations in the sample reviewed. Documentation was reviewed to see what follow-up had been completed to address the recommendations resulting from investigations. The following summarizes the results of this review: • DFPS Case #40231144 was referred back to the facility as an administrative issue. The facility documented follow-up to concerns addressed in the report. Disciplinary action was documented for staff involved in the allegation and all staff and supervisors in the home received an email reminding them of facility procedures that were not being followed at the time of the incident. • DFPS Case #40221764, immediate protections including removing the AP from direct client contact was documented. The AP was terminated following a confirmed allegation of neglect. There was no documentation in the investigation file to ensure that recommendations regarding monitoring of staff using lifts as prescribed was completed. There was also no documentation to address the recommendation that all lifts be checked to ensure that they were working properly. • For DFPS Case #39832468 and #40258735, immediate action taken to ensure the safety of the individual involved was taken and documented. All follow-up action to concerns was documented in the investigation file. • DFPS Case #39762627 was referred back to the facility for follow-up as it did not meet the definition of neglect. Immediate protections were put into place, but no additional recommendations to remedy the situation were made. According to staff interviewed, individuals were moved and living in “chaos.”	Noncompliance

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		According to the Assistant Independent Ombudsman, staff in the home were interviewed and it was "the unanimous consensus that the combination of individuals with such varying ages, intellectual abilities, and social abilities was the primary cause of the existing chaos." She further noted that there was a "complete lack of continuity of care under a very stressful situation." The facility investigation files should include documentation of protections put into place and follow-up corrective actions. The facility was not in substantial compliance with this item.	
	(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.	Files requested during the monitoring visit were readily available for review at the time of request. With regard to DFPS, DFPS investigations were provided by the facility and available as requested by the monitoring team. The team agreed with this facility's self assessment rating of substantial compliance with this item.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The facility had a system in place to collect data on unusual incidents and investigations. Data were compiled in a numerous logs requested by the monitoring team that included: • Type of incident, • Staff involved in the incident, • Individuals directly involved, • Location of incident, • Date and time of incident, • Cause(s) of incident, and • Outcome of investigation. The facility had not compiled quarterly trend reports that focused on all allegations of abuse and neglect, other incidents and injuries. Information collected by the facility should be used to address systemic problems that are barriers to protecting individuals from harm at the facility. There continued to be a high number of incidents and injuries 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 and take action to reduce the number of incidents and injuries. The facility was not in substantial compliance with this provision item.	Noncompliance

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D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	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 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. Background checks were conducted on new employees prior to orientation and 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. According to information provided to the monitoring team, for FYI 11, criminal background checks were submitted for 2229 applicants. There were a total of 15 applicants who failed the background check in the hiring process and therefore were not hired. No employees were dismissed due to background check. 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. • Signed acknowledgement forms were submitted for 23 of 24 employees (96%).	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The facility's POI indicated substantial compliance with this D.5. The monitoring team agreed that the facility remained in substantial compliance with this item.	

Recommendations:

1. All serious injuries should be reported for further investigation when a probable cause cannot be established during a preliminary investigation (D2a).

2. The facility will need to ensure that APs are not returned to direct care positions until at least a well- supported, preliminary assessment determines that the employee poses no risk to individuals or the integrity of the investigation (D2b).

3. The facility should document all immediate action taken in the designated area of the UIR, so that facility management can easily determine that adequate protections were put into place following incidents (D2b).

4. The facility needs to develop an audit process adequate for ensuring that significant injuries and trends of injuries are reported for investigation (D2i).

5. The facility should ensure cooperation by facility employees with outside investigators (D3b).

6. The facility needs to ensure that documentation reflects the time and date of investigative activities (D3e).

7. Significant injuries of undetermined cause or trends of injuries should be further investigated when a probable cause based on evidence cannot be determined (D3f).

8. The facility investigation files should include documentation of protections put into place and follow up corrective actions (D3i).

9. The facility incident management coordinator and director should immediately review completed DFPS cases and begin taking action on any recommendations (D3g).

10. Data 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 (D4).

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:** Documents Reviewed: o DADS policy #003: Quality Enhancement, dated 11/13/09 o DADS Draft revised policy on Quality Enhancement, undated o LSSLC facility-specific policies, Adm-14 Quality Assurance, Committee-12 QAQI Council, unchanged since last onsite review o Organizational chart, undated o LSSLC policy lists, dated 9/16/11 o List of typical meetings that occurred at LSSLC, undated o LSSLC POI, 10/17/11 o LSSLC Quality Assurance Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 10/31/11 o LSSLC DADS regulatory review reports, through 9/21/11 o QA department staff meeting notes, monthly, June 2011-October 2011 (except September 2011) o Training about quality assurance presented to QA staff, 10/18/11 o LSSLC Quality Assurance Plan/Manual and QA matrix, 10/18/11 o Set of blank tools used by QA department staff • To monitor ICFMR plans of correction (seven) • To monitor other activities (seven) o DADS LSSLC family satisfaction survey online summary, 88 respondents since last onsite review o Self-advocacy monthly meeting minutes and notes, and self-advocacy leadership meeting notes, monthly May 2011 through September 2011 (but not July 2011) o QAQI Council agenda and meeting minutes from May 2011 through November 2011 (seven meetings) o QAQI Council agenda and handouts for 11/3/11 meeting o Various summaries of Performance Improvement Team activities o Independent Ombudsman's annual report, September 2011 Interviews and Meetings Held: o Stacie Cearley, Director of Quality Assurance o QA staff: Tabitha Anastasi, Elizabeth Carnley, Gena Hanner, Stephen Webb, Charlene Brown, Melissa Latham o Gale Wasson, Facility Director o Sherry Roark, Settlement Agreement Coordinator o Residential Director and Unit Directors: Keith Bailey, Rotley Tankersley, Kenneth Self, Todd Miller, Mary Stovall

	Observations Conducted: o QAQI Council meeting, 11/3/11 o Administration meeting, 11/1/11 o Many residences, day program, and vocational program
	Facility Self-Assessment: LSSLC submitted its self-assessment, called the POI. It was updated on 10/17/11. In addition, during the onsite review, the QA director reviewed the presentation book for this provision and discussed the POI at length with the monitoring team. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the QA director wrote a sentence or two about what tasks were completed and/or the status of each provision item. An entry was made almost every month. In the POI, similar comments were written for each of the provisions. When the monitoring team conducts its onsite review, the results are 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. The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The QA staff self-rated the facility as being in noncompliance with all five provision items. The monitoring team agreed with these self-ratings. The action steps included in the POI should be written to guide the department in achieving substantial compliance. The action steps for this provision attempted to address many of the concerns of the monitoring team. The POI action steps should be updated based upon the content of this report and with direction from the new QA director. The facility will benefit from the eventual development of a self-monitoring tool for this provision of the Settlement Agreement. Perhaps this can occur after the state policy is finalized.
	Summary of Monitor's Assessment: LSSLC again made little progress towards achieving substantial compliance with the items of this provision since the last onsite review. A new QA director was appointed in September 2011 and she was just getting started on addressing the items of this provision at the time of this onsite review. The new QA director and the monitoring team met and discussed the important components of a QA program for LSSLC, such as a listing of all data collected at the facility, a QA plan that includes a matrix of data that are to be submitted and reviewed by the QA department, the outcome of QA department review of

	these data, a QA report that includes data submitted to QAQI Council and the other related committees, and a formal corrective action system. QA policy was not yet developed. The QA director, however, had written a QA manual that might be used as a QA plan. Further, she had created an initial QA report. Much work will be needed, but these activities indicated that progress could be expected by the time of the next onsite review. Progress was evident in one area: the creation and implementation of performance improvement teams (also called work groups) to address any concerns identified by the QAQI Council. Seven PITs were created since the last onsite review. A system of managing corrective actions was not yet in place. 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, and conducted a variety of audits.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	LSSLC again made little progress towards achieving substantial compliance with the items of this provision since the last onsite review. That being said, a new QA director was appointed less than two months prior to this onsite review. She was previously a member of the QA department and during her first two months on the job, she was becoming oriented to QA, the needs of the department, the need for the development of a QA program, completion of her previous duties, and various trainings and orientations at LSSLC and at DADS state office. The new QA director seemed to have good understanding of where the QA department needed to be headed. She had initiated some new activities and projects, such as creation of an initial QA plan/manual, updating of the QA matrix, and assembly of a draft QA report (all described in more detail below). Further, although the facility had not made progress towards substantial compliance regarding the overall QA program at LSSLC, the QA staff members had remained quite busy, implementing self-assessment tools, responding to ICFMR reviews and investigations, and working with various department heads at the facility. <u>Policies and General QA Planning</u> This state policy, #003: Quality Enhancement, dated 11/13/09, was being extensively revised. A draft of the new policy was disseminated a month or so prior to this onsite review. Although not finalized, the new policy should provide LSSLC with further direction in its QA activities. Two LSSLC facility-specific policies remained since the last onsite review and comments from previous monitoring reports will not be repeated here. LSSLC will, however, need	Noncompliance

#	Provision	Assessment of Status	Compliance
		to update, delete, and/or create new facility-specific policies when the state policy is finalized and as it develops the LSSLC QA Manual/plan. When the new state and facility-specific policies are finalized, training for senior management and department heads should occur. Below are comments from the monitoring team regarding LSSLC's status with some of the important component steps in the development of a QA program. The monitoring team had the opportunity to discuss these at length with the QA director. These component steps were listed in the previous monitoring report. Detail is again provided below in hopes that it will be helpful to the QA department. 1. Create a listing of all data collected at the facility that includes the following: a. Data collected by each discipline service department; this includes two categories of data: i. Data the discipline service department uses for its own service and operational purposes ii. 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 facility service department, if any (e.g., PNMP monitoring, AAC device monitoring) b. Data collected by the QA department staff: i. Data they collect themselves ii. Data that are the result of the QA department's interobserver agreement (reliability) assessments of the service department's own self-monitoring c. Data from the areas listed in the Assistant Commissioner's guidelines for QAQI Council, such as Life Safety Code, ICFMR regulatory activities, the FSPI, and any other types of data that DADS central office may determine necessary for submission to state office. Status: LSSLC had not yet begun to assemble this listing. During the week of the onsite review, this was discussed at length with the new QA director. The discussion included detail on the difference between this list and the QA matrix. The development of this listing will take a number of months to complete. It is likely that additional items will be added to whatever list is initially developed. Once completed, an annual or semi-annual update will likely be all that will be necessary. 2. Determine which of these data are to be submitted to the QA department for tracking and trending (and to be part of the QA matrix). Status: The QA department had not made any progress on this activity,	

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		other than the addition of more items. The QA matrix should indicate all the data that the QA department will track, trend, and comment upon. Further, the matrix will become part of the QA plan. Separation of the matrix from the overall listing of data (item #1 immediately above) will help the QA department in making this matrix and the QA plan functional and relevant. 3. Determine which of these data are to be included in the QA report. Status: A monthly QA report was not being completed, however, activities to initiate a QA report had begun. 4. Determine which of these data are to be presented regularly to the QAQI Council. QAQI Council should make this determination with suggestions from the service department heads as well as from the QA director. Status: The QAQI Council was reviewing some data, but they were doing so without the benefit of a listing of all types of facility data, the QA matrix, or any other guidance from the department heads or QA department. 5. Create and manage corrective actions based upon the data collected and direction from the QAQI Council. Status: A system of managing corrective actions was not yet in place (see E2 below). QA Department Stacie Cearley was the newly appointed QA Director. She had quality assurance experience at LSSLC as well as at other types of facilities. She appeared energetic, focused, and capable of bringing LSSLC towards substantial compliance with provision E. Although the QA program had not progressed, every QA staff member was extremely busy and highly engaged in QA activities, including conducting reliability observations of many of the statewide self-assessment tools, meeting with department heads, and responding to ICFMR reviews and investigation. The QA staff's competence and desire to engage in meaningful QA activities bode well for the department as it develops the structure and components required of a QA program. QA department meetings were initiated in June 2011. The new QA director planned to initiate weekly QA staff meetings. This seemed to be a good idea and will likely be well received by the QA staff. Moreover, she was beginning to address two items identified in the previous report: attending to the relationship between nursing and QA, and providing QA staff with more direction and support. The Settlement Agreement Coordinator (SAC) also had responsibilities that were quality assurance related. As the QA program develops (i.e., data collection, data analysis, meetings, reorganization), the QA department needs to ensure that the SAC and her	

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		activities are appropriately included and involved. <u>Quality Assurance Plan</u> LSSLC did not have an adequate or thorough QA plan in place, however, some progress was noted towards the creation of a QA plan. The QA director developed a draft QA manual. It contained the DADS state policy for QA and other relevant information regarding the goals and activities of the LSSLC QA department, including the QA matrix. The monitoring team believes that this manual would meet the standard for there being a QA plan, however, this needs to also be agreed upon by the DADS central office QA coordinator. Moreover, the DADS QA coordinator might consider this format for all the SSLCs. That is, having the QA plan be a QA manual at each facility that describes the overall operation of QA at the facility and that also includes the QA matrix. As the LSSLC QA director edits and updates the QA manual, some considerations from the monitoring team are provided below: • Make the statewide policy an appendix rather than part of the manual. • Include a one or two page overall description of how QA is conducted at LSSLC. • Include a description of the comprehensive listing of all data that are collected across the facility. • Describe the QA matrix as those data that are managed, reviewed, trended, and analyzed by the QA department. The QA matrix is good to include in the QA plan and can help guide the QA department (and QAQI Council) in understanding what data are being managed by the QA department (some of it collected by QA department staff, some of it submitted by the discipline departments at the facility). Ultimately, the QA matrix should be a component of the QA plan (as was the case with the LSSLC QA manual). Any data/items on the QA matrix should be reviewed, analyzed, perhaps graphed and trended, and commented upon, if necessary, by the QA department. <u>QA Activities and Indicators</u> LSSLC reported that it collected a variety of data, but none were presented to the monitoring team other than the statewide trend analysis (it contained four topics). LSSLC reported that it collected data on (a) seven different ICFMR plans of correction and (b) seven other QA-department tools (listed below). None of these data, however, appeared to have been summarized, graphed, trended, or analyzed. • Woodland Crossing observations • Lifting and transfers • Comprehensive lifting, transfer, and positioning	

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		• Comprehensive communication • Comprehensive mealtime • Environmental • Observations regarding provision item D2i The QA nurse had, in the past, participated in the facility's mortality/death review process. That was no longer the case at the time of this review. As indicated in sections L and N of this report, the monitoring recommends that facility management re-look at that assignment. A great deal of time was devoted to the implementation of the statewide Settlement Agreement provision self-monitoring tools. At LSSLC, the departments were, as of the time of this onsite review, collecting and entering their own data into the state database. A next important step in this process is to update the content of the statewide tools so that they are relevant and valid. Facility managers and clinicians would likely welcome the opportunity to participate in making suggestions for additions, deletions, and re-wording of items in each tool. Family satisfaction measures were being obtained via the statewide online system. LSSLC had received 88 responses over the past six months, a very good number. Overall, the responses were positive and some of the data were presented to QAQI Council by the Coordinator of Family Services. In addition, the data should be incorporated into the overall QA program, and follow up should occur on any problems or complaints identified. This would be especially relevant for the last two items, which were open ended questions. In addition, as noted in previous monitoring reports satisfaction measures should also target individuals, staff, and others in the community with whom the facility interacted, such as restaurants, stores, community providers, medical centers, and so forth.	
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	This provision item required the facility to analyze the data collected by the QA processes that were implemented at the facility. LSSLC continued to develop the QAQI Council and increased its usage of Performance Improvement Teams. Overall, to meet the requirements of this provision item, LSSLC needs to (a) analyze data regularly, and (b) act upon the findings of the analysis. <u>QA Data Management and Analysis</u> As the facility moves forward, it will be important for the QA director to review all data that are managed by the QA department (i.e., all of the data on the QA matrix). These	Noncompliance

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	action step; the person(s) responsible; and the time frame in which each action step must occur.	data will need to be summarized and trended, such as on a graph. The graphic presentations should show data across a long period of time. The amount of time will have to be determined by the QA director, perhaps in collaboration with the department or discipline lead. For most types of data, a single data point on the graph will represent the data for a month, two-month period, or quarter. The graph line should run for no less than a year. Not all of these graphs need to be created by the QA department. It is possible for the facility to set an expectation for the service departments to submit their data and their graphic summaries each month. This will have to be determined at the facility level. Many, if not all, of these graphic presentations should/can appear in the QA report and be presented to QAQI Council. The QA staff reported a number of problems with the database used for the statewide Settlement Agreement provision self-monitoring tools. Examples included an inability for entry of QA-collected data that was not for interobserver agreement purposes, and inability to extract a summary of interobserver agreement ratings for a group of observations. Regarding the statewide trend analysis: for the past few years, every SSLC created an almost identical monthly report on four sets of data: restraint usage, abuse and neglect allegations, injuries, and unusual incidents. These are important topics and the report typical provided a lot of valuable information. Each facility now had data for three or so years. The document, however, was cumbersome and lengthy. The QA director will need to take the most important parts of this trend analysis document and incorporate them into the facility's QA program (e.g., table/grid, QA report, report to QAQI Council). One aspect of the trend analysis that the facility (and state) should consider is trending the number of confirmed ANE allegations, not only the number of allegations made. While trend reports for ANE allegations may be useful, it is even more important that trend analyses be developed for confirmed instances of ANE. <u>QA Report</u> The QA director had just begun to form a QA report. She should work with the DADS central office QA coordinator, as well as with the facility director, to create a QA report that is meaningful and useful, while not being overly cumbersome or lengthy. To clarify and perhaps reiterate: the list of data collected at the facility, the QA plan, the QA department's analysis and trending of data in the QA plan, the QA report, QAQI Council agenda and reviews, PETs (if any), PITs, and CAPs should all line up with each other.	

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		QA-Related Meetings • QAQI Council: The QAQI Council met monthly since the last onsite review. The monitoring team reviewed the minutes from each meeting and attended a meeting during the week of the onsite review. Full operation of QAQI Council was hampered by the absence of a comprehensive QA program, as described throughout this section of the report. For instance, the QAQI Council did not have a listing of data to review, a QA report, a listing of PITs (see below), or corrective action plans. • Performance Improvement Teams: Since the last onsite review, LSSLC had increased the number and breadth of performance improvement teams (also called work groups at LSSLC). PITs were one of the strengths of LSSLC, that is, senior management was competent in forming, directing, and implementing them. The set of PITs, however, should be organized and tracked. At the current time, this was done in a somewhat haphazard way. After discussion with the monitoring team, the list of PITs was then included in the agenda/minutes for the most recent QAQI Council meeting. Corrective Actions Corrective actions were not yet being addressed in any organized manner and as required by provision items E2-E5. The monitoring team has a number of considerations for the facility as it moves forward with meeting the requirements provision items E2-E5. These considerations were in the previous monitoring report and are repeated here for the convenience of the QA department. These 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 specialized team to address the action and report back to the group. • 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	

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		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 state policy (E1).

2. Revise facility-specific policies after the state policy is approved and disseminated (E1).

3. Provide training to management and clinical staff on QA and on the new state and facility policies (E1).

4. Implement the five component steps numbered and described in E1 (E1)
   - Create a listing of all data collected at the facility.
   - Determine which of these data are to be submitted to the QA department for tracking, trending, and inclusion in the QA plan and matrix.
   - Determine which of these data are to be included in the QA report.
   - Determine which of these data are to be presented regularly to the QAQI Council.
     - QAQI Council should make this determination with suggestions from the department heads as well as from the QA director.
   - Create and manage corrective actions based upon the data, and direction from QAQI Council.

5. Include the SAC in QA activities as they relate to the Settlement Agreement (E1).

6. Revise the QA manual (i.e., the QA plan) and update the QA matrix of data (E1).

7. Work with state office to update the content of the statewide self-assessment tools (E1).
8. Obtain and consider QA staff comments and suggestions regarding the statewide self-assessment tool database (E1).
9. Manage the data that are in the QA matrix (e.g., graph, trend, analyze) (E2).
10. Create a QA report; summarize and present data in an understandable manner (E2).
11. Ensure trending of confirmed cases of abuse/neglect occurs (E2).
12. Include range of satisfaction measures in the QA program (e.g., individuals, staff, families, and related community businesses) (E1, E2).
13. Manage PITs in an organized manner (E2).
14. Implement and manage corrective actions as per items E2-E5 (E2-E5).

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 Supporting Visions: Personal Support Planning Curriculum o DADS Policy #004: Personal Support Plan Process o LSSLC Policy: Client Management - Personal Support Plan Process o Supporting Visions Training Curriculum o LSSLC Plan of Improvement o QDDP weekly meetings minutes o A sample of completed Observation Notes Monitoring Tool for July 2011 o A sample of State Office Living Discussion Review Tools for September 2011 o A sample of completed monitoring tools to assess the quality of the PSP meeting and the PSP o PSP Attendance Compliance Trends o Data on annual assessment filed 10 days prior to PST meetings o Reviews of living options discussion trend report o A sample of completed QDDP Facilitation Skills Performance Tool o Job Skills training curriculum: Working Out-Gaining Job Muscle o PSP, PSP Addendums, Assessments, SAPs for the following Individuals: • Individual #368, Individual #560, Individual #43, Individual #540, Individual #102, and Individual #132 o PSP, PBSP, PSP Addendums for the following Individuals: • Individual #192, Individual #176, Individual #407, Individual #410, Individual #285, Individual #88, Individual #99, Individual #504, and Individual #106 o Quarterly reviews for Individual #368. <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Kendra Carroll, Director of Competency Training and Development o Luz Carver, QDDP Coordinator o Jason Peters, Human Rights Officer o Royce Garrett, Director Consumer and Family Relations o Stacie Cearley, Quality Assurance Director o Sylvia Middlebrook, Chief Psychologist o Lisa Curington, Director of Day Programs o Ric Savage, DADS Consultant

	Observations Conducted: o Observations at residences and day programs o Oak Hill Morning Unit Meeting 11/1/11 o Incident Management Review Team Meeting 10/31/11 and 11/3/11 o Annual PSP meetings for Individual #116, Individual #321, and Individual #50 o Personal Focus Meeting for Individual #560 o Human Rights Committee Meeting 11/2/11 o Self Advocacy Meeting
	Facility Self-Assessment: LSSLC submitted its self-assessment, called the POI. It was updated on 10/17/11. During the onsite review, the QDDP Coordinator reviewed the presentation book for this provision. The facility reported that it was focusing on deficits noted in Section F, but acknowledged that many of these efforts were in the beginning stages. Most of the items required by this provision were not yet fully implemented. According to the POI, the facility's self-rating was, in part, determined through monitoring of the PSP and PSP process by the QDDP Coordinator. The POI, however, did not include results of that monitoring. Instead, the comments section of each item of the provision included a statement regarding what tasks had been completed or were pending. The POI indicated that a number of new processes had been implemented in regards to PSP development and implementation. It was too soon to evaluate the adequacy of most of these changes. The facility assigned a substantial compliance rating to the following provisions in Section F: F1a, F1b. F2a4, F2a6, F2f, and F2g. The monitoring team, however, did not find substantial compliance with any of the provisions in Section F. As noted throughout section F, while the monitoring team did see continued progress in this area with the new style PSPs, assessments were still not completed or updated as needed, key members of the team were not present at annual meetings, plans still did not integrate all services and supports, and plans were not consistently implemented and revised when needed.
	Summary of Monitor's Assessment: The QDDP Coordinator acknowledged that the facility was not yet in substantial compliance with many requirements of this provision. It was evident from conversations with the monitoring team that the facility was considering how to best implement the person centered planning process and ensure consistent implementation and monitoring of services. All staff had also been trained on the new risk identification process and the new process had just been implemented for some individuals at the facility. Moreover, DADS had recently initiated a thorough review of the PSP process and hired a set of consultants

	to help the SSLCs move forward in PSP development and the meeting of this provision's requirements. The monitoring team met with one of the consultants during the week of the onsite review. The consultant's work had recently begun at LSSLC. The facility was in the beginning stages of revising the PSP process. Seven annual PSP meetings were observed by the monitoring team. In meetings observed, the QDDPs were attempting to encourage team participation and ensuring that all necessary information was covered during the PST meeting. While the process was still understandably awkward to the teams, they were having a more integrated discussion at the team meetings and time was better spent on developing plans and talking about needed supports. Team meetings were well attended and it was noted that 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. During observation of residential and day programs, it was noted that many individuals spent a majority of their day not engaged in meaningful activities. There was a high incidence of self stimulatory and self abuse behaviors observed in the residential and day programs, due in part to lack of engagement. In one home, it was observed that three individuals were in bed by 5:00 in the evening and staff reported that they would not get back up until the next morning. Teams need to be more aggressive at addressing risk and a steer away from the attitude that injury, self abusive behavior, incidents, and illness is status quo for this population. Teams should identify when supports and services are not effective and act quickly to revise services to address problems. 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. Quality assurance activities with regards to PSPs were in the initial stages of development. The facility had begun to use state developed audit tools to review both meeting facilitation and the PSP development process. 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 PSPs that were reviewed were chosen from among the most recently developed PSPs. The sample included plans for individuals who lived in a variety of residences on campus. Therefore, a variety of QDDPs and PSTs had been responsible for the development of the plans.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	QDDPs were responsible for facilitating PST meetings at the facility. The QDDPs were also responsible for ensuring that team members were developing, monitoring, and revising treatments, services, and supports. While onsite, the monitoring team observed a number of PSP meetings, and also met with a PST to discuss the at-risk screening process. All PST meetings observed during the monitoring visit confirmed that QDDPs were facilitating PSP meetings. A sample of 10 PST attendance sheets was reviewed for presence of the QDDP at the annual PST meeting. At all annual meetings, there was a QDDP present. All QDDPs had attended facilitation skills training. Additionally, DADS had hired a team of consultants who were providing classroom training, coaching, and mentoring to the PSTs on facilitation skills and PSP development. While it was too soon to fully evaluate the effectiveness of this training, the QDDP Coordinator was attending annual PST meetings and continuing to mentor QDDPs with regards to meeting facilitation. At the PST meetings observed, QDDPs were at varying stages in learning to competently facilitate meetings. In some meetings, important areas of discussion were skipped, while other areas of discussion that were not as significant for the individual took a major portion of the meeting time. As QDDPs gain greater experience at facilitating meetings, they should be able to guide team members to hold a more in-depth discussion when necessary and move on to the next topic when additional discussion is not needed. Understandably, some team members were somewhat hesitant to contribute to the discussion. This was a new process and members of the monitoring team, representatives from the state office, and consultants were present at the meetings. At the June 2011 Monitors' meeting with DADS and DOJ, there was discussion regarding determining the definition and criteria for facilitation, that is, what does it mean for the QDDP to facilitate the PST in a way that meets this provision item The facility's POI indicated substantial compliance with this requirement. The monitoring team did not agree with that assessment. It will be important for the QDDP's	Noncompliance

#	Provision	Assessment of Status	Compliance
		to gain some facilitation skills that will allow them to keep the teams on track while making sure that everything is addressed particularly supports to address all risk that teams identify.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	A sample of attendance sheets was reviewed with the following results in terms of appropriate team representation at annual PST meetings. The sample included PSPs for the following individuals: Individual #540, Individual #132, Individual #368, Individual #43, Individual #560, Individual #102, and Individual #176. • 3 (42%) of seven indicated that the individual attended the meeting; o Exceptions included Individual #560, Individual #368, Individual #540 and Individual #102. • Four of the individuals in the sample had a guardian. Only one (25%) of four participated at the annual PST. o Exceptions included Individual #368, Individual #540, and Individual #176. The monitoring team does not expect that all individuals or their LARs will want to attend their PST meetings. When individuals are not present for meetings, the QDDP should document attempts made to include the individual or LAR and how input was gathered to contribute to planning if the individual did not attend the meeting. When individuals consistently refuse to attend meetings, the team should look at what factors contributed to the refusal to attend and brainstorm ways to encourage participation. For example, if the individual does not want to miss work to attend, try holding the meeting outside of work hours, or if the individual does not like crowded rooms, try holding the meeting in a larger space. A review of 15 signature sheets for participation of relevant team members at the annual PST meeting indicated that 0% of the meetings were held with <u>all</u> relevant staff in attendance. There was no documentation included in any of the PSTs that would indicate input was given prior to the meeting by staff that were unable to attend the meeting. Some examples where team participation was not found to be adequate include: • Individual #102 had been treated multiple times in the past year for pneumonia, UTI, and hypothermia. She had numerous complex health risks. Her dental health was noted to be poor and cooperation at dental appointments was poor. She needed intensive supports for dining, mobility, and positioning. Her physician, dental staff and PNM staff did not attend her meeting. Current supports had not been adequate to safeguard her health. Professional staff should have been in attendance to contribute their expertise in developing appropriate supports to address her identified risks. • Individual #43 also had multiple health risks, psychiatric diagnoses, and PNM	Noncompliance

#	Provision	Assessment of Status	Compliance
		support needs. Her doctor, psychiatrist, dietician, SLP, OT, and PT did not attend her annual PST meeting. Input from these team members was essential in developing an adequate support plan. • Individual #540 and his LAR did not attend his annual PST meeting. He attended school on campus. His teacher did not attend the meeting. He had many complex medical, nutritional, and therapy support needs. He could greatly benefit from integrated discussion among disciplines to ensure that all of his risks are being addressed and his supports are appropriate. Specialized staff that did not attend his meeting included his physician, SLP, OT, PT, and dietician. Inconsistent attendance at PSP meetings by specific team members, including physicians, psychiatrist, dental staff, OTs, PTs, SLPs, and RD was documented. The absence of key members was a significant barrier to integration in the development of PSPs. 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. Given the lack of resources in psychiatry, they attended a limited number of PSP meetings. Currently, other than the team participation in psychiatry clinic, and communication with primary care, there was little other integration of psychiatric services with other disciplines. The facility had implemented a data base to track attendance at PST meetings for relevant team members. The facility trend report showed much higher attendance rates than what was found by the monitoring team in the sample reviewed. Facility data indicated a 97% attendance rate in September 2011. The facility was not in compliance with the requirement. Team participation was not adequate to ensure the development of a comprehensive plan for supports.	
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 monitoring team found the quality of some assessments continued to be an area of needed improvement. In order for adequate protections, supports, and services to be included in an individual's PSP, it is essential that adequate assessments be completed that identify the individual's preferences, strengths, and supports needed (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 PFA was an assessment screening tool used to find out what was important to the	Noncompliance

#	Provision	Assessment of Status	Compliance
		individual, such as goals, interests, likes/dislikes, achievements, and lifestyle preferences. In the PSPs reviewed, the PFA was used to develop a list of priorities and preferences for inclusion in the annual PSP. This list was individualized to some extent, and offered a good starting point for plan development. The list of preferences developed from the PFA process was reviewed for the 15 individuals in the sample. Teams were at varying stages in developing a list of priorities and preferences that could be used for planning. For example, the PSP for Individual #407 included the following preferences: attention from staff, community outings, and being independent. This list did not give enough information to be beneficial in planning. Individual #368's PSP, however, included a good example of a more individualized list of preferences that would be a basis for person centered planning. His list included snacks, such as hamburgers, BBQ, coffee, cookies, chips and Dr. Pepper, animals especially chickens and cows, ride trains, gospel, country and western, and golden oldies music, picnics and grilling, fishing, swimming, holiday activities, and choosing which activity he wants to participate in. Information gathered from the PFA was discussed in the PST meetings observed. Each QDDP reviewed the individual's list of preferences and members of the team engaged in varying degrees of discussion on how this might be supported. Attempts were made to integrate these preferences into outcomes developed by the team. Since most individuals at the facility had limited exposure to options outside of what was offered at the facility, teams should use this list of preferences to brainstorm ways individuals might gain greater exposure to new activities that might be of interest. An assessment geared towards identifying activities not typically offered at the facility would broaden the spectrum of activities that individuals may want to be involved in. Consideration should be given to capturing and sharing information regarding possible areas of interests while individuals are in the community. This information should be discussed at the PST meeting and the team should plan for opportunities that might lead to discovering new activities that the individual might enjoy for leisure, and work. The Positive Assessment of Living Skills (PALS) was used by the facility to assess adaptive living skills. It appeared that staff were routinely completing the checklist, but not developing individualized recommendations from assessment results. It had become a rote check off that was not useful for planning. None of the assessments described specific supports needed by the individual. Section III of the PALS was a summary section that should have been used to develop a list of priorities for training objectives. Completed PALS were reviewed for Individual #310, Individual #102, Individual #132, and Individual #43. The summary section was only completed for one of the assessments in the sample. Individual #132 had one recommendation for training in the	

#	Provision	Assessment of Status	Compliance
		summary section of her PALS to participate in physical activities to promote weight loss. It was not clear how this was identified as a priority need in the PALS assessment. Some examples where adequate assessments were not completed for the individual prior to the annual PST meeting, or updated in response to significant changes included: • At the PSP for Individual #321, PST members all commented on regression in her ability to effectively communicate. Her communication assessment had not been updated prior to the PST meeting. A great deal of time was spent trying to develop outcomes where training was contingent on information from an updated communication assessment. After much discussion, the team agreed that they would need to meet again after the assessment was completed to integrate recommendations into her PSP. Similarly, the team also recommended an updated nutritional evaluation. The team did not have information necessary to develop appropriate supports at her annual PST. • Individual #540 had experienced multiple problems with his gastric tube over the past year including blockage and leakage leading to skin irritation. His PNM assessment noted that he did not present with risk indicators that would preclude return to oral intake. A swallow study was recommended for consideration to return to oral feedings. The swallow study should have been scheduled prior to the team meeting so that the team could have addressed optimal nutritional supports at the time of his annual team meeting. • Individual #50's PST had discussed his severe nail fungus at this quarterly meeting and recommended that he see a podiatrist for an assessment. He still had not been referred to the podiatrist three months later. The team spent quite a bit of time at his annual PST meeting discussing how to treat his nail fungus before again recommending that an appointment be scheduled for an assessment by the podiatrist. • Individual #43 had poor dental hygiene. Her dental assessment was not completed until after her annual PST date. Her annual PSP meeting was held on 8/16/11. Her OT/PT assessment was completed on 8/18/11. Numerous recommendations included in the OT/PT assessment should have been used in planning supports throughout her day. Her PALS assessment did not include any recommendations and was not adequately completed for planning purposes. The facility had begun using a data base to collect information on whether assessments were completed and filed at least 10 days prior to the annual PST meeting. Data indicated that in many cases, assessments were not filed prior to the PST meeting. Compliance rates were around 50%. All team members will need to ensure assessments are completed updated when	

#	Provision	Assessment of Status	Compliance
		necessary and accessible to all team members prior to the PST meeting to facilitate adequate planning.	
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.	PSPs included a summary of assessments information and recommendations, but as noted in F1c, it was not evident that assessments were completed prior to the annual PST meeting, were adequate to address needs, or were revised as individual's needs changed. In order to gain substantial compliance with F1d, an adequate assessment process will have to be in place. As evidenced by the following examples, assessments often included important information that should have been used as the basis for planning for individuals, however, this information was not used to develop and implement protections, services, and supports for the individual. • At Individual #368's July 2011 quarterly review meeting, it was noted that he had 10 injuries, four were related to falls. The review notes that "the PST has no recommendations at this time." At his October 2011 quarterly review meeting, his team noted that he had seven injuries during the quarter. Three of those were attributed to falls. The PST identified a trend for falls. Again, the review stated that the team had no recommendations. • Individual #407's behavioral and communication assessments indicated that when she was frustrated, disappointed, or angry, she will slap her face, hit furniture or staff, babble or cry. Her medical assessment noted that she was easily agitated and frequently slapped and bit herself. The team did not adequately address communication supports that might reduce her self-injurious behaviors. It was also not evident that she participated in meaningful programming based on her preferences. Additionally, she had chronic constipation, frequent UTIs and chronic knee pain, as well as, numerous other medical conditions that may cause pain or discomfort. The team did not discuss whether or not her SIB behavior may be related to discomfort from any of her medical conditions. • Individual #102's PFA included good information regarding her preferences and abilities. Specific information in her PFA regarding her communication style, living preferences, day programming preferences, favorite foods, and activities was not included in her PSP. Plans developed prior to August 2011 offered little indication of how each individual spent a majority of the day. A description of each individual's day along with needed supports identified by assessment should be included in PSPs. Plans developed after August 2011 showed improvement in this area.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The PSPs for Individual #132 and Individual #43 were examples of newer plans that integrated assessment information throughout the plan. The plans described preferences should be integrated throughout the day and what supports were needed in relation individual preferences.	
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).	Observation throughout the facility's day and residential programs revealed that individuals were involved in minimal programming that would provide meaningful learning opportunities to develop new skills and increase opportunities for community integration. A sample of 15 PSPs (see document list) was reviewed for indication that individuals and/or their LARs were offered information regarding community placement as required. All 15 (100%) indicated that this discussion took place at the annual PST meeting. None of the individuals in the sample had been referred for community placement. As evidenced by the summary below, this discussion, however, was not always adequate (also see section T of this report). • Individual #285's PSP indicated that he had been on a group home tour and started yelling and screaming with very little interest noted. A second tour was cancelled due to lack of transportation. It was not rescheduled based on the outcome of his first visit. The preference for living options section of his PSP noted he did not communicate verbally and there was no discernible response obtained during the discussion. The caseworker then stated that he did not express any expectations for moving to the community. The caseworker further noted that attempts to contact family members for input were unsuccessful. Obstacles identified by the PST included "does not have a legal guardian and he does not understand the CLOIP process and he also has significant behaviors that are targeted with a Positive Behavior Support plan." At the meeting, his mother did express a desire to have him moved closer to her. The team concluded that LSSLC was the most appropriate setting. • Individual #43's PSP noted that during her previous annual PST meeting, her team agreed that she would benefit from exploring community placement options since she was not aware of other living alternatives. Due to health issues, she did not attend community tours the previous year. Her grandmother had recently obtained guardianship. Her current PSP concluded that by doing this, "she would be the person who determines if Individual #43 moved into the community or if she remains at the Lufkin SSLC. At this time her desire is for her to remain at Lufkin SSLC." The team did not note any obstacles to her living in a less restrictive setting and did not develop a plan to further educate the individual or her LAR on living options. • The PSP for Individual #99 indicated that he was not familiar with community	Noncompliance

#	Provision	Assessment of Status	Compliance
		living options. No other barriers to community placement were noted. The team agreed that both he and his family needed to be exposed to other living options. His family had expressed a desire for him to live in the community with an alternate family with the appropriate supports. The PSP noted that his guardian was not in attendance at the meeting and would need to be contacted to talk about this decision. A referral was not made for community placement and outcomes were not included in his plan to provide greater exposure to the community. Discussion at PST meetings observed regarding community living options was not adequate: • At the PST meeting for Individual #50, each team member was asked to give an opinion on whether or not he could live in a less restrictive environment. The overall consensus was that he could live in a less restrictive environment with appropriate supports. The team could not think of any barriers to living in the community. His family stated that they did not wish to consider alternate placement. The team did not attempt to provide additional information to the family and there was no discussion regarding further exploration or referral. The QDDP stated that the team would support the family's decision to not consider alternate placement. • Individual #116's PST agreed that there were no barriers to community placement and that she could be served in a less restrictive environment with appropriate supports. She is an adult with no guardian, though her parents are very involved in decision making and are against alternate placement. The team did not discuss whether or not a referral should be considered, but again agreed that the decision should be up to her family. • Individual #132 had lived at LSSLC since 1967. She had not had the opportunity to visit any community homes. She informed the PST that she wished to remain at LSSLC and did not wish to explore community options. There were some common themes among the discussion and determination of optimal living placement in the PSPs reviewed: • Teams were not able to determine the preferences of individuals due to lack of exposure to other living options or inability to communicate choices and preferences. • Conversation around optimal placement was awkward at meetings observed. Team members were not comfortable having a discussion about community placement. These topics were being presented apologetically to family members at the meetings. • Community integration and employment was not adequately addressed in any of	

#	Provision	Assessment of Status	Compliance
		the PSPs reviewed or at any of the PST meetings observed. PSTs need to give consideration to the following: • The primary focus of all PSTs should be to provide training and supports that would allow each individual to live in the most integrated setting possible. • Outcomes should be developed to address communication skills, decision making skills, and increased exposure to life outside of the facility when these are identified as barriers to living in a less restrictive setting. • Team members need to be provided with updated training on services and supports that are now available in the community. • As evidenced throughout this report by the injuries due to inadequate supports and programming, incidents of substandard or compromised care, and lack of appropriate services available, LSSLC may not be the safest or optimal living environment for all individuals. The team needs to review each individual's history of incidents and injuries, any decline in health status, or regression in skills and hold an integrated discussion regarding whether or not the facility is able to provide the best care possible for each individual. The facility seemed to be beginning to collect some facility-wide data regarding obstacles to community placement identified by PSTs. Thirty-five of 82 (43%) of the PSTs cited LAR's reluctance to consider alternative placement. Twenty-nine of 82 (35%) of the PSTs cited the individual's reluctance to consider alternate placement. Lack of understanding of community living options contributed to 16 of the 29. Additional training needs to be provided to QDDPs to address this reluctance and lack of understanding of alternate placement with individuals and their LARs. Plans included limited opportunities for community based training. None of the plans in the sample included opportunities to develop relationships and gain membership in the community. Although the facility reported that some training was occurring in the community, it was not evident in PSP outcome documentation. Plans will need to include community based teaching strategies to ensure that training is consistent and measurable. There was no indication that employment or other day programming outside of the facility had been actively pursued for any of the individuals in the sample. 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. This provision is discussed in detail later in this report with respect to the facility's progress in addressing section T.	

#	Provision	Assessment of Status	Compliance
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 facility's POI indicated that each discipline, facility-wide, had implemented a new Assessment Summary Format that clearly defined the individual's vision, preferences, strengths, barriers to achieving vision, supports necessary to achieve their vision, as well as recommendation to support each area. The PSPs reviewed continued to include a list of the individual's preferences and interests. For individuals in the sample, this list was used as the basis for outcome development. Limited exposure to new activities meant that this list was often limited. In order to meet compliance requirements with F2a1, PSTs will need to identify each individual's preferences and address supports needed to assure those preferences are integrated into each individual's day. Observation did not support that individuals were spending a majority of their day engaged in activities based on their preferences. PSPs reviewed were reflective of the lack of options and programming available at LSSLC. As noted in F1e, outcomes were not functionally implemented in the community. There was very little focus on priority skills such as communication, socialization, and community integration. None of the PSPs in the sample provided for structured training opportunities in the community. Observation of activities occurring in the day programs and homes revealed that many individuals at the facility were engaged in nonfunctional isolated activities with very little social interaction. Active treatment occurring in small groups did not generally address individual preferences as stated in the PSP. The measure of engagement appeared to be based on staff engagement, not individual engagement. For example, the monitoring team observed staff standing in front of small groups of individuals showing the group pictures and lecturing the group on various topics throughout both the day and residential programs. Individual engagement was very low in most of these groups. Individuals were often sleeping or engaged in self-stimulatory behaviors though data collected indicated that the individuals were engaged in active treatment. See section S	Noncompliance

#	Provision	Assessment of Status	Compliance
		for additional comments regarding engagement in active treatment. Both observation and documentation showed that some individuals spent a majority of the day engaged in self-stimulatory and often self abusive activity. PSTs were addressing many of these behaviors with restrictive practices rather than looking at ways to actively engage individuals in activities based on preferences. For example, • Individual #368 had an alarming number of documented injuries. A majority of the injuries had occurred when he was not engaged in meaningful activities or trying to escape staff demands. According to his PSP, he was no longer interested in working since he did not understand the correlation between work and being paid and he was "older and tired of work." It was not evident that the team had explored how to relate work to being paid or that he had the opportunity to try other jobs that he might have found more interesting. It was not evident that his PST had adequately explored new options for engaging him in activities based on his preferences. His PFA resulted in a fairly comprehensive list of activities that he enjoyed. His trend of injuries was addressed by requiring the use of restrictive equipment (gait belt and helmet) and increasing his level of supervision. There was no indication that this increase in supervision had resulted in more meaningful engagement. • Individual #285's PSP stated that he "exhibits the following behaviors: physical aggression toward himself and others, projectile vomiting, holding his breath until his face turns red; hand banging wheelchair rocking/bucking; hand mouthing behaviors; screaming and yelling; slapping his face, hips and/or thighs with his hands or other objects; pulling out his hair; resistiveness, non-compliance, standing up in bed yelling; crawling around on the floor yelling; stripping; and rectal digging." His level of supervision had been increased and he had a gait belt and seatbelt for his wheelchair. According to his PSP, he enjoyed being outdoors, music, quiet environments, aquatic activities, and attending church. His PSP further noted that he would benefit from a day program with community outings built into the program. His outcomes did not include any of these activities. His team needs to develop structured meaningful programming based on his preferences to try to reduce the occurrence of identified behaviors. 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 move the individual closer to community employment. It did not appear that community employment was a real consideration for the individuals in the vocational program. Work outcomes tended to be just a continuation to work in the same job without any measurable outcomes to learn skills that would apply to new employment opportunities.	

#	Provision	Assessment of Status	Compliance
		The Director of Day Programs was focused on work opportunities and skill acquisition related to employment. The PST members did not support her efforts in planning for individuals. For instance, PSTs were making decisions regarding how much money individuals would receive weekly, but did not base this decision on how much work the individual had completed each week. Without making money received weekly relative to work, individuals could not grasp the concept of working for money. Teams did not discuss employment options in any detail at any of the PSP meetings observed. 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. Meaningful supports and services were not put into place to encourage individuals to try new things in the community. Changes or additions to PNMPs as developed by the therapists were generally reflected in a PSPA. Direct therapy goals were not consistently outlined, however, and documentation did not reflect the individual's status or progress toward achievement of specific objectives and did not provide a comparative analysis of change from one period to the next. In many cases, issues identified were not tracked through to resolution or interventions initiated were discontinued without adequate documentation. DADS had recently contracted with a set of consultants to help bring about change in the overall PSP process, including development and implementation. During the week of the onsite review, the monitoring team had the opportunity to meet with one of the consultants. Consultants were focusing on developing plans to address individual's support needs. In conjunction with this effort, the facility will need to address the lack of meaningful programming opportunities at the facility.	
	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;	Examples of where measurable outcomes were not developed to meet specific health, behavioral, and therapy needs can be found throughout this report. For example, rarely was the focus of the PNMP identified as a measurable outcome in the PSP actions. PSPs in the sample reviewed did not consistently specify individualized, observable, and/or measurable goals and objectives, the treatments or strategies to be employed, and the necessary supports to attain identified outcomes related to each preference and meet identified needs. Outcomes were not written to address all preferences and were not written in a way that progress or lack of progress could be consistently measured. For example: • Individual #368 had an outcome regarding education "about what is available concerning different living options." The action step stated that he would	Noncompliance

#	Provision	Assessment of Status	Compliance
		"continue going to Provider Fairs and outings in the community." There was no indication how information would be presented to him or what would be considered successful completion of this outcome. His action plans numbered #2 through #7 in his PSP each had three action steps that were identical to the first action step in the sequence. Service objectives to address oral care and falls were complex statements that offered no guidance to staff providing support. • A list of preferences and interests for Individual #285 was identified through the PFA process. None of his stated preferences or interests was addressed in outcomes developed by the team. • Individual #99's PST determined that he had not been exposed to any other living situations. The team recommended that have the opportunity to tour other living options. His outcomes did not address community living visits or other exposure to the community options. • Individual #102's PFA indicated that she would like to work. The team did not develop outcomes addressing work. Training in the community was not included in her outcomes • The PSP for Individual #368 included an outcome to address his pica behavior. The action plan stated, "Home staff will throw non edible items away and praise themselves." It was not clear what action the individual would have to take to successfully complete this objective. Teams were not consistently identifying measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs. See section F1e and T1b for additional comments related to this requirement.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	As noted in F1d, recommendations for assessments were not integrated into supports for individuals. PNM, healthcare management plans, and dining plans were not submitted as part of any of the PSPs in the document request. These plans should be attached to the PSP and considered an integral part of the plan. 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.	Noncompliance
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	For the goals and objectives identified, PSPs generally described the timeframes for completion and the staff responsible. Methods for implementation were not always adequate, as is discussed in further detail in the section of this report that addresses Section S of the Settlement Agreement.	Noncompliance

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		Professional or supervisory staff were often designated as the responsible person in action plans. Direct support staff's role was not specified when they typically played a key role in monitoring healthcare needs and providing daily support. The PSP should be a guide to providing support services for direct support staff. Their responsibility should be clearly stated in PSPs. For example: • The home manager was designated as the responsible person for Individual #106's action steps for checking and changing every two hours. All direct support staff assigned to provide support should be aware that this support needs to be provided every two hours. Monitoring for seizure activity was assigned to the physician, when in fact, it would be essential for direct support staff to monitor, provide intervention, document, and report seizure activity. The RN was assigned responsibility for insuring that he "had no injuries." • For Individual #368, the psychologist was assigned responsibility for supports to address physical aggression and pica. Direct support staff should have been designated as responsible for implementing the plan and providing daily monitoring, protections, and supports. • Similarly, the nurse was designated as the responsible person to for outcomes addressing skin integrity and bowel management for Individual #102. The psychologist was designated as the responsible person for decreasing physical aggression. A new skill acquisition plan format was recently implemented. A QDDP Assistant had been hired to monitor plan development and implementation. See Section S for further comments regarding this new process. The team should develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. The role of direct support staff in implementing plans should be clearly documented in the PSP.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	The facility had made little progress towards compliance with this item. As noted throughout the report, plans did not always adequately address supports needed by the individual to achieve the outcomes. Strategies to support functional learning 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 issues, PNM needs, and behavioral support needs. According to the POI, the facility had begun to address this requirement:	Noncompliance

#	Provision	Assessment of Status	Compliance
		• A pilot program was implemented in one of the living units to add specific skill acquisition programs for community integration in an effort to make track training occurring in the community. • Jay Bamburg, PhD, had provided training to all PST members on how to identify interventions, strategies, and supports to address individual needs for services and supports. It was too early to evaluate the efficacy of the newer processes being implemented in regards to developing adequate interventions and training methods. Training provided in the day programs observed throughout the monitoring visit did not support that training was provided in a functional way. Few training opportunities were offered in a natural setting, such as the home or community. Individuals attended group sessions during the day and in each group worked on training that was a focus of that group rather than a priority for that individual identified by the PST. There were certain constraints due to the fact that individuals were living at the facility rather than in the community that limited functional training opportunities. For instance, individuals did not participate in meal preparation and service. They did not bank in the community, or go to the pharmacy to get their medication. They did not have routine access to stores, libraries, and other facilities. They were not able to choose, join, or regularly participate in group and social activities such as church, art, and gym classes. Interventions, strategies and supports did not adequately address individual's needs and many were not practical and functional at the Facility and/or in community settings.	
	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.	PSPs identified the person responsible for implementing service and training objectives and the frequency of implementation. PSPs also included a column to note where information should be recorded. Data collection sheets were generated for some service objectives, but not all. A person was assigned to collect data, but it was not clear what happened with the information gathered from this process in terms of making changes when an outcome was completed or when there was no progress made. Training program/data collection sheets were generated for training objectives. This form included what data would be collected, the frequency of data collection, who would collect data and who would monitor data. Observation of PST, PSPA, and risk discussion meetings indicated that team members were not using data collected to drive planning in regards to necessary supports. This was particularly true in regards to risk discussions. Data that should have been reviewed by the team included test/laboratory results, skill acquisition goal data, injury and	Noncompliance

#	Provision	Assessment of Status	Compliance
		incident data, data related to nursing care plans (weight, number of seizures, hospitalizations, etc.), behavioral data, and response to medications. When requested during discussions, this information was often not available. See section S of this report for further discussion on the adequacy of data collection. Additionally, see section J of this report for comments regarding the collection and review of data for psychiatric care, section K for the behavioral/psychological data collection and review, sections L and M for the collection and review of medical and nursing indicators, and, sections P and O for data collection relevant to physical and nutritional indicators.	
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 item 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. Please refer to these sections of the report regarding the coordination of services as well as section G regarding the coordination and integration of clinical services. As noted in F1b and F1c, representation from all relevant disciplines was not evident during planning meetings and adequate assessments were not completed prior to the annual meetings. The monitoring team found a lack of coordinated supports and services throughout the facility. PSTs will need to work together to develop PSPs that coordinate all services and supports. The facility did not have a process to ensure coordination of all components of the PSP.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	A sample of individual records was reviewed in various homes at the facility. It was found that current PSPs were generally in the home and available to staff responsible for plan implementation. This was noted to be a problem during the last monitoring visit. The facility had implemented a plan to monitor individual records for the presence of a current plan. The plan appeared to be effective based on the sample reviewed. Improvements were seen in the manner in which plans were written to facilitate direct support professionals' understanding of job responsibility. Newer plans contained less clinical jargon and fewer instances where assessment information was just cut and pasted into the plan with no real description of what supports were needed. As noted in F2a4, plans did not offer a clear guide on who would be responsible for plan implementation. As a direct support professional, it would be difficult to read the PSPs as written and determine what supports should be provided for an individual during the course of a 24-hour day. Lack of integration of plans contributed to this confusion. Many	Noncompliance

#	Provision	Assessment of Status	Compliance
		separate plans existed that were not integrated into the one comprehensive plan. As the state continues to provide technical assistance in plan development, a strong focus needs to be placed on ensuring that plans are accessible, integrated, comprehensible, and provide a meaningful guide to staff responsible for plan implementation. Although positive progress was noted for this requirement, the facility remained out of compliance.	
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.	QDDPs were signing off on observation notes monthly to indicate review of notes for individuals on their caseload. A monitoring tool had been implemented by Campus Administrators to audit records for this review and to ensure that current plans were available to direct support staff. The audit of July 2011 records showed a 75% compliance rate with the requirement for QDDPs to review observation notes and integrated progress notes. August 2011 data indicated that 100% of the notes had been reviewed. 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. As noted throughout this report, it was not evident that teams were aggressively addressing regression, lack of progress, and risk factors by implementing appropriate protections and supports, and revising plans as necessary. A sample of quarterly reviews was requested for a sample of individuals but only provided for one individual in the sample. The quarterly review form included a section to note progress or regression on all service and training objectives monthly and a place for QDDPs to comment quarterly on the progress or lack of progress. The facility had begun graphing data to be reviewed by the team at the quarterly meeting. Comments regarding the quarterly review process for Individual #368: • The quarterly review dated October 2011 did not indicate a need to revise supports though he had a number of significant injuries during the quarter. Data indicated that he had met criteria for his outcomes to turn on the water and money skills in July 2011. He continued to work on the same action step with no change recommended. An outcome was implemented to identify a wet floor sign on 8/15/11. No implementation data had been collected and no recommendation or follow up was documented. There were similar finding for the previous quarterly review dated 7/26/11. The team noted that he had 10 injuries during the quarter and showed a pattern of falls, but made no recommendations to address this finding.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Quarterly reviews should address the lack of implementation, lack of progress, or need for revised supports. Follow-up on issues occurring during the quarter should be documented. As the facility continues to progress toward developing person centered plans for all individuals at the facility, QDDPs 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. QDDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow up on issues.	
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, QDDPs 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%) had completed the new training on PSP process entitled Supporting Visions. • All QDDPs had attended Q Construction: Facilitating for Success training. • Consultative support, training, mentoring, and coaching had recently been provided to QDDPs by a team of consultants and additional consultation had been planned over the next few months. As evidenced by findings throughout this report, training on the implementation of plans was not ensuring that plans were being implemented as written. The QDDP Coordinator was aware of deficits in the implementation of the PSP and was providing additional training to QDDPs in monitoring for this requirement. On the job training had been expanded to include additional training on implementation of skill acquisition plans by the QDDP Assistant. Home team meetings were now being held weekly as another way of sharing pertinent information regarding programming and needed supports for individuals. The facility's POI indicated noncompliance with this requirement. The monitoring team agreed with that assessment.	Noncompliance
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an	Of PSPs in the sample reviewed, all (100%) had been developed within the past 365 days. From a sample of 20 plans reviewed in the home, 17 (85%) were current. According to the QDDP Coordinator, the three plans that were outdated had been developed within the past 30 days.	Noncompliance

#	Provision	Assessment of Status	Compliance
	ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	As noted in F2d and other areas of this report, plans were not always revised when supports were no longer effective or applicable. The facility was rated as being out of compliance with this provision item.	
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 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 still in the initial stages of development and implementation (also see section E above). An effective quality assurance system for monitoring PSPs was not fully in place at the facility.	Noncompliance

Recommendations:

1. Team members must participate in assessing each individual and in developing, monitoring, and revising treatments, services, and supports as necessary throughout the year (F1).

2. It will be important for the QDDP's to gain some facilitation skills that will allow them to keep the teams on track while making sure that everything is addressed particularly supports to address all risk that teams identify (F1a).

3. When individuals are not present for meetings, the QDDP should document attempts made to include the individual or LAR and how input was gathered to contribute to planning if the individual did not attend the meeting. When individuals consistently refuse to attend meetings, the team should look at what factors contribute to the refusal to attend and brainstorm ways to encourage participation (F1b).

4. Consider the use of the multidisciplinary staff present in psychiatry clinic to hold (i.e., document) a PST/PSPA meeting during clinic. This would also allow for the documentation of a PSPA meeting, rather than simply the clinical encounter (F1b).

5. All team members will need to ensure assessments are completed, updated when necessary, and accessible to all team members prior to the PST meeting to facilitate adequate planning. Consideration should be given to capturing and sharing information regarding possible areas of interests while individuals are in the community (F1c).

6. A description of each person's day along with needed supports identified by assessment should be included in PSPs (F1d).

7. Provide additional training to PST members on developing and implementing plans that focus on community integration. (F1e, F2a).

8. The facility needs to address the lack of meaningful programming opportunities at the facility (F2a).

9. Outcomes should be developed to address communication skills, decision making skills, and increased exposure to life outside of the facility (F1e).

10. QDDPs need to be provided with additional training on facilitating the living option discussion with family members (F1e).

11. PSTs should review each individual's history of incidents and injuries, any decline in health status, or regression in skills and hold an integrated discussion regarding whether or not the facility is able to provide the best care possible for each individual (F1e).

12. PSTs will need to identify each person's preferences and address supports needed to assure those preferences are integrated into each individual's day (F2a1).

13. Meaningful supports and services should be put into place to encourage individuals to try new things in the community. The PSTs should develop action steps that will facilitate community participation while learning skills needed in the community (F2a1).

14. Teams should develop meaningful, measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs (F2a2).

15. PSTs 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 (F2a3).

16. Habilitation therapists should establish SAPs for interventions with measurable goals and clear consistent reporting on progress within the PSP system rather than in a separate manner (F2a3, also sections O, P, and R).

17. The team should develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. The PSP should be a guide to providing support services for direct support staff. Their responsibility should be clearly stated in PSPs (F2a4, F2c).

18. PSTs should develop outcomes that are practical and functional at the facility and in community settings (F2a5).

19. Outcomes should identify the data to be collected and/or documentation to be maintained, the frequency of data collection, the person(s) responsible for the data collection, and the person(s) responsible for the data review (F2a6).

20. Ensure plans are accessible, integrated, comprehensible, and provide a meaningful guide to staff responsible for implementation (F2c).

21. Develop a process in place to revise PSPs when there is lack of progress towards PSP outcomes or when outcomes are completed or no longer appropriate. Review and revise plans when there has been regression or a change in status that would necessitate a change in supports. Ensure that staff are retrained on providing supports when plans are revised (F2d, F2e, F2f).

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, dated 9/16/11 o List of typical meetings that occurred at LSSLC, undated o LSSLC POI, 10/17/11 o LSSLC Sections G and H Settlement Agreement Presentation Books o Presentation materials from opening remarks made to the monitoring team, 10/31/11 o QAQI Council agenda and meeting minutes from May 2011 through November 2011 (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 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 o Three psychiatry clinics o Morning medical meeting/clinical rounds
	Facility Self-Assessment: The facility updated its self- assessment, the POI, on 10/17/11. The POI provided little information on the types of activities the facility engaged in to complete the self-assessment. The POI did not provide information on how the self-assessment was used to determine the self-ratings of noncompliance for G1 or compliance for G2. The POI also included an action plan related to provision G2. There was no action plan for G1 even though the self-rating was noncompliance. All provision items will need attention and specific plans of action in order to take appropriate steps toward compliance. Development of a definitive state policy that provides

	greater detail on the activities needed to achieve compliance will be beneficial to the facility.
	Summary of Monitor's Assessment: LSSLC continued to make progress with this important provision and was taking numerous steps to address it. The facility director was the lead for this provision and was aware of its importance. Evidence of integration efforts on the part of numerous disciplines was presented to the monitoring team during the conduct of this review. The daily medical meeting was expanded to include all clinical disciplines and PCP attendance at the annual PSPs improved. Collaboration between psychology and psychiatry was observed to have improved significantly during clinics. Moreover, a multidisciplinary workgroup was formed to develop plans that would assist in overcoming barriers to dental treatment. The facility implemented a process to track external consults to ensure that appointments were secured in a timely manner and results were available soon after completion of the appointment. Physicians were trained on the requirements for indicating agreement/disagreement with consults as well as the need to document a synopsis of the consult in the IPN. Notwithstanding these efforts, most areas required additional work to ensure that integration resulted in the desired clinical outcomes for the individuals. This will likely occur as the processes are refined and the facility fully embraces a culture consistent with the provision of integrated services. The strategic move to appoint the facility director as the lead for this provision should foster a greater sense of collaboration and accountability among the various disciplines. LSSLC is in need of further direction by guidance from state issued policy. Additionally, a valid and reliable monitoring tool is needed. This will require that the facility determine what it needs to measure and identify the metrics that will be utilized for measurement.

#	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	The monitoring team met with the facility director, medical director, and chief nurse executive to discuss actions taken to move towards compliance with this provision item. There were many efforts being made in order to ensure that appropriate integration of clinical services occurred: • The daily medical meeting was expanded. Attendees included all PCPs, psychiatrists, the dentist, chief nurse executive, and a QDDP. Representatives from, psychology, habilitation therapies, and dietary also attended. The meeting focused on important health and behavioral issues that occurred after normal business hours. This appeared helpful in ensuring that issues were promptly addressed and received adequate follow-up. The meeting was followed	Noncompliance

#	Provision	Assessment of Status	Compliance
	receive the clinical services they need.	immediately by rounds in the infirmary. • Documentation provided by the facility indicated good attendance by the primary providers at PSP meetings. One PSP, attended by the monitoring team, however, did not have participation by the PCP. • A multidisciplinary workgroup was formed to address the issue of dental desensitization. The workgroup produced a plan that resulted in a formal mechanism for approaching dental desensitization. Plans for eight individuals were implemented during the weeks just prior to the onsite review. • There was evidence of good integration between psychiatry and medical. • Observations of psychiatry clinic revealed good consultation and collaborative efforts with psychology in the three clinics. • Neurology clinic was conducted monthly and was attended by the psychiatry director who produced a note for all individuals seen to indicate collaboration and review of information. • The facility director met with the medical staff on a monthly basis to discuss a variety of issues related to the provision of medical care. The primary providers believed this was an important meeting and found significant value in this process. • The IPNs contained increased documentation from the primary providers. • Habilitation services and nursing collaborated to ensure that individuals had the appropriate adaptive equipment for integration of clinical services within the Woodlands Crossing unit. Specific outcomes, however, were not presented. • Each day, meetings occurred at 2 pm in each unit. The purpose was to work towards more communication to help support the integration of services. There were numerous areas where it was identified that additional work was needed: • There was a need to have improved integration with neurology and psychiatry. The psychiatry director attended neurology clinic and wrote notes. True integration was lacking due to the fact that the three part-time psychiatrists were unable to attend neurology clinic. • There was a lack of adequate and appropriate integration of respiratory therapy into the plans/interventions implemented for individuals with acute and/or chronic respiratory problems. • The PNMT was fully staffed as of 5/1/11, but no assessments had been completed to date at the time of this review. Additionally, there were a number of individuals' records that revealed delays in the integration of habilitation services to ensure that individuals' their health needs and risks were addressed in a timely manner. • The medical director responded to the recommendations of the clinical pharmacist included in the QDRRs. Unfortunately, the response was consistently	

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		noted as "no action required."	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The facility director, medical director and chief nurse executive were all aware of the importance of sharing and following-up on information contained in the external consults. A series of actions, had either occurred or were in the process of occurring, with the intent of improving the consultation referral process: • The facility began tracking external consults from the date of order to the date of receipt. Each consultation form had a box to indicate physician agreement or disagreement with the recommendations of the consultant. The medical director reported that this was consistently being used. o Current medical policy required the primary provider to document an explanation in the IPN notes when recommendations were not implemented. The current policy did not reference the checkboxes being utilized. • To further improve the ability to address recommendations and disseminate information, consultations were forwarded to the RN case managers for review with the primary providers during sick call. This would allow the case manager to have information to relay back to the PSTs. The monitoring team noted that while the process for using the checkboxes was implemented, it was not consistently used. Numerous consults reviewed were initialed and dated by the PCP, but the checkbox was blank. There were also numerous examples in which the consults were not summarized in the IPN and there was a failure to ensure timely follow-up as recommended in the consult.	Noncompliance

Recommendations:

1. DADS should develop and implement policy (G1).
2. The facility should assess the need for increased neurology hours and take action to improve the integration of neurology and psychiatry (G1).
3. The primary providers should thoughtfully review the QDRRs and appropriately respond to the recommendations of the pharmacists (G1).
4. Medical policy should be revised to include the current requirements for review of consults (G2).
5. Consider the inclusion of a statement regarding the integration of clinical services in each individual's PSP document (G1).

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, dated 9/16/11 o List of typical meetings that occurred at LSSLC, undated o LSSLC POI, 10/17/11 o LSSLC Sections G and H Settlement Agreement Presentation Books o Presentation materials from opening remarks made to the monitoring team, 10/31/11 o QAQI Council agenda and meeting minutes from May 2011 through November 2011 (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 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, o Three psychiatry clinics o Morning medical meeting/clinical rounds
	Facility Self-Assessment: The facility updated it's self–assessment on 10/17/11. The POI provided little information on the types of activities the facility engaged in to complete the self-assessment. The POI did not provide information on how the self-assessment was used to determine the self-ratings of non-compliance..
	Summary of Monitor's Assessment: During the week of the onsite visit, the monitoring team had the opportunity to meet with the medical

	director, facility director and other facility management. While all acknowledged the importance of the provision, it was clear that attention had not been clearly directed towards these efforts. This appeared partly due to a lack of clarity on the specific requirements of the provision.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	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 state and the facilities need to determine how to proceed regarding section H across all of the SSLCs, including the determination of the detail, definition, expectations, and criteria for all of the items of this provision. Provision H refers to the minimum common elements of clinical care. It is very likely that many of the actions required for the seven provision items were actually occurring within various departments of the facility. Provision H provides a means of coordinating information to ensure that, overall, minimum common elements of clinical care are appropriately managed. Facility management was aware that much work was needed in this area. Because much was needed in many areas, the facility had yet to focus on this provision. Guidance from state office will be necessary. 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). Some activities had occurred at LSSLC regarding this provision item, but they had not yet done so for all of the clinical service departments as required by this provision item. Monitoring team examples: • The primary care physicians completed annual medical summaries in a timely manner. • The provision of preventive care and screenings was another method of	Noncompliance

#	Provision	Assessment of Status	Compliance
		ensuring the timely detection of needs. The secondary prevention afforded by the various cancer screenings was intended to detect disease in the early stages before significant morbidity occurred. Further discussion of preventive services is found in Section L1. • In addition to providing preventive treatment, physicians responded to the acute needs of individuals by conducting assessments, ordering diagnostic studies, and providing treatments. • The completion of the MOSES and DISCUS evaluations by the nursing staff and medical providers provided regular assessment of individuals in an effort to identify the development or presence of extrapyramidal symptoms and tardive dyskinesia. • The CNE reported that she had met with directors of each of the clinical departments in order to work towards meeting this provision item. • A new assessment form was reported to be created for individuals after returning to the facility from hospitalization or from a long term care facility. A review of information that comes back from hospitalization was to be reviewed at the next morning's clinical rounds. There were also examples of areas that were in need of further work: • The medical staff were not completing quarterly medical summaries as required by the Health Care Guidelines. This was a significant deficiency because the quarterly summary is an important opportunity for the primary provider to review medical care, recent health events, information, and diagnoses in an effort to ensure stability of the individual's health status. • Individuals' nurses had not consistently notified the individuals' physicians in a timely manner of significant changes in the individuals' health status and needs. There were many lapses in follow-up to ensure that individuals who suffered significant changes in their health status were monitored and/or evaluated until resolution of their health changes/problems. • Across all individuals reviewed, there was a pattern of failure to ensure that HMPs and ACPs were developed and implemented in a timely manner, and/or HMPs were reviewed and revised as significant changes occurred. • There were a number of cases where there was no current OT/PT or speech assessment provided in an acceptable interval. There was also evidence of changes in status with no assessment to identify PNM needs. This is further discussed in Section P. • The facility psychiatrists completed 69 comprehensive assessments, indicating a need for further improvement.	
H2	Commencing within six months of	There was no policy in place to require or guide the activities required to meet this	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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. Many of the psychiatric diagnostic reviews reviewed gave brief, unsatisfactory reviews of the diagnostic criteria/symptoms that an individual was experiencing, such that a specific diagnosis could be 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 so that collaborative case conceptualizations can be developed.	
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.	Although a plan to address this provision was lacking, the development of clinical guidelines will provide assistance in moving towards compliance. Clinical guidelines, for a specific disease or symptom, will provide a series of steps that include the diagnostic studies to be conducted, treatment to be provided and the assessment of the effectiveness of treatment. The timelines for each of these actions should be specified. The medical director noted that the facility had improved its process and speed of instituting transfers to emergency rooms and hospitals. The medical director reported using algorithms for common medical problems. The algorithms reviewed by the monitoring team often did not take into consideration the special needs of the population served at LSSLC. Moreover, these algorithms appeared to be very informal, as they were not linked to any approved medical policy. State office issued a policy on Preventive Health Care Guidelines on 8/30/11. The medical director was aware that this policy was issued in draft format, but was not aware that it was formally adopted.	Noncompliance
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	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. There was no evidence that the goals/desired outcomes of individuals' HMPs (i.e., the indicators of efficacy of treatments and interventions) were established with input from the individuals and their caregivers, in accordance with evidence based practice, or revised to reflect the changing needs/desires of the individual and their progress/lack of progress toward the achievement of their health goals. Rather, goals/desired outcomes	Noncompliance

#	Provision	Assessment of Status	Compliance
		were the same for most health problems and not individualized, in accordance with the specific health needs and risks of the individual. There were generally no measurable goals established for interventions provided. Documentation was more anecdotal in nature making tracking progress and comparing/contrasting data to describe progress over time difficult. Valid and reliable clinical indicators had not been developed in most disciplines. In order to move towards compliance, the facility will need to develop numerous clinical indicators, covering a wide range of health issue, inclusive of preventive care, that can be measured longitudinally.	
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). At the time of the onsite review, the health status of each individual was monitored through a series of assessments that included annual medical summaries as well as annual and quarterly nursing assessments. Quarterly pharmacy assessments were also completed. Additional oversights such as the adverse drug reporting system contributed to the monitoring of health status. DADS Draft Policy #005 outlined expectations for development of a health status monitoring system. Monthly monitoring of numerous aspects of health care services, such as staffing, resources, and clinical indicators was the goal. These requirements effectively translated into the framework of a medical quality program by utilizing a robust mix of process and clinical indicators to assess the quality of care. As discussed in Section L, the medical department had not developed a medical quality program and the data infrastructure was not in place to support such an initiative. Nonetheless, one absolute requirement for a quality program is the use of accurate data. Another vital component of the medical quality program will be the selection of the metrics for measurement, that is, the clinical indicators. Many clinical indicators will result from the development of the clinical guidelines. The facility collected some data that had the potential to measure quality. The facility will need to determine what indicators of medical quality are important as well as how the indicators will be measured. Assurances of data integrity will need to be implemented.	Noncompliance

#	Provision	Assessment of Status	Compliance
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.	The medical director informed the monitoring team that no clinical guidelines had been issued by the state. Information provided following the onsite review indicated that state office had issued a preventive heath care guidelines along with several clinical pathways. These clinical guidelines which included the use of diagnostics, defined treatment options and defined the outcomes should be used to determine if responses to problems are timely and adequate.	Noncompliance
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.	Noncompliance

Recommendations:

1. State office and the facilities should work together to determine how they are going to address all of the seven items of this provision. Therefore, specific recommendations for each of the seven provision items are not presented here (H1 – H7).

2. Develop and implement policy. Specifically indicate in the policy how it addresses each of the seven provision items of provision H (H1 – H7).

3. Ensure that all clinical services are addressed by the facility, not only medical activities (H1 – H7).

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 (H1 – H7).

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 LSSLC Policy: Client Management – At Risk Individuals effective 1/1/11 o At Risk/Aspiration Pneumonia Initiative Frequently Asked Questions o DADS Integrated Risk Rating Form dated 12/20/10 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 Aspiration Pneumonia/Enteral Nutrition Evaluation Form 12/29/10 o Aspiration Triggers Data Sheet o LSSLC POI for Section I o Log of At Risk meeting dates o LSSLC Aspiration Target List o List of serious injuries for the past six months o List of individuals seen in the ER since 9/1/11 o List of individuals admitted to the infirmary since 9/1/11 o List of individuals hospitalized since 9/1/10 o List of individuals with pneumonia incidents in the past 12 months o List of individuals at risk for respiratory issues o List of individuals at risk for choking o List of individuals at risk for GERD o List of individuals at risk for aspiration o List of individuals at risk for weight issues o List of individuals at risk for falls o List of individuals with contractures o List of individuals at risk for dehydration o List of individuals at risk for osteoporosis o List of individuals at risk for constipation o List of individuals with choking incident since the last review o List of individuals diagnosed with pica o List of individuals who are non-ambulatory or require assistance with ambulation o List of individuals requiring mealtime assistance o List of individuals requiring enteral feeding o List of individuals who have pain, including chronic and acute o List of individuals with poor oral hygiene o List of individuals considered missing or absent without leave o List of individuals required to have one-to-one staffing levels

	o List of 10 individuals with the most injuries since the last review o List of 10 individuals causing the most injuries to peers for the past six months o List of top ten individuals causing peer injuries for the past six months. o List of Incidents and Injuries since 4/1/11 o PSPs, Risk Rating Forms, Risk Action Plans and relevant assessments for determining risk: • Individual #43, Individual #102, Individual #540, Individual #106, and Individual #368. o PSPs for • Individual #192, Individual #407, Individual #410, Individual #132, Individual #88, Individual #144, Individual #99, Individual #308, Individual #176, and Individual #560 <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Kendra Carroll, Director of Competency Training and Development o Luz Carver, QDDP Coordinator o Stacie Cearley, Quality Assurance Director o Sylvia Middlebrook, Chief Psychologist <u>Observations Conducted</u>: o Observations at residences and day programs o Oak Hill Morning Unit Meeting 11/1/11 o Incident Management Review Team Meeting 10/31/11 and 11/3/11 o Annual PSP meetings for Individual #116, Individual #321, and Individual #50 o Personal Focus Meeting for Individual #560 o Risk discussion with PST for Individual #560
	Facility Self-Assessment: LSSLC submitted its self-assessment, called the POI. It was updated on 10/17/11. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, the comments section of each item of the provision included a statement regarding how the facility carried out the mandate (e.g., action plans were implemented related to standardized risk categories for individuals identified as being at high or medium risk). The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. As noted throughout Section I, the monitoring did not find that steps implemented to comply with Section I were adequately addressing risks The facility assigned a noncompliance rating to each of the three provision items in 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 monitoring team was in agreement with these self-ratings. It was unclear from a review of the POI how LSSLC came to this self-rating.
	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. 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. LSSLC had taken steps towards compliance with this provision including: • All individuals had PST meetings to address their risks utilizing the new At Risk Process. • A data base had been developed to track pneumonia. Data was being updated daily by the Infection Control Nurse. • The CNE had conducted training sessions on the At Risk process and policy for all PST members. • Action plans had been developed to address risk categories for individuals identified as being at medium or high risk. 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.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall	The 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 beginning in February 2011. The at-risk	Noncompliance

#	Provision	Assessment of Status	Compliance
	implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is 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 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. Each was to be rated according to how many risk indicators applied to the individual's case. A risk level of high, moderate, or low was to be assigned for each category. The facility captured data in a number of ways that should have been useful to identify risks for particular individuals, but it was not evident that the data were always being used to identify risks. For instance, Individual #368 had a number of documented falls, at least one resulted in a serious injury, and he was not considered high risk for falls. Individual #189 had two serious injuries requiring sutures attributed to falls. He also was not considered high risk for falls. The facility had identified a target list of individuals at risk for aspiration. • Twenty-eight individuals at the facility had been identified as high risk for aspiration and 76 were rated as at medium risk. • A list of all individuals diagnosed with pneumonia at the facility indicated that 46 individuals had been hospitalized due to pneumonia/aspiration pneumonia since 9/4/10. o Eight individuals had been hospitalized two or more times for pneumonia. Five of those individuals were rated high risk for aspiration and three were considered medium risk. o Individual #141 was rated as medium risk for aspiration and respiratory infections even though he received enteral feedings and had been hospitalized once for aspiration pneumonia and twice for bacterial pneumonia in the past year. o Individual #47 was rated as medium risk for aspiration pneumonia. He had been hospitalized twice in the past year for pneumonia, once was attributed to aspiration. The monitoring team met with the PSTs for Individual #560 during the review week to discuss how the team assigned risk ratings, as well as to demonstrate the type of interdisciplinary discussion that could occur during PST meetings. The monitoring team appreciated the PST's willingness to conduct this type of discussion with the monitoring team. This had complex health issues that had let to some immediate health care issues that the team was addressing. For both short and long range planning, the team will need to:	

#	Provision	Assessment of Status	Compliance
		• Frequently gather and analyze data regarding health indicators (e.g., changes in medication, results from lab work, engagement levels, mobility). For example, data showed a spike in seizure activity recently. The team did not review the data at the time of the spike, but instead waited until the next quarterly meeting to discuss a possible consultation with her neurologist. • The team needs to also focus on long term health issues and be more proactive in addressing risk via action plans to monitor for conditions before they become critical. The team engaged in a good integrated discussion regarding her current medical conditions that placed her at obvious risks, but did not adequately address possible long term health issues. For example, she did not currently have cardiac issues, but several factors put her at risk for cardiac issues in the future. The team should already had a plan in place to monitor for indicators. • Guidelines for determining risk ratings should only be used as a guide. Teams should discuss other factors that may not be included in the guidelines. For example, the team did not consider her at risk for fractures because she had no recent history of fractures. She did, however, have a diagnosis of osteoporosis and relied on staff for transfers. These factors placed her at a greater than normal risk for fractures. • The interrelatedness of risk factors should be considered and discussed in an interdisciplinary fashion. • The QDDP should monitor progress towards outcomes and share information with all team members frequently so that plans can be revised if progress is not being made or regression occurs. Observation of annual PST 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. QDDPs were responsible for attending meetings and facilitating the risk discussion. At meetings observed, the process appeared to be similar to the process that Health Status Teams were using during previous onsite reviews. Although, teams were beginning to engage in more in-depth discussions regarding health indicators, there was still a strong reliance on guidelines developed by the state that did not take into consideration integrated risk factors. Clinical indicators were not always available at meetings and, therefore, not always considered when determining health risk ratings. A sample of PSPs and the facility risk rating list were reviewed to determine if risks were being properly identified and addressed by PSTs. The following are examples where risks were not appropriately identified in documents reviewed. • Individual #102 was rated as low risk for respiratory compromise. She was diagnosed with pneumonia in December 2010. Her nursing assessment	

#	Provision	Assessment of Status	Compliance
		indicated that she was non-ambulatory which could contribute to her overall risk for respiratory infections. She was rated at medium risk for dental issues, when in fact; documentation indicated that she was at high risk for poor oral hygiene. Her risk action plan included dental desensitization and TIVA, but there were no action steps in place to indicate that she would be seen by the dentist for cleaning and follow up care. The team should have developed a plan with scheduled appointments for follow up treatment. The team had determined that she was at low risk for osteoporosis and fractures because she did not have a current diagnosis of osteoporosis or history of fractures. She did, however, have a number of risk factors including being a 56 year old non-ambulatory female on a number of medications with diagnoses of Vitamin D deficiency and Degenerative Joint Disease. The team should consider all risk factors, not just current diagnosis when assigning risk ratings. • The risk rating form for Individual #43 indicated that the rationale for risk assignment in each category was based on her current diagnoses and history. There was no indication that the team considered other risk factors that may contribute to her overall risk ratings. She was rated as low risk for osteoporosis because she did not have a current diagnosis for osteoporosis. She did have a number of risk factors including her gender, age, diagnosis of osteoarthritis, Vitamin D deficiency, and menopause. Her last bone density scan was in 2006 with a finding of a minimal decrease in bone density. She was determined to be at low risk for fractures, though she was at medium risk for falls due to her vision impairment and history of falls. • Individual #540's risk rating form dated 2/18/11 indicated that he was at low risk in all areas except for dental. Rationale for all risk ratings was based on current diagnoses or history of symptoms. He had multiple complex health issues that should have warranted an integrated discussion of risk factors by all team members. There was not adequate representation of team members at his meeting. Key members not in attendance included: his LAR, physician, OT, PT, SLP, and dietician. Factors that should have been considered in assigning risk ratings included enteral feeding, non-ambulatory status, dermatitis due to gastrostomy tube leakage, contractures, history of failure to thrive, and diagnoses including dysphagia, scoliosis, anemia, Vitamin D deficiency, constipation, GERD, and COPD. • Individual #106's risk rating form indicated that he was at high risk for weight issues and medium risk for dental issues. All other areas were rated as low risk. His OT/PT plan indicated that he was at risk for aspiration and GERD. He required frequent repositioning to prevent skin breakdown. He had been diagnosed with osteoporosis and was at risk for fractures. He was almost 100 pounds over his ideal weight range and was on medication for hypertension.	

#	Provision	Assessment of Status	Compliance
		Additionally, he had been diagnosed with anemia, chronic constipation, respiratory issues, COPD, hypothyroidism, and seizures. The team had not considered his complex medical issues when assigning risk ratings. • Individual #368's BSP indicated that he required close supervision for pica, had a diagnosis of dysphagia, and was on a modified diet to reduce the risk of choking. He should have been designated at high risk for choking. There were a number of falls documented over the past year attributed to behavioral issues. It appeared that he was more likely to be injured when not engaged in activities or when trying to escape staff demands. The team had addressed the falls through increased supervision and the use of helmet, knee pads, and gait belt. There were no documented attempts at providing programming based on his specific interest even with one-to-one staff assigned to him. Other factors that may contribute to his unsteadiness were not been discussed, such as unsteadiness due to ear infections, medication side effects, and poor vision due to cataracts. The team needs to take an integrated look at all risk factors and develop appropriate interventions and supports that may reduce those risk factors. • Individual #407's PSP noted that she had chronic constipation managed by medication and occasional enemas. She was rated as low risk for constipation according to the facility master list. • Individual #308 was rated as low risk for respiratory issues. She had been treated for chronic respiratory failure and pneumonia in the past year. Additional examples are listed in section M5. The facility needs to ensure that present risk assignments are reviewed for accuracy, adequate plans are in place to address all risks, and all staff are trained on plans to minimize and monitor 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	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. Additionally, as noted in section F of this report, the facility did not have an effective plan for monitoring and revising supports as needed. One of the most important aspects of a health risk assessment process is that it effectively prevents the preventable and reduces the likelihood of negative outcomes	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>possible but within five working days of the individual being identified as at risk.</td><td>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.</td><td></td></tr>
<tr><td>I3</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.</td><td>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 staff will be established by the PST in response to risk categories identified by the team.

According to data provided to the monitoring team, a plan was in place to address all risks for those individuals designated at high risk or medium risk. However, as noted in I1, accurate risk ratings were not necessarily being assigned, so adequate plans were not in place for all individuals. Additionally, plans that were in place did not always include clinical indicators to be monitored to accurately determine the adequacy of the plan.

<table><tr><th>High Risk Category</th><th>Number of Individuals Rated as High Risk</th><th>Individuals with Plan in Place to Address Risk/Percentage of Total</th></tr><tr><td>Aspiration</td><td>28</td><td>28/100%</td></tr><tr><td>Respiratory</td><td>26</td><td>26/100%</td></tr><tr><td>GERD</td><td>6</td><td>6/100%</td></tr><tr><td>Choking</td><td>16</td><td>16/100%</td></tr><tr><td>Falls</td><td>13</td><td>13/100%</td></tr><tr><td>Weight</td><td>48</td><td>48/100%</td></tr><tr><td>Skin Integrity</td><td>7</td><td>7/100%</td></tr><tr><td>Constipation</td><td>9</td><td>9/100%</td></tr><tr><td>Seizures</td><td>18</td><td>18/100%</td></tr><tr><td>Dehydration</td><td>9</td><td>9/100%</td></tr><tr><td>Osteoporosis</td><td>27</td><td>27/100%</td></tr><tr><td>Metabolic Syndrome</td><td>8</td><td>8/100%</td></tr><tr><td>Dental</td><td>66</td><td>66/100%</td></tr></table>
As noted throughout this report, intervention plans often did not provide enough information for direct support staff to consistently implement support or were not carried out as written, therefore, individuals remained at risk.</td><td>Noncompliance</td></tr>
</table>

Recommendations:

1. 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. QDDPs/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 (I1).

2. Ensure that risk rating accurately reflect risks identified through the assessment process (I1).

3. All health issues should be addressed in PSPs and direct care staff should be aware of health issues that pose a risk to individuals and know how to monitor those health issues and when to seek medical support (I1, I2, I3).

4. Ensure PSTs are monitoring progress on health and behavioral outcomes and plans are revised when necessary (12).

5. Ensure that plans to address risks are individualized to address specific supports needed by each individual identified as at risk (I2).

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 (I2 and I3).

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:** Documents Reviewed: o For the past six months, a numbered alphabetical list of individuals who received pretreatment sedation medication or TIVA for medical or dental procedures. o For the last 10 individuals participating in psychiatry clinic who received medical/dental pretreatment sedation, a copy of doctor's order, nurses notes associated with the incident, psychiatry notes associated with the incident, and documentation of any PST meeting associated with the incident. o Three examples of documentation of psychiatric consultation regarding pretreatment sedation for dental or medical clinic. o List of all individuals with medical/dental desensitization plans and date of implementation. o Six dental desensitization plans. o Any auditing/monitoring data and/or reports addressing the use of pretreatment sedation medication. o A numbered spreadsheet of individuals prescribed psychotropic/psychiatric medication, that included name of individual; name of prescribing psychiatrist; residence/home; psychiatric Diagnoses inclusive of Axis I, Axis II, and Axis III; medication regimen (including psychotropics, nonpsychotropics, and PRNs, including dosage of each medication and times of administration); frequency of clinical contact; date of the last annual BSP review; date of the last annual PSP review o A list of individuals prescribed benzodiazepines, including the name of medication(s) prescribed and duration of use. o A list of individuals prescribed anticholinergic medications, including the name of medication(s) prescribed and duration of use. o A list of individuals diagnosed with tardive dyskinesia. o Spreadsheet of individuals who had been evaluated with the MOSES and DISCUS scores, with dates of completion for the last six months. o Documentation of inservice training for facility nursing staff regarding administration of MOSES and DISCUS examinations. o Ten examples of MOSES and DISCUS examination for 10 different individuals. This included the psychiatrist's progress note for the psychiatry clinic following completion of the MOSES and DISCUS examinations. o A separate list of individuals being prescribed each of the following: anti-epileptic medication being used as a psychotropic medication in the absence of a seizure disorder; lithium; tricyclic antidepressants; Trazodone; beta blockers being used as a psychotropic medication; Clozaril/Clozapine; Mellaril; Reglan o List of new facility admissions for the previous six months and whether a Reiss screen was completed. o Spreadsheet of all individuals (both new admissions and existing residents) who had a Reiss

	screen completed in the previous 12 months. o For five individuals enrolled in psychiatric clinic who were most recently admitted to the facility: individual Information Sheet; Consent Section for psychotropic medication; personal Support Plan, and PSP addendums; Behavioral Support Plan; Human Rights Committee review of Behavioral Support Plan; Restraint Checklists for the previous six months; Annual Medical Summary; Quarterly Medical Review; Hospital section for the previous six months; X-ray, laboratory examinations and electrocardiogram for the previous six months.; Comprehensive psychiatric evaluation; Psychiatry clinic notes for the previous six months; MOSES/DISCUS examinations for the previous six months; Pharmacy Quarterly Drug Regimen Review for the previous six months; Consult section; Physician's orders for the previous six months; Integrated progress notes for the previous six months; Comprehensive Nursing Assessment; Dental Section including desensitization plan if available o A list of all meetings and rounds that are typically attended by the psychiatrist, and which categories of staff always attend or might attend, including any information that is routinely collected concerning 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 A list of all psychiatrists including board status (i.e., board-certified, board-eligible, or for these physician extenders, licensure status/supervision); indicate (a) if employee or contracted; (b) number of hours working per week; (c) the physician's previous experience in the area of developmental disabilities; (d) the physician's experience in the treatment of children and adolescents; (e) the physician's experience in forensic psychiatry; (f) the physician's licensure status; and (g) indicate who has been designated as the facility's lead psychiatrist. o Example of contract with contracted psychiatrists. o CVs of all psychiatrists who work in psychiatry, including any special training such as forensics, disabilities, etc. o Overview of psychiatrist's weekly schedule. o Description of administrative support offered to the psychiatrists. o Since the last onsite review, a list/summary of complaints about psychiatric and medical care made by any party to the facility. o Over the past 12 month, a list of continuing medical education activities attended by medical and psychiatry staff. o Over the past 12 months, a list of educational lectures and inservice training provided by psychiatrists and medical doctors to facility staff. o Schedule of consulting neurologist. o A numbered alphabetized list of individuals participating in psychiatry clinic who have a diagnosis of seizure disorder. This list included: Individuals name; Prescribing psychiatrist; Treating neurologist; Date of the two most recent neurology consultations; Medication regimen (Including both psychotropic and non psychotropic medications); Indication of each medication. o For the past six months, minutes from the committee that addresses polypharmacy. o Spreadsheet of all individuals designated as meeting criteria for intra-class polypharmacy. This included: Name of Individual; Name of treating psychiatrist; Prescribed medications grouped by

	class; Start date of the medication; Medications in process of active tapering; Justification for polypharmacy. o Facility-wide data regarding polypharmacy, including intra-class polypharmacy. o For the last 10 newly prescribed psychotropic medications, information including: Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication; Signed consent form; PBSP; HRC documentation. o For the last six months, a list of any individuals for whom the psychiatric diagnoses have been revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s). o List of all individuals age 18 or younger (include DOB) who are receiving psychotropic medication. o Name of every individual assigned to psychiatry clinic who has had a psychiatric assessment per Appendix B with the name of the psychiatrist who performed the assessment, date of assessment, and the date of facility admission included. o Ten examples of comprehensive psychiatric evaluations per Appendix B performed in the previous six months. o Documentation of psychiatry attendance at PSP, PSPA, BSP, or PST meetings. o For individuals requiring chemical restraint and/or protective supports in the last six months, a numbered spreadsheet indicating: Name of the individual; Date of incident (e.g., physical or chemical restraint); Type of restraint (e.g., physical or chemical); Medication/Dosage/Route; Reason the chemical restraint was given or the physical restraint was required; Name of prescribing physician; Name of treating psychiatrist o For the last two individuals requiring chemical restraint, a copy of the following: Doctor's order; Nurses Notes associated with the incident; Psychiatry notes associated with the incident; Documentation of any PST meeting associated with the incident. o Presentation book for section J <u>Documents requested onsite:</u> o Requirements for quarterly psychiatric review o Email regarding consultation for psychiatric medication o Agenda for pharmacy and therapeutics committee meeting, 10/31/11 o Infirmary Daily Census o Division of Psychiatry Patients o Physician Assistant Supervision Log o Physical Nutritional Management Plan for Individual #560 o Dental Education Rehearsal Simulation Training Description o Dental Desensitization Assessment Form o Integrated Risk Rating Form for Individual #447 o Minutes regarding the Restraint Reduction Team Meeting o These documents: • Demographic Data Sheet • Health Data • Laboratory examinations and electrocardiogram for the previous six months

	• Psychiatry clinic notes for the previous six months • MOSES/DISCUS examinations for the previous six months. • Pharmacy Quarterly Drug Regimen Review for the previous six months • Consult section • Physician's orders for the previous six months • Integrated progress notes for the previous six months. • Comprehensive Nursing Assessment • Personal Support Plan and addendums (last six months) • Psychotropic Medication Consents • Behavioral Support Plan • Restraint Checklists for the previous six months. o For the following individuals: • Individual #323, Individual #407, Individual #273, Individual #500, Individual #449, Individual #245, Individual #380, Individual #410, Individual #395, Individual #317, Individual #447, Individual #170, Individual #217, Individual #131, Individual #176, and Individual #490 <u>Individual Interviews and Meetings Held</u>: o Vasantha Orocofsky, M.D., Director of Psychiatry o JoAnne Lancaster, Dental Hygienist, Russell Riddell, D.D.S., Dental Coordinator, and Fred Glazener, D.D.S. facility dentist o James Buckingham, M.D., facility psychiatrist o Judd Williamson, R.N., Psychiatric Nurse o Kacie Collins, Psychiatric Assistant o Luz Carver, Director of QDDP 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 Mike Fowler, psychologist o Mary Bowers, R.N., Chief Nursing Executive <u>Observations Conducted</u>: o PSPA regarding Individual #170 o Pharmacy and Therapeutics Committee o Clinical Services Meeting o Psychiatry clinic with Doug Douglas, PA, regarding Individual #382, Individual #210, Individual #160, Individual #339, and Individual #497 o At risk meeting regarding Individual #560 and Individual #447 o Polypharmacy meeting o Psychiatry clinic with Dr. Vyas regarding Individual #363, Individual #572, and Individual #252 o Dental Desensitization meeting

	o Restraint Reduction Committee meeting o Psychiatry clinic with Doug Douglas, PA and James Buckingham, M.D. regarding Individual #245
	Facility Self-Assessment: LSSLC submitted its self-assessment, the Plan of Improvement, dated 10/17/11. In addition, during the onsite review, the monitoring team reviewed the presentation book for this provision. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. The facility indicated substantial compliance in subsections of one area, J1 (having qualified psychiatric physicians). The assignment of substantial compliance for J1 was echoed in this report because the psychiatric physicians and the physician's assistant currently providing care at the facility, were, by virtue of their board certification and/or eligibility status, experience, and clinical collaborative agreements, 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. The action steps included in the POI were written to guide the department in achieving substantial compliance. The action steps did not address all of the concerns and recommendations of the monitoring team or all of the provision items in set. Some of the actions were relevant towards achieving substantial compliance, but the facility will only achieve substantial compliance if a set of actions, such as those described in this monitoring report, are set out en banc as a system. Certainly, these steps will take time to complete; the facility should set realistic timelines, not just for initial implementation, but a timeline that will indicate the stable and regular implementation of each of these actions. The facility will benefit from the eventual development of a self-monitoring tool or a peer review process for this provision of the Settlement Agreement.
	Summary of Monitor's Assessment: Although psychiatry consultations were occurring, LSSLC was found to be in noncompliance with all but two of the items in this provision of the Settlement Agreement. The facility did have physicians and a physician's assistant providing care, however, there was limited availability of clinical resources with 1.63 FTE available. The four physicians and the physician's assistant were qualified by virtue of their board eligibility/certification status, or via their experience and collaborative practice agreement (in the case of the physician's assistant) to provide services at LSSLC. One of the physicians was 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. There had been some repositioning with respect to the psychiatric clinic staff, specifically the resignation of the psychiatric assistant, promotion of the administrative assistant into the role of psychiatric assistant, and ongoing recruitment to fill the administrative vacancy. The facility 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. Psychiatry was interacting with psychology on some levels. The psychiatric clinic had been expanded to include representatives from all disciplines. This was beneficial, given that psychiatrists were not available to regularly attend PST meetings. Given the lack of clinical resources, the facility will have to be creative with regard to the use of psychiatry resources in order to achieve integration. Psychiatry had made some gains in the area of informed consent. Psychiatrists were responsible for revised documentation regarding the risks, benefits, side effects, and alternatives to treatment with a particular medication. They were also responsible for contact with or attempts to contact the individual's legally authorized representative with regard to informed consent. This was a step forward with regard to psychiatry taking responsibility for tasks, which had previously been inappropriately relegated to psychology due to the lack of psychiatry resources. 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 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.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	<u>Board Certification</u> LSSLC had a total of 1.63 FTE (full-time equivalent) psychiatrists/physician's assistant. 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. The physician's assistant had significant experience in the treatment of psychiatric disorders, had experience in the treatment of individuals with developmental disabilities,	Substantial Compliance

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		and had the facility lead psychiatrist as his designated collaborating psychiatrist. As such, the physicians were qualified. Experience 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 months prior to this monitoring review. The physician's assistant had a history of providing services at the facility and had returned to clinical duty in the intervening period since the previous monitoring visit. The one full-time psychiatrist had been employed by the facility since May 2010, had been designated as the director of psychiatry, and performed administrative psychiatric functions, as well as having clinical responsibilities. Given the number of part-time providers, it will likely be a challenge for the physicians to effect full PST integration without the benefit of considerable time. There was cause for concern as during this review, the monitoring team was informed that this facility had been designated as the "children's facility." Although there was some child and adolescent psychiatric expertise available at this facility, these were part time practitioners. Practicing psychiatry in a supports and services 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 supports and services living center model. The facility should consider the development of a "pearls of wisdom" book. This would be an information book for psychiatry that outlines information that is specific to the practice of psychiatry within the facility, and that will likely ease the transition for both the physician and staff. Although the psychiatrists practicing at the facility were either board certified or board eligible, the report that follows will indicate areas of concern with regard to their practice at the facility. It was recognized that many of the challenges to providing care in the facility were out of the physician's control. For example, these included the lack 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 (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	Number of Individuals Evaluated The psychiatrists had continued to perform comprehensive psychiatric assessments per Appendix B. During the previous monitoring review, 16 evaluations had been completed,	Noncompliance

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	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.	per the documentation reviewed for this monitoring period, 69 evaluations had been completed. <u>Clinical Justification</u> 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 rarely 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 J8 and J13. Discussions with the facility lead psychiatrist revealed that she was aware of the variability in clinical documentation. She indicated that there were currently no quality assurance monitoring tools in place to review this documentation, however, she agreed that a peer review process could be beneficial. <u>Challenges</u> There remained 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 added a physician's assistant to the clinical staff, giving the facility 12 additional hours of clinical consultation time. Due to a misconception regarding other contract psychiatrists' available clinical consultation hours (they are contracted for eight hours, but only onsite for six hours due to travel time compensation), the facility did not obtain an overall increase in clinical availability. The facility currently had 1.63 FTE of clinical psychiatry time (including physicians and physician's assistant). With this level of available staff, current providers were struggling to retain the status quo of services. 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 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	<u>Positive Behavioral Support Plans (PBSP)</u> 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 (see provision J9 for further discussion regarding this). Further discussion regarding the quality and utility of the	Noncompliance

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	hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	PBSP is in section K of this report. As indicated in section K, overall, the PBSPs did not yet 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. Of the 16 records available for offsite review, all included a 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 was 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). <u>Psychiatric Diagnoses</u> 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. Given the lack of appropriate data presentation observed during psychiatry clinics and included in the documents available for off site review, it will be imperative that psychiatry and psychology staff meet to formulate a cohesive diagnostic summary inclusive of behavioral data and in the process generate a hypothesis regarding behavioral-pharmacological interventions for each individual, and to discuss strategies to reduce the use of emergency medications. Again, given that psychiatry clinic was evolving into a multidisciplinary team process in order to encourage collaborative efforts, further expansion of the clinical discussion could be encouraged.	

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		Emergency Use of Psychotropic Medications A review of documentation regarding the last 10 individuals who required chemical restraint revealed two instances of chemical restraint over the previous six months. This was a reduction from six instances in the period between 9/1/10 and 2/28/10. It should be noted that during this monitoring review, the monitor had the opportunity to observe Individual #170 during an episode of behavioral challenges. Staff were noted to be appropriate, calm, and patient with the individual. Finally, the individual, who refused to respond to redirection, was noted to be a danger to self and others because he was picking up metal trays and plastic pitchers from the lunchroom, and swinging them over his head in an apparent attempt to strike staff. He was placed in physical restraint three times in rapid succession over the course of a 90-minute period. Ultimately, in an effort to protect the individual and others due to his aggressive behavior, the psychiatrist appropriately gave the order for intramuscular medication. Approximately 20 minutes following the administration of this medication, the individual was calm and pleasant. The other two instances during this reporting period were attributable to two individuals who each received a chemical restraint: • Individual #176 received two intramuscular injections consisting of Ativan and Geodon (a benzodiazepine and a atypical antipsychotic medication). There were progress notes authored by psychiatry 9/1/11 on the day of the event. The individual was next seen in clinic by her regular clinic psychiatrist 9/7/11. This psychiatrist's notes showed review of the emergency psychiatric consultation. • Individual #490 received an intramuscular injection of Ativan (a benzodiazepine) on 5/27/11. Psychiatry documentation was noted beginning 5/23/11, where this individual was noted as being increasingly agitated and restless. This was attributed to medical concerns including abdominal pain. The psychiatric nurse documented on 5/27/11 numerous alternatives tried prior to the administration of intramuscular medication including walking outside with the individual, cuddling the individual in a blanket, low lighting, and a fan. The individual was next seen in psychiatry clinic on 5/30/11, however, a review of this documentation did not reveal knowledge of the recent chemical restraint. This review revealed good documentation from psychiatry regarding the justification for the utilization of additional medication. One concern was with regard to the use of combinations of medications, when multiple agents are utilized, the prescriber must document and justify the use for multiple agents. As psychiatry was now involved in the process of addressing acute behavioral challenges, the need for increased collaboration between psychiatry and psychology in the management of crisis behavior was apparent.	

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J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pretreatment 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 pretreatment sedation. The pretreatment 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.	<u>Extent of Pretreatment Sedation</u> The facility reported a total of 106 instances of pretreatment sedation between 5/1/11 and 9/20/11. Given the data presentation, however, it was not possible to determine which of these pretreatment sedation administrations were due to medical or due to dental. It was documented that TIVA accounted for 28 of the 106 instances of pretreatment sedation. Interestingly, the majority of individuals receiving pretreatment sedation (for either dental clinic or medical clinic) were also individuals who were also prescribed psychotropic medications. <u>Interdisciplinary Coordination</u> 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, and their medication regimen for review, two weeks prior to the scheduled TIVA session. Documentation of the coordination of the pretreatment sedation process with psychiatry specifically related to TIVA was provided for three individuals. A review of the integrated progress notes did not reveal documentation from psychiatry regarding the proposed TIVA. Per an interview with the facility psychiatrist, there had been a lapse in psychiatry review of TIVA protocols for psychiatry clinic patients. Psychiatry verbalized plans to resume this consultation. 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. 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 SSLCs.	Noncompliance

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		Monitoring A review of provided documentation regarding the nursing follow up and monitoring following administration of pretreatment sedation revealed that nursing did document review of the vital signs and assessment following TIVA and other pretreatment sedation administration, per protocol. Desensitization Protocols A request to review medical and dental desensitization plans revealed that the facility had developed six dental desensitization plans and no medical desensitization plans. A review of the six dental desensitization plans revealed that these were included in the individuals PSP, however, they were not dated or signed by the team members. During this review, the monitoring team attended a meeting regarding the "Dental Education Rehearsal Simulation Training (DERST)," a program that was in the process of development by psychology and dental staff. This program reportedly included a simulated dental clinic experience, and a video presentation for individuals to watch prior to presentation to dental clinic. Individuals could be referred to DERST by their PST. They were then evaluated via an assessment tool, and an action plan was developed to address their individualized desensitization needs. All individuals referred for DERST were given a preference reinforcer assessment, such that the most desirable reinforcer could be utilized during DERST. While the DERST team reported that they had identified individuals requiring supports, and had developed some action plans, the challenge was in having the required staff available to actually perform the desensitization training for the individuals. Given the above, it was apparent that the facility was making efforts with regard to dental desensitization. This was a positive step. Attention must also be focused on medical desensitization.	
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.	Psychiatry Staffing At the time of this onsite review, there were a total of four psychiatric physicians and one physician's assistant 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. A second psychiatrist, board certified in adult psychiatry, was providing one day of clinical services per week, six hours per day. A third psychiatrist, board certified in both adult and child psychiatry, was providing one day of clinical services per month, six	Noncompliance

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		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, six hours per day. The physician's assistant provided two days of clinical services per week for a total of 12 hours. In previous monitoring reports, the clinical consultation time was reported at eight hours per day, however, in discussions with the facility lead psychiatrist as well as per document review provided for this monitoring report, it was noted that the physicians/physician's assistant actually spent six hours onsite each workday. Other hours were assigned to travel. These four physicians and physician's assistant accounted for a total of 1.63 full-time equivalents (FTE). Even with the addition of the physician's assistant (12 hours per week), this was not an increase in clinical consultation hours over the previous monitoring period. <u>Administrative Support</u> Given that the lead psychiatric physician was the only full time psychiatric provider at the facility, it was not surprising to find that she was overwhelmed by both administrative and clinical duties. Additional departmental staff included a psychiatric nurse and a psychiatric assistant. In the intervening period since the previous monitoring review, the psychiatric assistant resigned. As such, the psychiatric administrative assistant was promoted to the role of psychiatric assistant and the department was in the process of recruiting for an administrative assistant. Observation and interviews performed during the monitoring review revealed some tension within the psychiatry department. This was not unexpected given the newness of the department itself and the challenges the department was facing with respect to the need to move toward providing more comprehensive services. It was apparent that staff were diligent, hard working, and committed to the improvement of psychiatric services in the facility, however, due to the high demand population, the need for vast improvements in the clinical documentation, and the lack of available clinical consultation time, staff expressed frustration with being unable to meet the high expectations they had of themselves and their department. <u>Determination of Required FTEs</u> At the time of this monitoring review, there were 196 individuals prescribed psychotropic medication. With this volume of individuals, it was uncertain what the optimal number of FTEs would be for this facility. Similar to Mexia SSLC, at LSSLC, psychotropic medications were being reviewed by psychiatry a minimum of quarterly as opposed to monthly. Individuals were seen more frequently, however, if they had adjustments to their medication regimen or were experiencing increased psychiatric symptoms or behavioral challenges. Therefore, it would be useful to develop workload	

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		indicators to determine optimal staffing, taking into account not only clinical responsibility, but required meeting time (e.g., physician's meetings, staffing, behavioral management consultation, emergency PSPAs). LSSLC should engage in an activity to determine the amount of psychiatry service FTEs required. This computation should consider hours for clinical consultation, the evaluation of new admissions, attendance at meetings (e.g., polypharmacy committee, behavior therapy committee, physician's meetings, behavior support planning), and any other clinical activity. And then, add to this the need for improved coordination of psychiatric treatment with primary care, neurology, other medical consultants, pharmacy, and psychology.	
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.	<u>Policy and Procedure</u> 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, a psychiatric evaluation must follow the format of Appendix B. <u>Evaluations Completed</u> A listing of all individuals evaluated per Appendix B was requested. This list contained the names of 69 individuals. Per an interview with the lead psychiatrist, the psychiatry clinic was scheduling individuals for comprehensive psychiatric evaluation per Appendix B as clinic time was available. Reportedly, there was no projected date for the completion of all Appendix B evaluations. A review of the listing of individuals currently receiving treatment via psychiatry clinic revealed 196. As such, the facility psychiatric practitioners had completed 35% of the evaluations on the individuals currently assigned to clinic. This does not include evaluations on newly referred individuals (e.g., new admissions, evaluation requests following a positive Reiss Screen). <u>Review of Completed Evaluations</u> A review of 10 completed comprehensive evaluations revealed that these evaluations were completed between 5/25/11 and 9/12/11. There were sample evaluations provided from all facility practitioners. Specific challenges noted with the reviewed evaluations 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 J8 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	Noncompliance

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		the case formulation and treatment plan (for additional information regarding this issue, please see the discussion under J8). 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.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	<u>Reiss Screen</u> 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. <u>Timeliness of Reiss Screen</u> Per the documents requested for this monitoring review, there were five individuals admitted to the facility since 8/12/10. Two of these admissions were attributed to the same individual (due to re-admission after 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 no delay with regard to performance of the Reiss Screen. Documents revealed that the screen was performed on the day of admission. This was an improvement over the prior monitoring report where there was, on average, a delay of 2.75 months between the date of admission and the date of the Reiss Screen. <u>Referral for Psychiatric Evaluation Following Reiss Screen</u> Per the documents reviewed, 123 individuals had been screened with the Reiss Screen in the previous 12 months. Of these, 47 were performed in 2011. A review of the individuals on this list revealed that a proportion of them were receiving services from psychiatry clinic at the time of the screening. Data regarding the number of individuals who were referred for a psychiatric evaluation following this screening were not provided, however, documentation regarding psychiatric screening of individuals following a positive Reiss Screen was provided for three individuals (Individual #250, Individual #366, and Individual #351). In none of these cases was an evaluation per Appendix B included. Per an interview with the lead psychiatrist, there was no policy or documented method for the referral of an individual for psychiatric evaluation following a positive Reiss Screen. Given the challenges with the data review documented above, as well as the lack of a formal process for the referral of an individual for a psychiatric evaluation in	Noncompliance

#	Provision	Assessment of Status	Compliance
		response to a positive Reiss Screen, this provision will remain in noncompliance.	
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.	Policy and Procedure Per the Psychiatry Services Procedure Manual dated 3/15/11, "psychiatrist will integrate pharmacological treatments with behavioral and other interventions through combined assessment and formulation." While this was stated by the procedure, there were no specific procedural elements denoted for the physician to follow, therefore there were no written documents to guide the development and implementation of a system to integrate pharmacological treatment with behavioral and other interventions. Collaborative Efforts 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 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. Interviews with the lead psychiatrist and other psychiatric treatment providers revealed that "psychology does participate in the quarterly clinic…and they weigh in on the case formulation." Documentation, however, did not support this. Integration of Treatment Efforts 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 the change in format of psychiatry clinic to include representatives from other disciplines. There were opportunities for interaction between psychology and psychiatry during psychiatry clinic; these were observed during three clinic observations performed during this monitoring review. For additional information regarding this, please see the discussion in section J13. 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. 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. Collaborative Diagnostic Formulations A review of the psychological and psychiatric documentation for 16 individual records	Noncompliance

#	Provision	Assessment of Status	Compliance
		did not reveal case formulations that tied together the information regarding a particular individual's case. Psychology and psychiatry need to formulate diagnoses and plans for treatment as a team. There was no documentation located regarding objective assessment instruments being utilized to track specific symptoms related to a particular diagnosis. The use of objective instruments (i.e., rating scales and screeners) that are normed for this particular population would be useful to psychiatry and psychology in determining the presence of symptoms and in monitoring symptom response to targeted interventions. A review of 10 examples of Appendix B evaluations revealed that three that documented the receipt of input from psychology staff. One of these evaluations evidenced documentation of the case formulation. This was for Individual #122 and, while brief, did review the diagnostic criteria for at least one of the Axis I diagnoses. The other evaluations reviewed either omitted this section altogether, or were inadequate. For example: • Individual #43: Per the psychiatric evaluation dated 7/13/11, "biological factors…include developmental delays and multiple medication conditions including menopause and related issues, arthritis and pain related issues…psychosocial factors…include prolonged institutionalization and limited support due to elderly family members with change of dorm and change of staff and residence recently." The document did not note non-pharmacological interventions for this individual's challenges, which included physical aggression and self-injury. • Individual #235: Per the psychiatric evaluation dated 8/2/11, "institutionalized since age six…doubtful she has any concept regarding spirituality…multiple medical problems seem to be well controlled with the medication…history of crying spells and irritability suggests a depressive component to her mood…her non pharmacological intervention will be to continue with the positive behavioral support plan."	
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	<u>Psychiatry Participation in BSP</u> 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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. 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. It was not possible to determine collaboration between the disciplines via a review of this document. 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 was utilizing 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.	
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	<u>Policy and Procedure</u> State and facility-specific policies appeared to be appropriate for meeting the requirements of this provision item. For example, in DADS policy "Psychiatry Services" dated 8/20/11, "The psychiatrist must solicit input from and discuss with the PST any proposed treatment with psychotropic medication…must determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications."	Noncompliance

#	Provision	Assessment of Status	Compliance
	determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	Facility-specific policy "Psychiatry Services Procedure Manual," dated 3/15/11, stated, "the PST, including the psychiatrist…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 then the medications." This policy went on to state, "assessment of the risk versus benefit of continued psychotropic medication therapy as well as the appropriateness of drug selection, effectiveness, dosage and presence or absence of side effects must be reviewed on a quarterly basis by the psychiatrist in conjunction with the PST and documented in the record." Another facility-specific policy "Client Management," dated 8/11/11, outlined "guidelines for long term use of psychotropic medication regimens." Per this policy, a "Consent/Authorization for Treatment with Psychotropic Medication" must be completed. These forms included a section that required the prescribing physician to document "potential risk/side effects related to using this medication" and to document "any alternatives that exist and rationale for not implementing them at this time." The policies, however, were not yet being fully implemented at LSSLC. <u>Review of Documentation</u> Per discussions with the facility lead psychiatrist and other psychiatric providers, the process of psychiatry documentation of risk/benefit analysis and description of other alternative treatment strategies by psychiatric providers was just beginning. A review of the records of 16 individuals at the facility who were prescribed various psychotropic medications did not reveal sufficient documentation by the psychiatric physician of an individualized specific risk/benefit analysis with regard to treatment with medication as required by this provision item. For example: • Individual #131: Per the newly implemented consent documentation requirements, information documented for the addition of the atypical antipsychotic medication Seroquel XR stated, "potential positive outcomes…decrease in psychotic symptoms. Ability to stay at work, decrease in depressive symptoms (crying)…potential risk/side effects…she may further destabilize…sedation, dry mouth, weight gain, and tachycardia…any alternatives that exist…Abilify was considered but she has been on it before without any success. Behavior plan alone is not sufficient to address symptoms." There was additional information regarding the risk/benefit analysis and description of other alternative treatment strategies in this individual's PSP, however, the signature page regarding the staff members participating in the creation of the PSP did not include psychiatry.	

#	Provision	Assessment of Status	Compliance
		This documentation was insufficient because it did not consider alternative treatments as an option, rather, simply stated the behavior plan as not sufficient. The psychiatrist, as part of the PST must consider other behavioral or treatment alternatives. A review of documentation for this and other individuals revealed a paucity of documentation regarding treatment alternatives to medication. The above illustrated the need for improved assessment of whether the harmful effects of the individual's mental illness outweighed the possible harmful effects of psychotropic medication, and whether reasonable alternative treatment strategies were likely to be less effective, or potentially more dangerous, than the medications. The success of this process will require a collaborative approach from the individual's treatment team inclusive of the psychiatrist, primary care physician, and nurse. It will 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 reviews 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. As stated in J13 below, as representatives from various disciplines are present in psychiatry clinic, the inclusion of the PST process during psychiatry clinic could be an avenue for ensuring the PST process is followed with respect to the requirements of this provision.	
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	<u>Facility-Level Polypharmacy Review</u> Per interviews with the lead psychiatrist, clinical pharmacist, and psychiatric nurse, the monthly polypharmacy review committee had been established on 3/3/11. A request of minutes for the previous six months revealed documentation of meetings only in August 2011 and September 2011. The monitoring team attended the monthly polypharmacy meeting during this monitoring review. At this meeting, the facility lead psychiatrist and the clinical pharmacist essentially reviewed individual records much in the fashion of a quarterly drug regimen review. The observed meeting did not include the physician's rationale for polypharmacy. Minutes reviewed from the available two months of meetings did reveal some basic justifications for polypharmacy, but no interventions that could be implemented in an effort to reduce polypharmacy. The facility lead psychiatrist and the clinical pharmacist reported that other than those individuals assigned to the lead psychiatrist's caseload, pharmaceutical regimens had not	Noncompliance

#	Provision	Assessment of Status	Compliance
	the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	been reviewed with respect to polypharmacy. Given the above, the facility did not currently have a facility-level review process for monitoring polypharmacy. Review of Polypharmacy Justifications Per the newly developed "Requirements for Quarterly Psychiatric Review," implemented 9/15/11, the psychiatric physicians and physicians assistant were required to include polypharmacy justification as part of the quarterly clinical documentation. Of the 16 medical records available for off site review, three individuals met criteria for polypharmacy. Documentation regarding the justification for polypharmacy was reviewed for all these cases, but was insufficient to justify polypharmacy. For example: • Individual #449 was prescribed atypical antipsychotic medications of Seroquel and Zyprexa. Per the documentation regarding polypharmacy justification, "due to his prior history, patient requires these medications and they need to be continued…we are observing his agitation and seeing if we have to go back to his original dose of Zyprexa, 10 mg three times a day." • Individual #131 was prescribed Buspar, Haldol, Benztropine, and Seroquel. Per the documentation regarding polypharmacy justification, "…[polypharmacy] has been a factor…in treatment…gradually tapering…Seroquel…intend to discontinue that today…had a discussion with the treatment team that since the Seroquel has been reduced gradually, there has been no adverse change in the patient's behavior. Another goal is also to gradually taper her off Cogentin." • Individual #323 was prescribed Doxepin, Risperidone, and Temazepam. Per the documentation regarding polypharmacy justification, "on three different…medications…at this point…the Temazepam has had little impact on his sleeping and likewise the shift in Risperdal to bedtime has not had much effect, and Doxepin too…adjustment in medication would seem warranted at this point." Polypharmacy Data A review of the current data available regarding polypharmacy revealed a listing of individuals who met criteria for polypharmacy. Per interviews with the facility clinical pharmacist and the facility lead psychiatrist, the facility did not currently trend polypharmacy data, nor did the facility review the prescribing practices of individual psychiatric practitioners to determine trends. In the absence of these data, monitoring of polypharmacy at this facility was not possible to do. A review of the documentation regarding individuals meeting criteria for polypharmacy revealed a total of 75 individuals, with 14 of these individuals prescribed intra class polypharmacy. It should be noted that in the prior monitoring report, 80 individuals met criteria for polypharmacy.	

#	Provision	Assessment of Status	Compliance
		• Of the 14 individuals prescribed intra class polypharmacy, six individuals were prescribed two antipsychotic medications, five individuals were prescribed two antidepressant medications (one of these was documented to be in the process of a taper/switch from one antidepressant to another), and one individual was prescribed two mood stabilizing medications. There were 75 individuals prescribed three or more medications. Of these, there were 42 individuals prescribed three psychotropic medications, 26 individuals prescribed four psychotropic medications, and seven individuals prescribed five 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.	<u>Tracking</u> The facility had a tracking system in place for documentation of completion of MOSES and DISCUS assessments 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 2011 revealed only one overdue DISCUS (Individual #244 instrument due 8/15/11). 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. <u>Training</u> A review of requested information regarding in-service training for nursing staff revealed that a 15-minute block in nursing orientation was devoted to MOSES and DISCUS assessments. Three staff reportedly attended this training in May 2011. Additional inservice trainings were documented July 2011 (one participant) and June 2011 (eight participants). From review of the documentation, however, it was difficult to determine the work assignments of the training participants, and it appeared that not all participants were nurse case managers who would be responsible for completion of the MOSES and DISCUS assessments. <u>Record Review</u> The review of a sample of 16 records revealed documentation that the Monitoring of Side	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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). 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. In all psychiatry clinics observed during this monitoring review, for those individuals requiring them, completed MOSES and DISCUS forms were available for the psychiatrist to review, and information from these instruments was included in the quarterly psychotropic medication review as required by the newly developed "Requirements for Quarterly Psychiatric Review," implemented 9/15/11. Additional 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 revealed that in all cases, the rating forms were signed by the prescribing practitioner. In one case, the physician signed both documents, but failed to complete the boxes indicating review and clinical correlation. The documentation was variable with regard to the documentation of the use of MOSES and DISCUS results in clinical decision-making. The majority of the available examples, however, had the data included in the document. In an effort to address the need for documentation of data review and the impact of said data in clinical decision making, the facility could consider physician education regarding documentation requirements, quality assurance monitoring with ongoing corrective action, or a peer review process utilizing physician reviewers from another DADS facility.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the	<u>Psychiatric Participation in PSP Meetings</u> At the time of the onsite monitoring review, there was some psychiatry participation in the PSP process. As one full time psychiatrist staffed the facility with other, contracted, part time psychiatric providers (including one physicians assistant), the schedules of providers other than the full time facility lead psychiatrist did not allow for their attendance or participation in the PSP process. A review of the documentation revealed 32 examples of psychiatry participation in the PSP process between the dates of 4/24/11 and 8/15/11. One other attendance sheet was provided indicating that the psychiatric nurse had attended the PSP meeting in the psychiatrist's absence. Given the manner of the data request, it was not possible to determine what percentage of the total number of meetings the psychiatrist attended. As the total number of individuals participating in psychiatry clinic during this monitoring	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	review equaled 196, it can be deduced that attendance in approximately two PSP meetings per week would not allow for the psychiatrist to integrate fully into the PSP, nor would it allow for clinical collaboration. In an effort to utilize staff resources most effectively, the facility could consider incorporating PST meetings into the psychiatry clinic process. Given the interdisciplinary model utilized during psychiatry clinic, the integration of the PST into psychiatry clinic may allow for improvements in overall team cohesion, information sharing, collaborative case conceptualization and management. <u>Psychiatry Clinic</u> The psychiatrists did have contact with PST members during psychiatry clinic. During this monitoring review, three clinic observations were conducted. These clinical observations varied with regard to staff participation and data presentation. During these observations, multiple opportunities for discussion regarding the individual and his or her treatment were afforded, however, staff did not take advantage of these opportunities. 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. In previous monitoring reviews, one long-standing psychiatrist/psychologist dyad was noted to be functioning well and approximating the level of clinical consultation required by this provision. Unfortunately, during the intervening period since the previous monitoring review, this team was dissolved during a reassignment of caseloads. Three teams observed during this monitoring review were in the early phases of team development. During this monitoring review, three psychiatry clinics were observed. In all instances, the team, including the psychiatrist, met with the individual for a brief period (two to 12 minutes) at their home, and then adjourned to a conference room to complete clinic in the absence of the individual. All treatment team disciplines were represented during the clinical encounter. The team did not rush clinic, spending an appropriate amount of time (often 35-45 minutes) discussing the individual's treatment. 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. Individuals who would clearly be amenable to presenting in psychiatry clinic and	

#	Provision	Assessment of Status	Compliance
		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 because individuals have the right to participate in team decisions regarding their treatment program. During clinic, the psychiatrist/physician's assistant made attempts to review behavioral data. In general, the data were graphed, however, data were not up to date, and graphs were difficult to understand because they did not follow a chronological order. In addition, timelines for medication dosage changes or stressful life events were not included in the data graphs. This made data based decision making difficult for the psychiatrist, as medication changes and other events that may affect behavior or psychiatric symptoms were not noted. In all observed clinical encounters (and in all documentation reviewed) the individual's weights and vital signs were documented and reviewed, MOSES and DISCUS results were reviewed, and recent laboratory results were reviewed. The individual's record was available and reviewed during the clinical encounter. <u>Policy and Procedure</u> Per a review of the DADS statewide policy and procedure "Psychiatry Services," dated 8/20/11, "state centers must insure that individuals receive needed integrated clinical services, including psychiatry." In section 7.b., the policy directly quoted the language in this provision. A review of facility-specific policy revealed that, per the "guidelines for long-term use of psychotropic medication," the psychiatrist was responsible for completing authorizations for treatment with psychotropic medication, which included documentation regarding "potential risks/side effects." Per a review of the newly developed "Requirements for Quarterly Psychiatric Review," implemented 9/15/11, there were requirements for the review of data, a diagnostic review and a review of target symptoms. Other information regarding the behavioral/pharmacological hypothesis was required via the comprehensive psychiatric evaluation per Appendix B. As such, the documentation of information required to satisfy this provision was spread throughout the individual's record, but in the intervening period since the previous monitoring report had been designated as the responsibility of the prescribing psychiatrist as a participant in the PSP process. <u>Record Review</u> 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 #370: Comprehensive Psychiatric Evaluation dated 9/12/11 -	

#	Provision	Assessment of Status	Compliance
		"Autistic Disorder…Severe Mental Retardation…sleep disturbance addressed with Trazodone…has some sleep problems…has history of agitation and aggression which has been addressed with the Risperdal…also receives Clonidine 0.1 mg three times daily." This documentation did not adequately describe the behavioral/pharmacological hypothesis regarding this individual's treatment with three psychotropic medications. • Individual #106: Comprehensive Psychiatric Evaluation dated 9/1/11 – This document provided a good biopsychosocial formulation that described the individual's history of experiencing signs and symptoms of the diagnoses "Major Depression, recurrent, mild; pedophilia; moderate mental retardation." The document went on to indicate, "on Prozac…seems to have controlled…depression reasonable well, and as a side benefit, may have reduced his libido such that he is sexually inappropriate much less often…positive behavioral support plan…weekly counseling by the chaplain…revolving around grief…also reinforces discussion about moral code…Boy Scout morals…." This document did a good job of describing the behavioral and pharmacological basis for treatment with medication, and it discussed other alternatives to medication that the individual will be receiving. Unfortunately seven out of 10 Appendix B evaluations reviewed during this monitoring period were lacking in documentation of data required to meet the requirements of this provision. 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	<u>Policy and Procedure</u> Per DADS revised policy and procedure "Psychiatry Services," dated 8/30/11, "State Centers must provide education about medications when appropriate to individuals, their families, and LAR according to accepted guidelines…State Centers must obtain informed consent (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures." In the facility-specific policy "Psychiatry Services Procedure Manual," dated 3/10/11, the psychiatrist "provides education about medication side effects and the reason for choice and reason to hep [sic] abbreviate [sic] symptoms…Psychiatrist must obtain informed	Noncompliance

#	Provision	Assessment of Status	Compliance
	consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	consent (except in the case of an emergency) prior to administering psychotropoic medication or other restrictive procedures." Further, in the facility-specific policy "Legally Adequate Consent/Authorization for Treatment," dated 8/11/11, delineated the steps that must be followed when obtaining informed consent and indicated what staff are responsible for specific tasks. The "Consent/Authorization for Treatment with Psychotropic Medication" form included requirements for information regarding the selected medication, diagnoses, dosage, dosage range, allergies, target symptoms/behavioral characteristics, potential positive outcomes related to the medication, potential risk/side effects related to the medication, any alternatives and the rationale for not implementing them at this time, and signature space. It was a positive step that the facility had begun the process to formalize informed consent. There are, however, areas in need of improvement. First, the individual and his or her LAR should receive not only a verbal discussion of the medication information, but if the LAR is not present (or present via telephone), a copy of the medication information should be sent to them via mail. Additionally, the consent form should include space to document the conversation or conversation attempts with the individual and the LAR. <u>Consent Documentation</u> Per interviews with facility staff, including the facility psychiatrists and the psychiatric nurse as well as review of facility medical records, psychiatric physicians were increasing their involvement in the informed consent process. A review of 10 examples of informed consent documentation revealed five examples of documentation performed prior to the implementation of the consent process noted above, and five utilizing the new consent forms. For the purposes of this monitoring review, only documentation consistent with the current policy and procedure will be reviewed. The five examples included an attached signed PST document regarding review of the proposed medication, including documentation of psychiatric attendance at the PST. There was, however, varying quality with regard to the completeness of information provided on the form. One specific weakness was the documentation of alternatives to medication treatment and the rationale for not implementing these at the time medication was recommended. In all five examples reviewed, there was a lack of documentation regarding non-pharmacological interventions considered or utilized. For example: • Individual #170: consent for the sleep medication Lunesta listed as alternatives, "none helpful at this time." Improved documentation would note alternative treatments that had been trialed and failed, for example, sleep hygiene. It could also note other behavioral interventions that would be continued during the	

#	Provision	Assessment of Status	Compliance
		administration of the sleep agent in an effort to reduce the need for this particular medication. The efforts of the psychiatry staff with regard to completion of consent documentation were laudable and indicative of a transition toward appropriate practice. At the time of the monitoring visit, records reviewed and staff interviewed showed that the psychiatrists had performed 41 annual medication consents and 21 consents for newly prescribed medication. The facility had moved forward with respect to this issue. As they now had policy and procedure in place, and were actively following them, a review of the quality of the documentation will be necessary. Although some improvements were noted, given the deficits outline above, a noncompliance rating was appropriate. 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, 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.	<u>Policy and Procedure</u> Per DADS policy "Psychiatry Services" number 007.2 dated 8/30/11, "the neurologist and psychiatrist must coordinate the use of medications, through the PST process, when medications are prescribed to treat both seizures and a mental health disorder." The facility-specific policy "Psychiatric Services Procedure Manual," dated 3/15/11, stated "the neurologist and psychiatrist will coordinate the use of medications, through the PST process, when the medication is prescribed to treat both seizures and a mental health disorder." Neither of these policies, however, described the process by which this would be accomplished. Per an interview with the facility lead psychiatrist, neurology consultation was available at the facility once a month. Neurology clinic reportedly lasted approximately three hours. Also, per an interview with the facility lead psychiatrist and the facility medical director, individuals can travel to the consulting neurologists office "if need be." The facility lead psychiatrist reportedly attended every scheduled neurology clinic. Per the facility lead psychiatrist, attendance at neurology clinic was a priority, and if she was unable to attend, the facility psychiatric nurse would attend in the psychiatrist's place. Other psychiatrists and physician extenders providing services at the facility were contracted to work a limited number of days per week/month and were not able to attend neurology clinic. While it was apparent that psychiatry staff were making an effort to attend clinic, deficits in availability of neurology consultation and the	Noncompliance

#	Provision	Assessment of Status	Compliance
		coordination of clinical care via the PST process were noted. <u>Adequacy of Clinical Resources</u> A listing of individuals treated in psychiatry clinic with a concomitant seizure disorder diagnosis revealed a listing of 66 individuals. In addition, the date that the individual was most recently seen by neurology was included. The information revealed that of the 66 individuals, there was "none found" for two individuals (indicating no recent neurology clinic evaluations). Fourteen individuals had not been seen in neurology clinic in the past year. Of these, two individuals were last seen in 2001, three individuals were last seen in 2002, one individual was last seen in 2003, one individual was last seen in 2004, two individuals were last seen in 2008, one individual was last seen in 2009 and four individuals were last seen in 2010. Thus far in 2011, 50 individuals were seen in neurology clinic. Given these data, the need for increased neurological clinical consultation was apparent because 24% of the individuals treated in psychiatry clinic with a concomitant seizure disorder diagnosis had no documented evaluation by neurology in the previous 12 months. Given the above, 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 should continue the pursuit of 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. <u>Adequacy of Clinical Consultation</u> Of the 16 records available for off site review, six had a diagnosis of seizure disorder. A review of these six records revealed one individual who received a neurology consultation dated within the previous six months, Individual #170. This example illustrated the need for improved integration of clinical care. The second example regarding Individual #217 was also illustrative of the lack of coordination of care between primary care, neurology, and psychiatry. • Individual #170 was evaluated in neurology clinic 1/12/11, 4/27/11, and 9/14/11. Integrated progress notes revealed that the psychiatrist was present in neurology clinic for the latter two examinations. Neurology documentation reviewed from 1/12/11 revealed prescriptions for Valproic acid and Lamictal in an effort to address seizure activity. These medications also have concomitant mood stabilizing effects. Documentation from the 4/27/11 neurology clinic revealed a review of other prescribed psychotropic medications, including Propranolol and stimulant medications. At this time, the neurologist	

#	Provision	Assessment of Status	Compliance
		recommended a taper of Lamotrigine, ostensibly to simplify the medication regimen, as no other rationale for the taper and discontinuation of this agent was documented. The most recent encounter, 9/14/11 revealed no added anticonvulsant medications, and noted, "he is doing much better." Additional documentation revealed a quarterly psychiatric review dated 7/13/11 noting increased physical aggression (19 for the current quarter and seven for the previous quarter), increased disruptive behavior (32 in the current quarter and 22 in the previous quarter). There was no notation in the quarterly psychiatric review considering the taper and discontinuation of Lamictal as a potential etiology of increased behavioral challenges. In addition, an annual PSP dated 2/15/11 did not note the recent taper and discontinuation of Lamictal or the potential behavioral/psychiatric effects this medication regimen change could have. Per a review of the team signature sheet from this PSP meeting, there was no psychiatrist in attendance. It was noted that this individual had escalating behavioral challenges. The monitoring team observed these increased challenges during an episode where this individual required three successive physical restraints, culminating in a chemical restraint. • Individual #217 was last evaluated in neurology clinic in 2002. Per the annual medical examination dated 2/4/11, documented diagnoses included neurofibromatosis and seizure disorder, among others. A review of the integrated progress notes revealed multiple entries where this individual was experiencing "severe" headache. Ultimately, brain imaging was ordered 5/17/11 by primary care, however, the individual was unable to tolerate the procedure and it was not obtained. In the PSP quarterly review dated 9/21/11, there was notation that this individual had experienced increased behavioral challenges, and that "medications have been changed so much to find the right combination, he is not the [individual's name] he used to be." Per a review of the team sign in sheet for this meeting, there was no psychiatrist in attendance. Review of other documentation did not reveal that team members or psychiatry considered a referral to neurology for this individual. Unfortunately, the neurologist was not available for interview during this review, and therefore, there was no opportunity to observe neurology clinic. The lack of neurology resources, the inadequacy of clinical consultation, and lack of integration of the present neurology resources via psychiatric participation in the PST process resulted in a noncompliance rating for this provision.	

Recommendations:

1. Complete Appendix B comprehensive psychiatric evaluations for all individuals participating in psychiatry clinic (J2).

2. 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 (J2).

3. Develop quality assurance monitoring (e.g., record reviews, peer review process) for psychiatry (J2, J4, J6, J8, J9, J10, J11, J12, J13, J14)

4. Integrate psychiatry into the overall treatment program at the facility. This would include the continued involvement of psychiatrists in decisions to utilize emergency psychotropic medications and, more importantly, in discussions regarding treatment planning, non-pharmacological interventions, and behavioral support planning (J3, J8).

5. Reduce the use of multi-agent chemical restraints. If the use of multiple agents is absolutely necessary, documentation and practice must reveal attempts/failures of single agent interventions. Additionally, when multiple agent chemical restraints are required, this should prompt a review of both the individuals current psychotropic medication regimen to determine adequacy in light of breakthrough symptoms, as well as the individuals behavioral support plan (J3).

6. Review those individuals requiring pretreatment sedation for medical and dental clinic and prepare individualized desensitization plans for them (J4).

7. Ensure that psychiatry is aware of when an individual requires pretreatment sedation and documents this knowledge in his or her progress notes (J4).

8. Individualize the desensitization plans for dental and medical clinic. Begin cross discipline consultation regarding pre treatment sedation options (J4).

9. Monitor 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 (J1, J5).

10. Review the need for additional ancillary staff for psychiatry clinic. This staff could gather data and other information necessary for monitoring while allowing psychiatrists more time for clinic and other activities directly related to patient care (J5).

11. 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 (J6)

12. Examine the scheduling process of psychiatric clinic at the facility. This should include the protocol by which individuals are referred to psychiatry clinic following a positive Reiss Screen and designate timelines within which evaluations must be completed (J7).

13. If the Reiss screen is completed, document the outcome of the screen and the referral's made as a result (J7).

14. All individuals residing at the facility who are not currently attending psychiatry clinic should have a baseline Reiss Screen (J7).

15. Improve coordination between psychiatry and psychology, specifically with regard to case conceptualization, identification and justification of diagnoses, the identification and definition of specific target symptoms for monitoring, the monitoring of the response to treatment with psychotropic medications, and the identification/implementation of nonpharmacological interventions (J8, J9).

16. Include psychiatry in the development of behavioral support plans. This would include collaborative identification of nonpharmacological interventions to address symptoms and behavioral challenges exhibited by individuals (J9).

17. Improve the documentation regarding the review of risk/benefit ratios for the prescription of psychotropic medications that are authored either by psychiatry. This documentation must include consideration of treatment alternatives to psychotropic medication (J10).

18. Improve the facility level review of polypharmacy to include reviews of medication regimen justifications authored by the prescribing physician (J11).

19. Expand the current monthly polypharmacy committee meeting to a multidisciplinary, facility level review of polypharmacy trends, prescribing practices, and justification of individual psychotropic medication regimens (J11).

20. Gather and review polypharmacy data such that trends in prescribing practices may be reviewed from a facility level (J11).

21. 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 (J11).

22. Improve documentation of psychiatric review and clinical utilization of DISCUS and MOSES examination results (J12).

23. Ensure that all nursing staff responsible for performing MOSES and DISCUS assessments has had appropriate documented training (J12).

24. Ensure that the indications for specific medications correspond to the 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 (J13).

25. Consider incorporating PST meetings into the psychiatry clinic (J10, J13).

26. 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 (J13).

27. Improve psychiatric documentation to include a diagnostic formulation and justification for each specific diagnosis (J13).

28. 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, timing of data collection) 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) (J8, J13).

29. Review facility specific policy and procedure to ensure that it addresses all requirements of the provisions (J14, J13, J6, J8, J10, J13).

30. Review the quality of documentation with regard to the informed consent process (J14).

31. Ensure that non-pharmacological alternatives are addressed in the informed consent process (J14).

32. Ensure that all involved in the informed consent process for psychotropic medications, the individual, their LAR, the facility director, receive written information regarding currently prescribed or proposed medication as part of the informed consent process (J14).

33. Explore options to increase the availability of neurology consultation (J15).

34. Include the process for psychiatric participation in neurology clinic and report to the PST during psychiatry clinic in policy and procedure (J15).

35. Continue clinical consultation clinic for psychiatry and neurology. Documentation for both psychiatry and neurology participation should be included in the individual's medical record (J15).

36. 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 (J14).

37. Given the marked variability in documentation included in completed Appendix B evaluation and the need for improvement overall with respect to collaborative case conceptualization, consider the development of a peer review process (J6).

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:** Documents Reviewed: o Annual Psychological updates for: • Individual #468 (9/26/11), Individual #344, (7/27/11), Individual #345, (8/18/11), Individual #424, (6/8/11), Individual #205 (8/26/11), Individual #308 (10/31/11); Individual #354 (10/24/11), Individual #4 (8/15/11), Individual #91 (8/15/11), Individual #9 (9/7/11) o Full Psychological Assessments for: • Individual #134 (5/9/11), Individual #484 (5/16/11), Individual #43 (8/16/11), Individual #102 (7/26/11), Individual #511(7/25/11), Individual #424 (8/11/11), Individual #317 (7/25/11), Individual #39 (7/7/11), Individual #506 (5/20/11), Individual #345 (8/29/11), Individual #380 (6/14/11), Individual #466 (7/28/11), Individual #330 (6/28/11), Individual #126 (8/3/11), Individual #457 (10/5/11), Individual #90 (7/20/11) o Functional Assessments for: • Individual #134 (5/9/11), Individual #484 (5/16/11), Individual #43 (8/16/11), Individual #102 (7/26/11), Individual #511 (7/25/11), Individual #424 (8/11/11), Individual #317 (7/25/11), Individual #39 (7/7/11), Individual #506 (5/20/11), Individual #345 (8/29/11), Individual #380 (6/14/11), Individual #466 (7/28/11), Individual #330 (6/28/11), Individual #126 (8/3/11), Individual #457 (10/5/11), Individual #90 (7/20/11) o Positive Behavior Support Plans for: • Individual #134 (6/15/11), Individual #484 (6/17/11), Individual #43 (8/17/11), Individual #102 (8/1/11), Individual #511 (8/1/11), Individual #424 (8/8/11), Individual #317 (8/10/11), Individual #39 (7/13/11), Individual #506 (6/14/11), Individual #345 (9/2/11), Individual #380 (7/1/11), Individual #466 (7/28/11), Individual #330 (6/28/11), Individual #126 (8/3/11), Individual #457 (10/5/11), Individual #90 (7/20/11), Individual #106 (7/4/11), Individual #285 (9/1/11), Individual #166 (10/10/11) o Six months of PBSP progress notes for: • Individual #134, Individual #484, Individual #43, Individual #102, Individual #511, Individual #424, Individual #317, Individual #39, Individual #192 o Peer Review policy and procedures, 9/1/11 o Minutes of Internal and External Peer Review meetings during the last six months o Spreadsheet of Individuals with a PBSP o Plan of Improvement, 10/17/11 o Status of enrollment in BCBA coursework for all psychology staff, 9/16/11

	o Copies of signed consent forms for: • Individual #134, Individual #102, Individual #317, Individual #43, Individual #484, Individual #424, Individual #294, Individual #39, Individual #511 o Psychological Evaluation, Structural and Functional Assessment, and Positive Behavior Support Plan format, LSSLC, 9/13/11 o Annual Psychological Summary format, LSSLC, undated o IOA, ABC, and Treatment Integrity data sheet format, undated o Section K Presentation Book, 10/1/11 o Replacement Behavior Data Collection sheet, undated o Target Behavior Data Collection sheet, undated o List of Individuals with functional assessments completed in the last six months, 5/3/11-9/20/11 <u>Interviews and Meetings Held</u>: o Sylvia Middlebrook, Ph.D., Director of Psychology o Martha Thomas, M.S., Associate Psychologist V o Robin McKnight, M.A., Associate Psychologist V o Mike Fowler, M.A., Associate Psychologist V <u>Observations Conducted</u>: o Internal Peer Review Meeting • Staff Present: - Sylvia Middlebrook, Ph.D., Director of Psychology; Edward Hutchison, M.A., BCBA consultant; Martha Thomas, M.S., Associate Psychologist, V; Robin McKnight, M.A., Associate Psychologist V; Mike Fowler, M.A., Associate Psychologist V; Julie Bradbury, M.S., Associate Psychologist III; Keri Leggett-Bush, M.Ed., Associate Psychologist III; Jackie Price, M.Ed., Associate Psychologist III; Richard Mendola, M.A., Associate Psychologist III; Schuler Ivey, M.A., Associate Psychologist III; Tracie Swan, M.S. Associate Psychologist III; Kari Staley, M.A., Associate Psychologist III; Charles Snook, M.Ed., Associate Psychologist III; Donna Kimbrough, M.A., Associate Psychologist III; Jill Harris, M.A., Associate Psychologist III; Kenny Ellerson, M.A., Associate Psychologist III; Christi Wall, Psychological Assistant; Xavier Mims, Psychological Assistant; Troy Finch, Psychological Assistant; Cheryl Bennett, RN; Karla Terry, Psychology Administrative Assistant • Individuals presented: - Individual #354, Individual #166 o Psychiatry Clinic • Individuals presented: - Individual #507, Individual #128 • Staff Present: - Doug Douglas, PA; Mary Herrington, QDDP; Melissa Latham, QDDP, Chris Drahas, RN Case Manager; Donna Kimbrough, Psychologist; Linda Thompson, Home Manager, Robin McKnight, Psychologist; Mike Fowler, Psychologist

	o Behavior Support Committee Meeting • Individuals presented: - Individual #273, Individual #14 • Staff present: - Mike Fowler, M.A., Associate Psychologist V; Robin McKnight, M.A., Associate Psychologist V; Martha Thomas, M.S., Associate Psychologist, V; Sylvia Middlebrook, Ph.D., Director of Psychology; Edward Hutchison, M.A., BCBA consultant; Cheryl Bennett, RN; Donna Kimbrough, M.A., Associate Psychologist III; Christi Wall, Psychological Assistant; Karla Terry, Administrative Assistant 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: The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. In the comments section of each item of the provision, the director of psychology identified what tasks had been completed and the status of each provision item. The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. LSSLC's POI indicated compliance for items K2 and K3, and noncompliance for all other 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, the monitoring team suggests that the facility establish, and focus their activities, on short-term goals. The specific provision items that the monitoring team suggests that the facility focus on in the next six months are summarized below, and discussed in detail in this section of the report.
	Summary of Monitor's Assessment: Although only two of the items in this provision were found to be in substantial compliance with the Settlement Agreement, there were several improvements since the last onsite review. These included:

	• Establishment of external peer review (K3) • The use of more informative graphs (K4, K10) • The beginning of the collection of replacement behaviors (K4) • The establishment of the collection of Inter-Observer Agreement (IOA) data (K4) • The establishment of treatment integrity data (K4, K11) • Improvements in the quality of PBSPs (K9) The areas that the monitoring team suggests that LSSLC work on for the next onsite review are: • Collect data collection reliability, establish goals, and pilot a method to ensure that they are achieved in at least one home (K4) • Establish IOA goals, and pilot a method to ensure that they are collected and recorded, and goals are maintained in at least one home (K4) • Establish treatment integrity goals, and pilot a method to ensure that they are collected and recorded, and goals are maintained in at least one home (K4, K11) • Ensure that all functional assessments include direct observations of target behaviors, and provide additional information about the antecedents and consequences potentially affecting the target behavior (K5) • Ensure that all Positive Behavior Support Plans (PBSPs) are based on the hypothesized function of the target behavior (K9)

#	Provision	Assessment of Status	Compliance
K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, 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 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). As reported in the last review (April 2011), 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, an individual 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		writing of Positive Behavior Support Plans (PBSPs). To achieve compliance with this item of the Settlement Agreement the department needs to ensure that all psychologists who are writing Positive Behavior Support Plans (PBSPs) attain BCBA certification.	
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 was enrolled to take the BCBA coursework. Supervisees interviewed indicated that 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.	The facility has continued to provide weekly internal peer review and had begun monthly external peer review in June 2011. Therefore, this item is now rated as being in substantial compliance. LSSLC had been conducting Behavior Support Committee (BSC) meetings that contained many of the elements of internal peer review, however, these meetings only reviewed PBSPs that required annual approval. The newly established internal peer review meetings provided an opportunity for psychologists to present complex cases that were not progressing as expected. Additionally, peer review meetings were recently expanded to include other disciplines, such as nursing and psychiatry. The internal peer review meeting observed by the monitoring team reviewed Individual #354's and Individual #166's functional assessments and Positive Behavior Support Plans (PBSP) and included participation by the majority of the psychology department. The peer review meeting included active participation among the psychologists, and resulted in the identification of several new interventions to address these individuals' target behaviors. Review of internal peer review minutes indicated that these meetings consistently occurred weekly, and that once a month, these meetings included a participant from outside the facility, therefore, achieving the requirement of monthly external peer review meetings. Operating procedures for both internal and external peer review committees were established and appeared to be appropriate and useful to the committees. The monitoring team will review meeting minutes to ensure that internal peer review consistently occurs weekly, and external peer review consistently occurs at least monthly to maintain substantial compliance with this provision item.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	The monitoring team noted several improvements in this provision item since the last onsite review. More work, however, is necessary before the facility achieves substantial compliance. LSSLC continued to use the simplified data system discussed in the last report (April 2011). In this data system, the direct care professionals (DCPs) were required to record the occurrence of target behaviors in each interval, and record a zero or their initials in each recording interval if target or replacement behaviors did not occur. This procedure was implemented to ensure that the absence of data in any given interval did not occur because staff forgot to record the data. This requirement also allowed the psychologists to review data sheets and determine if DCPs were recording data at the intervals specified (i.e., data collection reliability). The monitoring team did its own data collection reliability by sampling individual data books across in several homes across all four residential units, and noting if data were recorded up to the previous recording interval for target behaviors. The results were disappointing. • The target behaviors sampled for only two (both in 557A) of 13 data sheets reviewed (15%) were completed up to the previous recording interval. The majority of data sheets reviewed included data only up to shift change, suggesting that staff fill out data sheets at the end of their shift. When asked why the data sheets were not filled out, most direct care professionals (DCPs) reported that they did not know that they needed to fill out data sheets at the end of each recording interval. These observations indicated that DCPs were not consistently recording target behaviors immediately after they occurred and, therefore, were increasing the likelihood that staff would not accurately record target behavior. This is a serious problem because if the DCPs are not accurately recording data, the psychologists cannot evaluate the effects of their interventions. It is recommended that all psychologists inform DCPs, and their supervisors, that data should be recorded as soon as possible after it occurs. Additionally, if no target behaviors occurred, a zero should be recorded soon after that interval ends. Additionally, it is recommended that the facility ensure that data collection reliability data for all target behaviors is consistently collected in each home and day/vocational site. Finally, specific reliability goals should be established, and staff retrained or data systems modified, if scores fall below those goals. As recommended in the last report (April 2011), the facility began to collect replacement behaviors in one unit. It is now recommended that the facility extend the collection of replacement behaviors to all residential homes and day programs. It is also recommended that replacement behaviors be graphed.	Noncompliance

#	Provision	Assessment of Status	Compliance
		An area where the facility had improved since the last review was in the development of inter-observer agreement (IOA) measures. As discussed in the last report, the addition of data collection reliability described above (which assesses whether data are recorded), along with IOA 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. Now the facility needs to establish specific IOA and data collection goals, and arrange to provide staff with performance feedback to achieve and maintain those goals. Because the systems necessary to track and increase data collection reliability, IOA, and treatment integrity (see K 11) require the cooperation of departments other than psychology (e.g., DCPs, unit directors) and require the development of new tools (e.g., tracking systems), it is suggested that the facility pilot the tracking of these behavioral systems in one or two homes. This will allow the facility to work out the logistical challenges, and better assess the additional resources that will be necessary to implement it across the all homes and day/vocational sites. LSSLC had also improved the graphing of target behaviors. The monitoring team found some evidence that data were graphed in increments necessary to ensure sufficient data based decision-making. For example: • Individual #380's physical aggression was graphed in hourly increments to better understand the effects time of the day had on his target behavior. • Individual #285's vomiting was graphed in daily increments to better understand the effects of various dietary changes on this behavior. Additionally, some of the graphs appeared more useful for making data based decisions. For example: • In Individual #507's psychiatric meeting, target behaviors were current (i.e., they represented the previous week's behavior) and graphed in such a way that the psychiatrist was able to make a data based decision concerning a change in Individual #507's medication. The monitoring team was encouraged by these examples and recommends that the facility routinely include the most relevant data in graphs, and ensures that these data are graphed in increments based on individual needs. In reviewing at least six months of PBSP data representing severe behavior problems (i.e., physical aggression and self-injurious behavior) for 13 individuals, three or 23% (Individual #511, Individual #102, and individual #90) indicated clear decreases in at least one severe behavior. This compares with the results from the last onsite review when 20% of the plans reviewed suggested improvements in dangerous behaviors.	

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		There was evidence that some PBSPs were modified, before the annual review, due to lack of progress (e.g., Individual #106, Individual #285). Clearly, the lack of treatment progress is not likely to be solely the result of an ineffective PBSP, however, the monitoring team does expect that the progress note or PBSP would indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred if an individual was not making expected progress. The monitoring team 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.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	This provision item was rated as being in noncompliance due to the absence of initial (full) psychological assessments for each individual, and the lack of comprehensiveness of many of the functional assessments. <u>Psychological Assessments</u> The director of psychology reported that approximately 50% of individuals at LSSLC had an initial (i.e., full) psychological assessment. Sixteen of the initial psychological assessments completed since the last review were reviewed. All (100%) initial psychological assessments reviewed were complete and included 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. This represented an improvement in the comprehensiveness of initial psychological assessments at LSSLC compared to the last review (April 2011) when 86% of the initial psychological assessments reviewed were complete. It is recommended, however, that all individuals at LSSLC have an initial psychological assessment. <u>Functional Assessments</u> A spreadsheet of all individuals with a PBSP provided to the monitoring team indicated that approximately 215 of the 372 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 65 functional assessments had been completed since the last review. Sixteen of those 65 functional assessments (25%) were reviewed to assess compliance with this provision item. 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. This format was revised just prior to the onsite review (9/13/11). As discussed below, the quality of some of these components, however, was insufficient for the functional assessments to be as effective as they could be.	Noncompliance

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		All functional assessments should include direct and indirect assessment procedures. A direct assessment procedure consists of direct and repeated 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. Indirect assessment procedures help to understand why a target behavior occurred by conducting/administrating questionnaires, interviews, or rating scales. All 16 of the functional assessments reviewed included appropriate indirect assessment procedures. Only one (i.e., Individual #380) of the functional assessments reviewed (6%) utilized direct assessment procedures that were rated as complete. This represented a slight decrease in the percentage of direct observations rated as complete in the last review (i.e., 13%). The complete direct assessment procedure is described below. • Individual #380's functional assessment included an analysis of time of the day and physical aggression to determine if the target behavior was more likely to occur at particular times of the day. This direct observation revealed that Individual #380's physical aggression was most likely to occur at shift change and when medications were presented. The other 15 functional assessments reviewed did not clearly include direct observations (e.g., Individual #39) or direct measures were incomplete. For example: • Individual #134, Individual #484, and Individual #457's direct assessment procedure consisted of direct observations, but did not provide any additional information about relevant antecedent or consequent events affecting the target behavior. Some of the functional assessments reviewed (e.g., Individual #90, Individual #317, Individual #126, Individual #345) provided potentially useful information for identifying variables affecting the target behavior, however, it was not clear that this information was based on direct observation and/or data. For example: • Individual #317's direct assessment procedure included specific antecedents (e.g., making a request to leave the home) and consequences (reduction of future demands) based on the psychologist's many direct observations of Individual #317's home. No documentation, however, of these antecedents and consequences was presented. • Individual #345's direct assessment procedures did not include an observation of the target behaviors and, therefore, did not provide any additional information about relevant antecedent or consequent events affecting her undesired behavior. In reading the entire functional assessment, however, the psychologist did articulate specific, and potentially useful, antecedents and consequences of Individual #345's physical aggression and self-injurious	

#	Provision	Assessment of Status	Compliance
		behavior (SIB). It was not apparent, however, that these hypotheses were based on direct observation. Direct and repeated observations of target behaviors in the natural environment are an important component of an effective functional assessment. All functional assessments should attempt to include direct functional assessments that include target behaviors and provide additional information about the antecedents and consequences affecting the target behavior. The accuracy and usefulness of these direct observations is greatly enhanced by recording the relevant antecedents, behaviors, and consequences as they occur. As discussed in the last report, one 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 need to be collected for a duration long enough to observe several examples of the of the target behavior, and sufficiently repeated so that patterns of antecedents and consequences could be identified. Recent modifications in the data collection system at LSSLC (discussed in K4) included regular ABC data collection, which is likely to substantially improve the collection of meaningful ABC data. Given these changes, the monitoring team is optimistic that direct assessment procedures will be substantially improved in the next onsite review. All of the functional assessments reviewed (100%) identified potential antecedents and consequences of the undesired behavior. As discussed above, however, it was not clear what types of assessments (or what data) these hypothesized antecedents and functions were based on. As discussed in the last report, 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 (i.e., direct and indirect assessments) into a comprehensive plan (i.e., a conclusion or summary statement) that will guide the development of the PBSP. Three functional assessments reviewed (19%) did not include a summary statement (i.e., Individual #39, Individual #126, and Individual #345). This represented an improvement from the last review when 50% of the functional assessments reviewed did not have a clear summary statement. The following represents an example of a good summary statement: • Individual #102's functional assessment included a summary statement that included a clear hypothesis that Individual #102's physical aggression was maintained by access to tangible items and escape from undesired activities. All functional assessments should include a summary statement that integrates the results of the various assessments into a comprehensive statement of the variables	

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		affecting the target behaviors. 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 (with a maximum of one year between reviews). One (Individual #380) of the sixteen functional assessments reviewed (6%) was evaluated to be comprehensive and clear. This represented a slight improvement over the last report when none of the functional assessments reviewed were evaluated as acceptable. Several functional assessments, however, contained excellent components that should be modeled for future reports. Those included: • Good comprehensive summary statements for Individual #102 and Individual #90. • Good description of potential antecedents and consequences affecting target behaviors for Individual #345 and Individual #90.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	The majority of LSSLC's initial (full) psychological assessments were not current and, therefore, this provision item was rated as being in noncompliance. Only one of the intellectual assessments contained in the 16 initial psychological assessments reviewed (6%) was conducted in the last five years. Psychological assessments (including assessments of intellectual ability) should be conducted at least every five years.	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.	In addition to the initial or full psychological assessment, an annual update should be completed each year. The purpose of the annual psychological assessment, or update, is to note/screen for changes in psychopathology, behavior, and adaptive skill functioning. Thus, the annual psychological assessment update should contain the elements identified in K5 and 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. Annual psychological assessments (updates) were completed for all of the individuals at LSSLC. The monitoring team reviewed 10 of the annual psychological assessments to assess their comprehensiveness. All 10 psychological updates (100%) contained a standardized assessment of intellectual and adaptive ability, a review of personal history, and a review of behavioral/psychiatric status, but did not include a review of medical	Noncompliance

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		status. In order to achieve compliance with this item of the Settlement Agreement, all psychological updates will need to contain all of the components described in K5. Finally, psychological assessments should be conducted within 30 days for newly admitted individuals. A review of the one admission to the facility in the last six months indicated that this component of this provision item continued to be in substantial compliance.	
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.	The director of psychology reported that no psychological services, other than PBSPs, were provided at LSSLC during the last six months. At the previous review (April 2011) the facility reported eight individuals receiving psychological services, however, this item was rated as being in noncompliance because there was no evidence provided that these services were goal directed with measureable objectives and treatment expectations. In order to receive substantial compliance with this item the facility will need to ensure the following when providing psychological services, other than PBSPs: • The need for psychological services other than PBSPs is documented in each participating individuals PSP or PBSP. • All psychological services other than PBSPs should contain the following: o A treatment plan that includes an initial analysis of problem or intervention target o Services that are goal directed with measurable objectives and treatment expectations o Services that reflect evidence-based practices o Services that include documentation and review of progress o A service plan that includes a "fail criteria"— that is, a criteria that will trigger review and revision of intervention o A service plan that includes procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings	Noncompliance
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	This item was rated as being in noncompliance because many of the interventions were not clearly based on functional assessment results. Ninety-seven PBSPs were written or revised since the last onsite review, and 19 of these (20%) were reviewed to evaluate substantial compliance with this provision item. All PBSPs reviewed contained the necessary consent and approvals. All of the necessary components of a PBSP were included in the PBSPs (or in the accompanying functional assessments) reviewed.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	All PBSPs reviewed included descriptions of target behaviors, and 18 of 19 (95%) of these were operational. This represented an improvement in operational definitions from the last review when 80% of PBSPs were rated as having operational definitions. The one PBSP reviewed rated as including definitions that were not operational is highlighted below: • Individual #484's PBSP defined disruptive behavior as "… talking about inappropriate subjects… obsessing on certain topics, making provocative comments…." This definition required the reader to infer if Individual #484 was indeed talking about inappropriate subjects, obsessing, or making provocative comments. An operational definition should not require DCPs to infer if something is inappropriate, provocative, or obsessive. An operational definition should only include specific, observable behavior (e.g., talking about other individual's behavior, repeating the same questions or comments three times in five minutes). All PBSPs should include operational definitions of target behaviors. All 19 of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors, but nine (i.e., Individual #102, Individual #424, Individual #317, Individual #39, Individual #457, Individual #330, Individual #506, Individual #166, and Individual #126) of these (47%) identified antecedents and/or consequences that did not appear to be consistent with the stated function of the behavior and, therefore, were not likely to be useful for weakening an undesired behavior. Examples of interventions not related to the hypothesized function were: • Individual #457's PBSP hypothesized that his physical aggression may have been maintained by negative reinforcement (i.e., a way to escape or avoid unpleasant activities). His antecedent procedures, however, included reducing demands if he was upset. If avoiding undesired activities was reinforcing for Individual #457, then this intervention would likely increase him being upset, which could increase the likelihood of physical aggression. On the other hand, encouraging him to escape and/or avoid (whenever practical) undesired activities by engaging in desired behaviors (e.g., asking for a break) would represent a more effective antecedent intervention. Ideally, after the aggression occurs, Individual #457 should not be allowed to escape the undesired activity until he appropriately requests it. If the nature of the aggression is such that it is dangerous to maintain him in the activity following aggression, however, then the PBSP should specify his return to the activity when he is calm, and again encourage him to escape or avoid the demand by using desired forms of communication. The point is that the PBSP should clearly state that staff should encourage Individual #457 to use desired forms of communication to tell us	

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		when he wants to terminate, or have a break from, an activity. Once the target behavior occurs, it may be necessary to remove the source (i.e., the undesired activity) for safety reasons. The PBSP, however, needs to clearly state that removal of the undesired activity should be avoided whenever possible, because it encourages future aggressive behavior. • Individual #424's PBSP hypothesized that her yelling, screaming, and slapping were primarily maintained by attention. The intervention following these behaviors, however, included problem solving with her which likely would require a considerable amount of staff attention. If her target behaviors were maintained by attention, this intervention would likely result in an increase in the undesired behavior. An alternative procedure, that would be more consistent with the hypothesized function, would be to attempt to redirect her, but minimize the attention until the undesired behaviors end (see example below). An example of a PBSP where both antecedent and consequent interventions appeared to be based on the hypothesized function of the targeted behavior and, therefore, were likely to result in the weakening of undesired behavior was: • Individual #511's PBSP hypothesized that his physical aggression and SIB functioned primarily to gain staff attention. Antecedent interventions included ensuring that Individual #511 was provided with preferred activities when staff could not provide attention, and providing "…ample attention when exhibiting appropriate behavior." His intervention following physical aggression included telling him to stop, but specified that staff should not provide more attention than necessary to ensure his and other's safety. 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. Replacement behaviors were included in all 19 PBSPs reviewed. Replacement behaviors should be functional (i.e., should represent desired behaviors that serve the same function as the undesired behavior) when possible. That is, when the reinforcer for the target behavior is identified and providing the reinforcer for alternative behavior is practical. The monitoring team found that 16 of 19 (84%) of the replacement behaviors that could be functional were functional. Nonfunctional replacement behaviors were found in Individual #166's, Individual #424, and Individual #457's PBSPs. This is consistent with the percentage of replacement behaviors judged to be functional in the last report. An example of a replacement behavior that was not functional included:	

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		• Individual #457's targeted behaviors were hypothesized to be maintained by negative reinforcement. His replacement behavior consisted of attending work and directed activities. These activities may represent important skills for Individual #457, however, it was not functionally equivalent to the proposed function of his target behaviors, that is, escaping or avoiding undesired activities. An example of a more functional replacement behavior would be to teach him an appropriate way to postpone or terminate an undesirable activity. If practical, this would represent a good example of a functionally equivalent replacement behavior because it would provide the same reinforcer (i.e., a way to escape non-preferred activities) as hypothesized to be maintaining his target behaviors. Approximately 50% of the functional replacement behaviors appeared to represent behaviors that staff needed to comply with, rather than skills the individual needed to acquire. For example • Individual #90's replacement behavior was to walk a few steps away to indicate to staff that she does not want to participate in a learning situation. In contrast, one example of a functional replacement behavior that appeared to require the acquisition of a new skill was: • Individual #345's replacement behavior consisted of teaching her to say "No" or refuse in other appropriate ways. It is recommended that replacement behaviors that require the acquisition of new behaviors include skill acquisition plans (SAPs) for training. Moreover, these plans should be included into the current methodology, data system (when appropriate), and schedule of implementation for other SAPs 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). Finally, although the majority of PBSPs reviewed included functional replacement behaviors (see specific details above), only Individual #90's plan included the reinforcing of the replacement behaviors in the PBSP. In other words, the majority of PBSPs reviewed specified a functional replacement behavior (such as appropriately engaging staff in conversations if the undesired behavior was maintained by staff attention), but did not indicate in the antecedent procedures that staff should reinforce the replacement behaviors (e.g., provide attention when the individual appropriately attempts to have a conversation). It is recommended that when functional replacement behaviors are determined to be practical and possible, that they be included in each PBSP.	

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		Overall, four (Individual #511, Individual #466, Individual #90, and Individual #285) of the 19 PBSPs reviewed (21%) 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. This represented an improvement over the last review when only 7% of the PBSPs reviewed were judged to be acceptable. The monitoring team was encouraged by the overall progress in the quality of PBSPs at LSSLC, and looks forward to continued improvements in this provision item.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	The monitoring team was encouraged that the collection of IOA measures were recently begun in some of the homes at LSSLC. In order to achieve substantial compliance with this provision item, however, a system to regularly assess and maintain minimum levels of accuracy of PBSP data across the entire facility will need to be implemented (See K4). Target behaviors were consistently graphed monthly at LSSLC. 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). Replacement behaviors were not, however, consistently graphed. All Individuals should have replacement/alternative behavior graphs (See K4). The graphs reviewed contained horizontal and vertical axes and labels, condition change lines and label, data points, and a data path. It is recommended that all graphs contain clear demarcation of changes in medication, health status, or other relevant events.	Noncompliance
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	Another area of improvement since the last review was the establishment of the collection of treatment integrity in some homes at LSSLC. This provision item was rated as being in noncompliance, however, because at the time of the onsite review, treatment integrity was not consistently collected and recorded across the entire facility. LSSLC continued to monitor the reading level of each PBSP to ensure that they were written so that DCPs could understand and implement them. This process will likely result in more practical and useful PBSPs that are more likely to be implemented with integrity by DCPs. The only way to ensure that PBSPs are implemented with integrity, however, is to regularly collect treatment integrity data. In order to achieve substantial compliance with this provision item, the integrity data should be tracked and reviewed regularly, and minimal acceptable integrity measures established and maintained. As discussed in the last report, these integrity data need to include direct observations of staff implementing PBSPs. The monitoring team looks	Noncompliance

#	Provision	Assessment of Status	Compliance
		forward to reviewing integrity data during the next onsite review.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	As reported in the previous review, 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. Additionally, the facility added a competency based staff-training component. Although improving, more work in this area is needed to achieve substantial compliance with this item. The facility recently began retraining staff on data collection and the implementation of PBSPs. Unfortunately, none of those trainings were scheduled during the onsite review. The monitoring team will observe and comment on the strengths and weaknesses of the current training procedures during subsequent onsite reviews. 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 meet the requirements of this provision item, the facility will need to present documentation that every staff assigned to work with an individual has been trained in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter. 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.	Noncompliance
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	This provision item specifies that the facility must maintain an average of one BCBA to every 30 individuals, and one psychology assistant for every two BCBAs. At the time of the onsite review, LSSLC had a census of 372 individuals and employed 13 psychologists responsible for writing PBSPs. Additionally, the facility employed seven psychology assistants. In order to achieve compliance with this provision item, the facility must have at least 13 psychologists with BCBAs.	Noncompliance

Recommendations:

1. Ensure that all psychologists who are writing Positive Behavior Support Plans (PBSPs) attain BCBA certification (K1).

2. Ensure that data collection reliability data for all target behaviors is consistently collected in each home and day/vocational site (K4).

3. Extend the collection of replacement behaviors to all residential homes and day programs (K4).

4. Replacement behaviors should be graphed (K4).

5. Establish specific IOA and data collection goals, and arrange to provide staff with performance feedback to achieve and maintain those goals (K4).

6. Data should be routinely graphed in increments that allow data-based treatment decisions (K4).

7. PBSP progress notes should indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred if an individual was not making expected progress (K4).

8. All Individuals should have an initial (full) psychological assessment (K5).

9. All functional assessments should include direct functional assessments that include target behaviors and provide additional information about the antecedents and consequences affecting the target behavior (K5).

10. 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 (K5).

11. 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 (with a maximum of one year between reviews) (K5).

12. Psychological assessments (including assessments of intellectual ability) should be conducted at least every five years (K6).

13. Ensure that all psychological updates contain all of the necessary components (K7).

14. The need for psychological services other than PBSPs should be documented in each participating individuals PSP or PBSP (K8).

15. All psychological services other than PBSPs should contain the following (K8):
    - 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

16. All PBSPs should include operational definitions of target behaviors (K9)

17. 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 (K9)

18. It is recommended that replacement behaviors that require the acquisition of new behaviors include specific program objective (SPO) plans for training (K9)

19. When functional replacement behaviors are determined to be practical and possible, they should be included in each PBSP (K9)

20. It is recommended that all graphs contain clear demarcation of changes in medication, health status, or other relevant events (K10)

21. The treatment integrity system should be expanded to all homes, data regularly tracked, and minimal acceptable integrity scores established (K11).

22. The facility needs to provide 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. This training should include a competency-based component. 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 (K12).

23. It is suggested that the facility pilot the tracking of the recently developed behavioral systems (i.e., data collection reliability, IOA, and treatment integrity) in one or two homes, prior to attempting to implement them across the entire facility (K4, K11).

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009: Medical Care, 2/16/11 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 #044.2: Emergency Response, 9/7/11 o DADS Policy #003: Quality Enhancement, 11/13/09 o LSSLC POI for Section L o LSSLC Organizational Charts o LSSLC Medical Services Policy, 8/11 o LSSLC Policy and Procedure Manual, Seizure Management .411, Rev 4/8/11 o Listing, Individuals with seizure disorder o Listing, Individuals with pneumonia o Listing, Individuals with a diagnosis of osteopenia and osteoporosis o Listing, Individuals over age 50 with dates of last colonoscopy o Listing, Females over age 40 with dates of last mammogram o Listing, Females over age 18 with dates of last cervical cancer screening o Listing, Individuals with DNR Orders o Listing, Individuals hospitalized and sent to emergency department o Report of external medical reviews conducted in 2/11, 5/11 and 8/11 o Medical caseload data o Presentation Book for Section L o Physician POI Meeting, 9/6/11 o Clinician Meeting Notes, 9/7/11 o Physician-Director Meeting Notes, 8/4/11 o Integrated Clinical Services Morning Meeting Notes 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, quarterly medical summaries, 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 #252, Individual #468, Individual #492, Individual #273, Individual #507, Individual #538, Individual #524, Individual #249, Individual #552, Individual #321, Individual #353, Individual #39, Individual #449 o Neurology Notes for:

	o Individual #545, Individual #310, Individual #77, Individual #306, Individual #114, Individual #423, Individual #170 Interviews and Meetings Held: o Brian T. Carlin, MD, Medical Director o Dickerson Odero, MD, Primary Care Physician o Ronald G. Corley, MD, Primary Care Physician o Nelda Johnson, APRN, Family Nurse Practitioner o Vasantha Orocofsky, MD, Psychiatry Director o Mary Bowers, RN, Chief Nursing Executive o Gena Hanner, RN, QA Nurse o Kathleen Lockhart, Administrative Assistant Observations Conducted: o Daily Clinical Services Meeting o PSP o PSPA o Risk Discussion with PST for Individual #560 o Meeting with medical director, chief nurse executive, QA nurse
	Facility Self-Assessment: The facility updated the POI on 10/17/11 and self-determined that it was in compliance with Provision L2 and noncompliant with provisions L1, L3, and L4. An action plan was also included in the POI. It contained nine action steps that addressed provision items L1, L2, and L3. Actions related to achieving substantial compliance with the facility medical review system, updating of the APL, increasing neurology services, tracking preventive services were listed as complete. Actions related to tracking refractory seizure activity were listed as ongoing. Self–assessment of compliance will require that the facility engage in a number of activities and utilize information and data from multiple sources. Although the POI provided very little information related to the self-assessment, multiple data streams were available that had the potential to provide some objective assessment of compliance status. The monitoring team rated the facility in noncompliance with all four provision items based on issues related to the provision of preventive and routine services, inadequate follow-up of abnormal studies, a lack of reviews that assessed clinical outcomes, a lack of a formal medical quality program and the absence of clinical guidelines.

	Summary of Monitor's Assessment: The medical department had significant staffing changes with the retirement of a long-term primary provider. There was evidence that basic health care services were provided as individuals received the appropriate immunizations and basic preventive services. Completion of other screenings appeared more problematic. There was some increase in neurology hours provided through off site services. The on-campus clinic remained limited to two hours. Overall, the medical staff responded to the needs of the individuals, but there were lapses noted in follow-up of acute issues as well as chronic issues. There were numerous instances in which clinic follow-ups did not occur as needed as well. External reviews were completed and corrective actions implemented. All of the efforts targeted processes as the review included no clinical outcome indicators. The third audit showed no significant improvement in overall compliance rates. Compliance in the essential elements was consistently far below the required 100%. With one exception, most primary providers failed to fully correct problems that were amenable to correction. Mortality reviews were completed by the facility. During a meeting with the chief nurse executive, QA nurse, and medical director, it was quite evident that there was conflict among the participants of the clinical review committee relative to the effectiveness of the process. What was evident to the monitoring team was that there was no objective physician review of the cases to address the standards of medical care provided to the individual. For example, the monitoring team's review of one case noted events that were not noted in any of the documents provided to the monitoring team (Individual #552). There was no development of a medical quality program and efforts initiated six months earlier appeared to have been abandoned as there was no continuation or follow-up related to the issues. No clinical guidelines were developed. The medical director presented a series of flowcharts related to several medical issues. Several of the medical staff were not familiar with these and the information was not tied to any policy, procedure, or methodology. Based on these findings, the monitoring team found the facility in noncompliance with all provision items.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with	The process of determining compliance with this provision item included reviews of records, documents, facility reported data, staff interviews, and observations. Records were selected from the various listings included in the documents reviewed section. Moreover, the facility's census was utilized for random selection of additional records. The findings of the monitoring team are organized in sub-sections based on the various requirements of the Settlement Agreement and as specified in the Health Care Guidelines.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	**Overview** The medical staff was comprised of two primary care physicians, a medical director, and one advanced practice registered nurse. The medical director maintained a caseload of 94. Primary physicians maintained caseloads of 156 and 43. The APRN's caseload was 83. One full time and three part-time psychiatrists provided psychiatric services. 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 events occurring since the close of business and lasted approximately 30 minutes. It was immediately followed by rounds in the infirmary. The provisions for providing acute care services remained in place as informal agreements with local practitioners continued. Individuals were transferred to local hospitals in Lufkin for evaluation and/or admission. 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. Neurology clinic was conducted each month for two hours. The clinic was held onsite, which allowed participation by the director of psychiatry. An onsite ENT clinic was also conducted monthly. Labs were drawn at the facility and sent to Austin State 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. **General Medical Care and Documentation** Individuals were provided a wide array of preventive, routine, and specialty services. Acute care services were provided at several local facilities. The medical staff responded to the needs of the individuals. Notwithstanding these efforts, there were significant issues identified with the provision of care that had the ability to negatively impact health outcomes. Gaps were noted in the provision of some preventive services, follow-up of chronic issues, and abnormal diagnostics. Several of the requirements of the Health Care Guidelines are discussed below. Examples of findings related to the requirements are provided in the case reviews documented later in this section.	

#	Provision	Assessment of Status	Compliance
		Annual Medical Assessments Current annual medical summaries were found in all but one of the records included in the sample. The quality of the summaries varied among the medical staff. Interval histories were not detailed. Immunizations were listed as "up to date" even when there was no documentation that all were current. Almost all providers failed to provide a concise summary of the active problems with a corresponding plan of care. When considering the format of the Annual Medical Summary, a few key issues should be addressed: • Interval history- Inserting an interval history (what has occurred since the last annual assessment) provides one way of linking all relevant information. Discussion of an individual's interval health history should be organized by active health problems with information presented chronologically. o All history – illnesses and other events, diagnostic tests, surgeries, interventions, consultations, medication trials, etc. – should be documented in the discussion of each active health problem. Health issues that are related to each other (e.g., dysphagia, aspiration, pneumonia) should be discussed together. • Immunizations should be noted in the assessment. • Preventive care requirements and screenings, including vision and hearing, should be documented and include dates. • The active problems should be listed along with a plan of care that addresses each problem. The reader should be provided adequate information on overall management. The Quarterly Medical Summary would provide the interval update. Active Problem List The Active Problem Lists were noted in the records. It appeared that many were updated at the time the annual medical assessment was completed. The documents were not consistently up dated as problems changed. Integrated Progress Notes Medical providers documented in the integrated progress notes. The notes were usually timed, dated, and signed. One provider generated typewritten notes. The others produced hand written notes. Illegibility of notes was a problem for some providers. It was good to see that the SOAP format was used more consistently. Nonetheless, many SOAP notes were too brief and did not contain the components required by the Health Care Guidelines. The frequency of documentation of acute issues had increased, however, the notes often	

#	Provision	Assessment of Status	Compliance
		lacked the positive and negative findings required by the Health Care Guidelines. Pre-hospital transfer notes were frequently missing. Post-transfer notes were found more consistently. <u>Documentation of Diagnostic and Laboratory Results</u> There was improvement noted in documentation of results and consultations, but the requirement was not consistently executed. <u>Quarterly Medical Summaries</u> The medical staff did not complete quarterly medical summaries. <u>Physician Orders</u> Physician orders were usually signed, timed, and dated. Several were noted to be incomplete. A major problem with orders was legibility. <u>Consultation Referrals</u> Consultation referrals frequently lacked key information from the primary provider. As mentioned in previous reports, the date of the request was the same date as the date of the actual consult. There was no way to determine if the consults occurred in a timely manner. **Routine and Preventive Care** Routine and preventive services were available to all individuals supported by the facility. Vision and hearing screenings were provided with high rates of compliance. The core vaccinations were usually provided to individuals. Other preventive services and immunizations were provided, but consistency was not always evident. <u>Immunizations</u> • 10 of 10 (100%) individuals received pneumococcal and yearly influenza vaccinations It was difficult to identify administration of some vaccinations, such as hepatitis B, varicella, and Zoster. The annual medical summaries typically stated that vaccinations were "up to date." This was noted even in instances when Hepatitis B was not proven or antibodies were not present. It would be helpful to include a vaccination section in the annual medical summary that could be updated yearly.	

#	Provision	Assessment of Status	Compliance
		Screenings • 10 of 10 (100%) records contained documentation of appropriate vision screening • 9 of 10 (90%) records contained documentation of appropriate hearing testing The preventive care flowsheets did not always contain the most recent screenings. Locating this information required extensive searching in the records. Documenting this information in the preventive care section of the annual medical summary would improve the overall quality of the documents. Prostate Cancer Screening • 4 of 5 males met criteria for PSA testing • 4 of 4 (100%) males had appropriate PSA testing Breast Cancer Screening • 5 of 5 females met criteria for breast cancer screening • 3 of 5 (60%) females had current breast cancer screenings A list of females age 40 and older, date of last mammogram, and reasons for noncompliance was provided. The list contained 119 individuals. • 60 of 119 (50%) individuals had current breast cancer screenings • 59 of 119 (50%) individuals did not have current screenings o 38 of 59 (64%) individuals were within the past two years o 16 of 59 (27%) individuals were not able to complete exams o 5 of 59 (9%) individuals had no reason for not completing screenings Cervical Cancer Screening • 5 of 5 females met criteria for cervical cancer screening • 0 of 5 (0%) females completed cervical cancer screening within the past year A list of all females age 18 and older was provided. The list contained 155 individuals and dates of last pap smears. The ages of each individual and risk classifications were not listed. • 12 of 155 (8%) females had documentation of cervical cancer screening • 143 of 155 (92%) had no documentation of cervical cancer screening with the following explanations o 31 of 143 (22%) unable to do o 30 of 143 (21%) hymen intact o 26 of 143 (18%) hysterectomy o 17 of 143 (12%) deferred by PCP or gynecologist	

#	Provision	Assessment of Status	Compliance
		o 14 of 143 (10%) unable to do due to condition o 10 of 143 (7%) unknown o 8 of 143 (6%) post menopausal o 5 of 143 (3%) deferred due to age o 2 of 143 (1%) other <u>Colorectal Cancer Screening</u> • 6 of 10 individuals met criteria for colorectal cancer screening • 5 of 6 (83%) individuals had undergone colonoscopy for colorectal cancer screening A list of individuals, age 50 and older, was provided. The list contained 192 individuals. • 174 of 192 (90%) of individuals had completed colonoscopies • 18 of 92 (10%) of individuals had not completed a colonoscopy o 1 individual had a colonoscopy 11 years ago o 2 individuals had documented colostomies <u>Additional Discussion</u> The facility recently updated the preventive care flowsheet. Many of the guidelines in the flowsheet were not consistent with the state issued Health Care Guidelines and local policy. The following are examples of deviations from local medical policy: • Medical policy required that The American College of Obstetrics and Gynecology's (ACOG) guidelines be used for cervical cancer screening. The preventive care flow sheet indicated that pap smears would be "q 1 year x 3 then as per gynecologist (for non-virgins)." According to the ACOG guidelines, adopted in medical policy, pap smears were to be completed as follows: o Start at age 21 (regardless of age of first intercourse) o Age 21-29 → screen every 2 years o Age 30 + → screen every 3 years if… ▪ Negative cytology x3 previous Paps ▪ NIELM and negative High Risk HPV test in 1 year ▪ No history of high grade lesions o Annual screening if… ▪ Immunocompromised (e.g., HIV, transplant patients) ▪ History of CIN II, III or cancer ▪ Exposure to DES in utero o Stop screening at 65 or 70 years if … ▪ 3 prior consecutive normal Paps ▪ No history of abnormal screening in last 10 years	

#	Provision	Assessment of Status	Compliance
		o Stop screening if hysterectomy for benign disease with no history of abnormal pap smears • The Health Care Guidelines stated indicated that mammograms were to be completed per guidelines of the American Cancer Society. The PCFS recommended a baseline mammography age 35-39, q 2 years age 40 – 49, q 1-year age 50>. ACS guidelines recommended: o Yearly mammograms starting at age 40 continuing for as long as a woman is in good health o Clinical breast exam about every 3 years for women in the 20s and 30s and every year for women 40 and over. The monitoring team recommends that the medical director review the entire preventive care follow sheet for accuracy and consistency with the adopted guidelines. It is also suggested that the medical director revise the flow sheet to provide additional guidance to the medical staff. **Medical Management** <u>Osteoporosis</u> A list of all individuals with a diagnosis of osteoporosis and osteopenia, medication regimens, and the date of the last DEXA scan was requested. The monitoring team was provided with a list of individuals with the diagnosis of osteoporosis and the date of the last DEXA. Information related to treatment was not provided. <u>Constipation</u> A list of individuals with the diagnosis of constipation was provided. The medications used for treatment were included. <u>Pneumonia</u> Documents provided indicated that from August 2010 through September 2011, there were 43 individuals diagnosed with pneumonia and 66 incidents of pneumonia reported. Two individuals were diagnosed with pneumonia six times and three were diagnosed three times. There were seven individuals that were reported to have two episodes of pneumonia.	

#	Provision	Assessment of Status	Compliance
		Case Reviews Individual #507 had profound mental retardation, hypertension, and bipolar disorder. Observations noted related to care included: • The core vaccinations were up to date • The active problem list and preventive are flowsheet were not updated. • Vision and hearing screening were appropriately completed. • Serial DEXA scans were done. • Mammography was completed, but cervical cancer screening was not done. • Colonoscopy was completed in 2005. • Neurology appointments were not scheduled as required. The appointment on 3/8/09 requested follow-up in three months. The appointment was completed in April 2010. • An eye consult completed on 4/15/11 was received on 10/19/11. The previous appointment on 1/10/09 recommended follow-up in one year. Individual #273 had the diagnoses of seizure disorder, constipation, osteopenia, and hyperlipidemia: • Immunizations were appropriately provided. • Vision screening was documented. The hearing screening was not in the record, but was documented to have occurred in 2007. • The DEXA done in 2007 showed osteopenia. There was no follow-up, although the individual was treated with alendronate. Osteopenia was not listed • Mammography was completed in 2008 and reported documented "due 2010." There was no follow-up in the record, though the facility later reported that follow-up occurred in November 2010. • Cervical cancer screening was not completed due to "condition." • Vitamin D level was 27 on 10/6/11 and was signed on 10/13/11. There was no IPN note for this abnormal value. • The last neurology consult was in 2002. The individual received two AEDs. • The annual medical summary did not provide date of last seizure activity. It did state that there was no seizure activity since the last annual assessment. • On 10/31/11, nursing documented that the individual fell and sustained scrapes to thigh with broken skin and abrasions at the elbow. There was no MD notification and no further assessment or follow-up.	

#	Provision	Assessment of Status	Compliance
		Individual #552 had multiple medical problems. Observations noted related to care included: • Vaccinations, vision and hearing screenings were appropriately provided. • The active problem list was not updated. • Mammography was up to date. • There was no cervical caner screening done. • There were issues related to follow-up of medical problems. On 4/18/11, a physician order was written to obtain several labs and a cervical spine series due to a diagnosis of neck pain. The labs were completed, but the individual did not cooperate for x-rays that were attempted on 4/22/11. There was no documentation of follow-up by the medical staff of the neck pain. The individual was seen in neurology clinic on 4/27/11 due to the complaint of neck stiffness and gait abnormalities. The neurologist did not note any problems at that time. Several hours later, the individual was reported to have fallen in the shower and was transported to a local medical facility. A diagnosis of a C2 fracture was made. The individual required ventilatory support. An additional review was conducted by the DADS medical coordinator regarding this case. The monitoring team appreciated this additional information. **Seizure Management** The facility conducted onsite neurology clinics. The psychiatry director attended neurology clinic. Notes were generated for all individuals seen, indicating review and collaboration. A request was made for a list of individuals with a diagnosis of seizure disorder, seizure classification, and medication regimens. The facility provided a listing of individuals that included the home number and type of seizure. A separate pharmacy report was provided on "Anticonvulsant Medications by Patient." This 53-page document contained individuals that received AEDs for seizure disorder as well as other diagnoses. It appeared that in, some instances, medications used to treat other diagnoses were counted in the AED data. The facility data for AED polypharmacy was calculated based on these data and the facility's census served as the denominator. As noted in previous reports, the use of the total census in calculating polypharmacy significantly lowered the rate of reported polypharmacy. This was discussed with the medical director who indicated that much of the data calculations were done by administrative support. An additional listing was provided after the onsite review. This document contained the names of 191 individuals with a diagnosis of seizure disorder and the medications used for management of seizure disorder. With regards to drug use:	

#	Provision	Assessment of Status	Compliance

		• 17 of 191 (9%) individuals received 0 AEDs
		• 174 of 191 (91%) individuals received AEDs
		  o 67 of 174 (39%) individuals received 1 AED
		  o 63 of 174 (37%) individuals received 2 AEDs
		  o 31 of 174 (17%) individuals received 3 AEDs
		  o 6 of 174 (3%) individuals received 4 AEDs
		  o 5 of 174 (3%) of individuals received 5 AEDs
		
		The medical director reported that clinic was conducted once a month for two hours. Copies of the clinic schedule were provided to the monitoring team. There were six onsite clinics held from May 2011 through September 2011. Appointment times for each clinic ranged from 10:30 am to 12:00 pm. Approximately 17 to 20 individuals were seen during these clinics.
		
		Overall care appeared appropriate, but several issues related to the provision of neurology services were noted:
		• There were numerous delays of three to four months in follow-up appointments.
		• The clinic notes were brief and lacked key information related to seizure management, such as the number of seizures, date of last seizure, drug side effects, information from side effect evaluation tools, and lab results.
		• Recommendations were vague. Clinic note for Individual #310 stated that a B12 could not be found and "could be done at some time."
		• Information contained in the side effect evaluation tools was not included in clinic notes.
		
		The Health Care Guidelines provided a comprehensive set of guidelines related to seizure management. The facility should develop a local policy based on these guidelines. In order to provide additional guidance to the medical staff, information on osteoporosis prophylaxis, and laboratory monitoring could be included. The MOSES evaluation should also be considered a part of the transfer packet for neurology clinic appointments.
		
		<u>Additional Discussion</u>
		Data calculations were completed by administrative support and results were not analyzed by the medical director. This was congruent with the monitoring team's findings that data were not appropriately or consistently used for the purpose of improving medical quality.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>L2</td><td>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.</td><td>Medical Reviews
A total of three external reviews were completed. Each review was conducted by a team of primary care providers from other SSLCs. During the conduct of each review, a five percent sample of records was examined for compliance with 32 requirements of the Health Care Guidelines. The requirements were divided into essential and nonessential elements. In order to obtain an acceptable rating, essential items were required, in addition to receiving a score of 80% on nonessential items. Findings of the audits were shared with the medical providers during the physician's monthly POI meeting. According to the POI, an exit meeting was conducted at the end of the third audit to share the findings with the PCPs and other facility leadership.

Composite compliance rates were based on the average of rates for all providers. Results of the three audits are presented in the table below.

<table>
<tr><td colspan="4">External Medical Reviews
% Compliance</td></tr>
<tr><td></td><td>Dates of Review</td><td>Essential</td><td>Non-Essential</td></tr>
<tr><td>Round 1</td><td>2/23–25/11</td><td>69</td><td>79</td></tr>
<tr><td>Round 2</td><td>5/9-11/11</td><td>82</td><td>86</td></tr>
<tr><td>Round 3</td><td>8/23–25/11</td><td>68</td><td>78</td></tr>
</table>
There were marked variations in the compliance rates for individual providers. The results of the third audit revealed no significant improvement in aggregate data.

The QA department generated provider-specific and facility aggregate data. The medical director shared this information with the providers. Corrective action plans were generated and followed-up by the QA nurse. Follow-up audits for the third review noted:
• 1 of 5 (20%) providers corrected all deficiencies
• 1 of 5 (20%) providers corrected none of the documented deficiencies
• 3 of 5 (60%) providers corrected some of the documented deficiencies

This provision item addresses the issue of completing a review that results in an assessment of the quality of medical care and provides data for use in implementing corrective actions. Assessing the quality of care requires that processes and outcomes be evaluated. In its current format, the review excluded outcome indicators. In order to achieve compliance with this provision item, the facility will need to add components to the review that address targeted clinical outcomes. Selecting clinical outcome indicators based on the state-issued clinical guidelines would be an appropriate starting point, since these are the high priority issues targeted by the state.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		<u>Mortality Reviews</u> There were six deaths since the last onsite review. The facility followed state policy regarding completion of clinical death and administrative death reviews. The majority of the reviews resulted in no recommendations. In some instances systemic issues were identified and corrective action plans were implemented. Even so, the monitoring team identified the following concerns regarding the mortality review process: • The process for completing the nursing review was changed such that reviews were no longer completed within the QA department. • There was no comprehensive physician review. • The external physician reviewer, designated to participate in the clinical death review, did not review the actual records and did not participate in the actual scan call. The external reviewer discussed findings with the medical director who then presented the information during the clinical death review meeting. The facility should ensure that for each death review there is a physician review that determines if the medical care provided meets an acceptable standard. Specific issues and systemic issues related to care should be identified and discussed during the clinical death reviews. Corrective action plans should be developed as warranted.	
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 monitoring team noted some degree of regression in this area. During the April 2011 visit, the medical director presented a series of documents related to quality efforts in areas such as diabetes management and osteoporosis. Based on data collected, corrective actions were implemented. During this onsite review, data related to breast, cervical, and prostate cancer screening were provided. Performance improvement data on diabetes and osteoporosis were also presented to the monitoring team. The last two documents were duplicates of those provided in April 2011 and contained no updated information or status reports. The medical director indicated that the data were provided by administrative support and he was not aware that the same documents were submitted. Moreover, it was reported that no additional data were collected to determine if corrective actions implemented six months ago were effective. Notwithstanding the absence of a formal quality program, there were many opportunities to assess the quality of medical services. Data were collected related to pneumonia, seizure disorder, and hospitalizations. Preventive services data were also collected. There was no indication that the information was used to improve quality.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Moreover, the facility will need to ensure that staff receives the appropriate training in data management and that more attention is given to collecting and reporting data accurately. In numerous instances, there was evidence of a lack of attention to data management. Notwithstanding evidence presented in previous monitoring reports related to inaccurate seizure management quality data, there was no correction of the errors and the same incorrect methodology was utilized to calculate AED polypharmacy. Corrective actions should be driven by the findings of data analysis. The use of inaccurate data will limit the effectiveness of any quality program.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The department implemented the local medical services policy in March 2011. The medical department had not drafted any clinical guidelines since the last review. The medical director reported that state office had not issued any approved clinical guidelines. The medical director provided a series of flow charts that he stated had been used for many years. Flowcharts for skin lesions, infections, elevated liver enzymes, and other conditions were provided. The origin of the content of the flowcharts was not clear in several instances, the information had not been updated in more than 10 years. The documents were often incomplete and referred the reader to a second page which was not provided. Most contained no heading or title and if was difficult to determine under what circumstances these were to be used. This series of flowcharts was not attached to any policy or operational procedure. Moreover, there were no clinical guidelines for the most common problems affecting those with developmental disabilities, such as aspiration, aspiration pneumonia, bowel management, and seizure disorder. All three of these conditions were common to those individual supported by the facility. All of there conditions were associated with significant morbidity and mortality and were noted to be problematic for several individuals at the facility.	Noncompliance

Recommendations:

1. The facility should take steps to ensure that the caseloads of medical providers are reasonable given the medical complexity of the individuals. Ideally, the medical director should not have the primary responsibility for provision of care. If the medical director must serve as a primary provider, the facility should consider that the caseload be limited to 30 individuals or less (L1).

2. The format of the Annual Medical Summary should be revised. Consideration should be given to the items outlined in Section L1 (L1).

3. The medical director should discuss the requirements for documentation in the APL with all providers. The Health Care Guidelines required that the APL be updated as problems changed (L1).

4. IPNs: The medical director should emphasize the importance of legibility with all providers (L1).

5. The medical staff should draft a template for the quarterly medical summaries (L1).

6. Consults should contain the information necessary for the consultant to answer the question that is being asked. The date of request of the consult should be the date that it is ordered or requested by the primary care physician and not the date that the consult occurs (L1).

7. The medical director should ensure that the preventive care flow sheet contains guidelines consistent with the Health Care Guidelines and local medical policy (L1).

8. The facility is in need of numerous guidelines for clinical management including osteoporosis, diabetes mellitus, pneumonia, and seizure management (L1, L4).

9. The preventive care database should be updated on a regular basis and the information should be reviewed by the medical director and medial staff. Feedback should be provided to the medical staff on performance (L1).

10. The medical director should work with consulting neurologists to ensure that clinic notes contain key data related to seizure management. Recommendations for additional testing and medication management should be specific as should timelines for follow-up appointments (L1).

11. The facility should determine why individuals are not receiving follow-up in neurology clinic in a timely manner (L1).

12. The facility should increase the number of neurology clinic hours as no changes were noted from the previous visit. This should preferably occur on campus, but increased community visits would be acceptable (L1).

13. The medical director should ensure that the AED polypharmacy data are corrected. That data should be analyzed, trended ad corrective action taken if warranted (L1).

14. The MOSES evaluation tool should be included in transfer packet (L1).

15. The external medical audit tool should be revised to include a mix of process and outcome indicators (L2).

16. The current mortality review system should be reviewed (L2):
    a. The facility director should assess the team dynamics of the clinical review committee and take appropriate corrective action if warranted.
    b. A comprehensive physician review is needed. This should include a review of the actual integrated records and all other relevant documents. The external physician should formalize the findings of the review and present that information to the entire CDR Committee and not just the medical director.

c. If a comprehensive review cannot be completed by the external community physician, the medical director or a physician from a sister SSLC should assume this role.
d. The nursing review should be completed within the QA department and not nursing management.

17. Address the issues listed in the case reviews, and determine if these are system-wide issues or if they are only specific to that individual (L1).

18. Creation and implementation of a thorough medical quality improvement program; consider inclusion of the data already being collected by the medical department (L3).

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:** Documents Reviewed: o Active Record Order and Guidelines o Map of facility o An organizational chart, including titles and names of staff currently holding management positions. o New staff orientation agenda o For the Nursing Department, the number of budgeted positions, staff, unfilled positions, current FTEs, and staff to individual ratio o LSSLC Nursing Services Policies & Procedures o LSSLC POI o Alphabetical list of individuals with current PSP, annual nursing assessment, and quarterly nursing assessment (due) dates o Nursing staffing reports for the last six months o The last six months, list of all individuals admitted to the Infirmary, length of stay, and diagnosis o The last six months, minutes from the following meetings: Infection Control, Environmental/Safety Committee, Specialty Nurses Meeting, Nurse Manager Meeting, Pharmacy and Therapeutics, Medication Error Committee Meeting, o The last six months infection control reports, quality assurance/enhancement reports o List of staff members and their certification in first aid, CPR, BLS, ACLS o Training curriculum for emergency procedures o The last six months, all code blue/emergency drill reports, including recommendations and/or corrective action plans o Emergency Drill Checklists 10/1/11-10/31/11 o Infection control monitoring tools o Policies/procedures addressing infection control o Weekly Walk-Thru Monitoring reports by Infection Control Nurse, 10/1/11-10/31/11 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 o List of individuals and weights with BMI > 30 o List of individuals with weights with BMI < 20 o Resident list for HST and Skin Integrity meetings o Pressure Ulcer Prevention, Treatment, and Management Policy and Procedure o List of individuals on modified diets/thickened liquids o Documentation of annual consideration of resuming oral intake for individuals receiving enteral nutrition o 24-Hour Nursing Logs for 10/15/11-10/31/11 o Last six months peer reviews for Nursing Department

	o Last six months mortality reviews for individuals who died o Nursing Education Calendar for September and October 2011 o Curriculum of 0200 Clinical Indicators Course/Training o Policy regarding training/education to contract/agency nurses during orientation and annual refresher training o For the last five individuals who transitioned to the community, their completed nursing discharge summary o Records of: • Individual #267, Individual #494, Individual #368, Individual #97, Individual #321, Individual #232, Individual #518, Individual #361, Individual #419, Individual #271, Individual #345, Individual #463, Individual #102, Individual #507, Individual #502, Individual #100, Individual #570, Individual #265, Individual #310, Individual #385, Individual #285, and Individual #298 <u>Interviews and Meetings Held</u>: o Chief Nurse Executive, Mary Bowers o Nursing Operations Officer, Laura Flowers o Infection Control Nurse, Bobbi Duke o Quality Assurance Nurse, Gena Hanner o Hospital Liaison, Maria Jenkins o Nurse Educator, Zalinda Colston o Nurse Compliance Coordinator, Gerald Davis o Nurse Recruiter, Elizabeth Moody o Nurse Manager, Whiterock, Lyn Coleman o Director of Risk Management, Norma Crawford o Infirmary Nurse Manager, Paul Vann o Respiratory Therapist, Leah Jarvis <u>Observations Conducted</u>: o Medication Administration- 524, 549a, 557a, 559a, and 559b o PSPAs – 11/1/11, 11/2/11 o Infection Control Committee Meeting – 11/2/11 o Psychiatry Clinic – 11/1/11 o Medication Variance Committee Meeting – 10/31/11 o Nurse Managers Weekly Meeting – 11/3/11
	Facility Self-Assessment: LSSLC submitted its self-assessment, called the POI. It was updated on 10/17/11 and was separated into two sections. The first section consisted of lists of discrete events, usually trainings, monitoring activities, and policy revisions, in accordance with state directives that had occurred over the past year. It was left to the reader to assume what, if any, effect the event/activity had on promoting progress toward achievement

	of the provisions of the Settlement Agreement. The second section, however, referenced some specific actions that were expected to help the Nursing Department achieve the provisions of Section M of the Settlement Agreement. The action steps, which were targeted toward achieving compliance with Sections M1 and M6, were assigned a responsible person(s), time frames were allotted for completion, and evidence of compliance was specified. According to the Chief Nurse Executive and Center Lead for Section M, at the time of the updated POI, all but two of the action steps were designated as "completed," yet the facility's self-rating indicated that it was in noncompliance with all provisions of Section M. The monitoring team was in agreement with these self-ratings, and it was unclear why action steps, in addition to those completed, had been identified to address the facility's self-ratings of noncompliance. During the onsite review, the presentation book was not reviewed because it was reported that it contained no more information than what was already submitted vis a vis the monitoring team's document request and what was already reviewed by the monitoring team in preparation for the visit.
	Summary of Monitor's Assessment: LSSLC was making progress toward meeting many of the provisions of Section M and addressing the problems noted during the prior review. For example, in response to the prior review's finding of failure to ensure complete assessments in the presence of acute illness/injury, the Nurse Educator and nurse managers provided re-training to some nurses and initial training to all direct care staff members. Also, there was evidence that some of the problems noted regarding the development of nursing interventions to address individuals' needs associate with high risk or at-risk health conditions had improved. During the monitoring team's attendance at PSPAs, which were held to address the health needs of individuals, the nurses were knowledgeable of the individuals' immediate problems and relevant history, significantly contributed to the discussions, and were responsive with recommendations and interventions to meet the individuals needs. Also, there was evidence that the administration of medications continued to be closely monitored by supervisors and nurses. For the most part, nurses reported that they have accepted the various strategies that were recently implemented to improve the safety and accountability of this important aspect of health care. Notwithstanding these positive findings, there were problems noted during the review and areas where progress was delayed or not made since the prior review. For example, the prior review indicated that it was a top priority of the Nursing Department to improve nursing care. However, during the conduct of the review, there were a number of observations, which occurred in the presence of nurses, home managers, and other supervisory staff members, that indicated the need for much more work to be done in this area. For example, during unit-based observations, individuals who had plans in place to reduce their health risks related to aspiration, blood clots, and inactivity and immobility were not carried out. Thus,

	individuals were observed lying flat on their backs after meals, sitting/lying in the same positions for prolonged periods of time, and, for those individuals who had capacity to engage in moderate forms of physical and mental activity, not engaged. In addition, there were failures to provide individual with privacy and dignity during changes of their clothes and undergarments, nursing assessments, and when they engaged in self-stimulating behavior that most certainly required privacy. The prior review also indicated that another top priority of the Nursing Department was to improve the competence of the direct care staff members in the implementation of their various delegated health care duties. Thus, their lack of knowledge of the most basic health needs of individuals, even as they occurred in the setting of the infirmary, was striking. This problem was significantly more evident and pervasive on other units where the direct care staff members were unable to speak beyond whether or not the individual was a "check and change." During the review, it was consistently noted and observed that effective collaboration and coordination between the Nursing Department and other departments, such as Quality Assurance, Habilitation, and Psychology had not been achieved and needed improvement in order to meet the many and multidisciplinary needs of the individuals who reside at LSSLC.

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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.	Since the prior review, LSSLC had taken steps towards meeting this provision item. For example, according to the POI, LSSLC implemented the state's standardized policy for nursing documentation, and discussed and determined strategies for improving identification of health care problems, documentation of nursing assessments, and notification of physicians of health care problems. In addition, LSSLC's Nurse Compliance Coordinator, who had conducted focused reviews of individuals with vomiting as the prequel to their diagnosed pneumonias, provided Nurse Managers with information and suggestions for improvement of the identification, assessment, and documentation of plans to address these health problems. The facility also continued to utilize its previously established "Sick Call Log" and "Weekend 24-Hour Coverage Report" to track health care problems and the outcomes of assessments and results of follow-up interventions to help ensure that its nurses would consistently identify, document, report, and follow-up on individuals' emergent health care problems and changes in health status. A review of the Sick Call Log for the period of 10/1/11-11/2/11 revealed that on any given day anywhere from two to 53 individuals were listed on the log for various medical interventions, such as acute sick call, review sick call, signature, diet order, diagnostic, consultation, annual, orders, ACP, etc. A review of the Weekend 24-Hour Coverage Report for the period of 10/15/11-10/30/11 revealed that, over a weekend, the Campus RNs responded to the health problems of 15 to 30 individuals who resided on homes	Noncompliance

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		across the campus. The logs included information that pertained to the date that an assessment/follow-up was due, the reason for the assessment/follow-up, the results of the assessment/follow-up, the name of the nurse who "ensured completion of the assessment," and the status of the assessment/follow-up. It was clear from the review that the Campus RNs assessed and/or referred a number of individuals to sick call and/or to their case manager for follow-up. Although there were some problems noted in the documentation of the Weekend 24-Hour Coverage Report, it was evident that both the Sick Call Log and the Weekend 24-Hour Coverage Report were evidence of positive steps that LSSLC had taken to improve the timeliness of identification and reporting of significant changes in individuals' health. However, a rating of noncompliance was made because a review of a sample of individuals revealed that there were frequent and regular absences of performing complete assessments, implementing planned interventions, conducting appropriate follow-up, and keeping appropriate records to address the significant changes in individuals' health status and needs from identification to resolution. During the conduct of this onsite monitoring review, 22 individuals' homes were visited and 22 individuals' records were reviewed. The facility should be commended for maintaining well-organized records in a unified record-keeping system with active records and individual notebooks. Despite the facility's reported plan to comply with the state's initiative to implement uniformity of nursing documentation across its facilities, nurses' notes were usually in the DAP (Data, Assessment/Analysis, Plan) versus SOAP (Subjective and Objective (data), Analysis, and Plan) format. There were some nurses' notes that failed to adhere to any format, a number of occasions when errors and/or incorrect entries, especially date/time of entry, were written over and not properly designated as an erroneous or late entry. Also, there were several records where nurses and other clinical professionals documented progress notes out of chronological order and/or on the margins of the pages, versus starting at the top of another page of the IPNs, which resulted in illegible entries. The Nursing Department's POI referenced that several "training sessions" were conducted in an effort to improve the facility's nurses' documentation of progress notes, assessments, and care plans. The review of 22 individuals' records, however, revealed that most of the records included cryptic, uninformative, and incomplete assessments and evaluations of individuals' health needs and risks. For example: • Re: Individual #502's pain assessment and management – "I can't tell if [she] is actually in pain." • Re: Individual #507's fall assessment – "Kinda fell on knees and hands."	

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		• Re: Individual #368's assessment of cognitive status and functioning – "Had not significant decrease LOC [level of consciousness] today." • Re: Individual #100's assessment of her overall health status after she received word of her neck mass, weight gain, and increased falls – "Had a fairly decent quarter…" • Re: Individual #463's assessment of adaptive equipment – "Does not know wear have glasses (sic)." Across the sample individuals reviewed, direct care staff members were usually the first responders and reporters of health care problems. As noted in the prior reviews, the direct care staff members usually reported their concerns to the LVNs. Thus, there was heavy reliance upon the LVNs to promptly respond to the direct care staff member's report, review the individual and situation, and report their findings to RNs for assessment, monitoring, and referral to the physician and/or placing the individual on the "sick call" list. As evidenced by the Sick Call Logs and Weekend 24-Hour Coverage Reports, on a daily basis, there were indeed a number of individuals with health care problems that were reported to RNs/physicians. However, in order meet the provision of M1, in addition to reporting, there must also be evidence of adequate and appropriate assessment, intervention, and monitoring to ensure that identified changes in status were addressed. Across the sample records reviewed, breakdowns in this process continued to have both an actual and potential risk of negative outcomes for individuals. For example, on 9/15/11, Individual #265's direct care staff member reported to his nurse that he had "some redness to his coccyx area." According to the nurse's assessment, Individual #265, who had spastic quadriplegia, multiple contractures, and severely impaired mobility, definitely had redness, but had "no broken skin or open areas." Individual #265's nurse instructed the direct care staff member to apply a topical medication to the area every two hours. However, absent an adequate plan to address the change in Individual #265's skin integrity and risk of developing a pressure sore, within 24 hours, Individual #265 suffered skin breakdown, and, on 9/19/11 was noted to have a Stage II pressure sore on his coccyx. A review of 22 sample individuals' records showed that the facility failed to ensure that nurses were consistently documenting interventions to address individuals' health care problems and changes in health status, and appropriately recording follow-up to problems once identified. Examples from this sample indicated the seriousness of this problem at LSSLC:	

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		• On 9/9/11, at 12:00 am, Individual #419's nurse noted that she had rapid breathing. Individual #419's direct care staff member reported to her nurse that she breathes rapidly when her gastrostomy tube has migrated. Individual #419's nurse adjusted her gastrostomy tube and noted that he/she would "recheck later to see if tube migrated again." Several hours later, Individual #419's nurse found her moaning, in possible pain, and with rapid pulse and respirations. Individual #419's nurse administered Tylenol for "possible pain" and noted that he/she would "follow-up in one hour and report to 6-2." Less than one hour later, Individual #419's nurse noted that although she was "no longer moaning," she was "having periods of apnea." Notwithstanding these significant changes in Individual #419's health status, there was no evidence that the nurse notified Individual #419's physician. Over four hours later, during Individual #419's physician's regularly scheduled sick call hours, she was evaluated and emergently transferred to the hospital. • During the period of 7/1/11-10/30/11, Individual #100 suffered many significant health changes, which included falls, vomiting, alteration in skin integrity, and hyperthermia. Despite the significant changes in Individual #100's health, on most of these occasions, there was no evidence that these changes were adequately evaluated and addressed by her nurses. For example, on 9/3/11 at 9:30 pm, Individual #100's direct care staff member reported that her temperature measured 101.4. At this time, Individual #100's nurse noted that Tylenol was administered, and "no further action needed." The next morning, despite the fact that Individual #100's nurse noted that she had a fever during the night and, at the time of her morning assessment, had expiratory wheezing and cough, Individual #100's nurse "deferred" her sick call without explanation and failed to conduct follow-up to this significant change in Individual #100's health status. On 9/30/11, Individual #100's direct care staff reported that she had "partially fallen out of her wheelchair after hitting a bump in the concrete outside." Individual #100's nurse noted that she had a 5.5 cm by 3.5 cm abrasion on her knee. Based upon an incomplete assessment, Individual #100's nurse recommended "monitoring" for changes in her status, but failed to conduct any follow-up to this significant event. On 10/7/11, Individual #100's LVN reported to her RN that she "vomited 1½ - 2 cups of whole carrots." Although Individual #100's RN recommended that she be "monitored" by her direct care staff members, there was no evidence of follow-up to this significant change in her health status. • Individual #463 had many health needs and risks, such as chronic kidney disease stage IV, uncontrolled diabetes, hypertension, hypercholesterolemia, GERD, peripheral vascular disease, s/p thyroidectomy due to thyroid cancer, and right parotid submandibular mass. In addition, her primary language was not	

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		English, thus, she only expressed herself in very few words and gestures. On 10/13/11, two nurses – an RN and LVN – heard Individual #463 call out, fall, and start to cry. Both nurses reported that they found Individual #463 "leaning against the wall" in the dayroom. They also reported that they "examined her," and found "no injuries." Although Individual #463 reported to the nurses that she fell after she was pushed by another individual, there was no evidence that the nurses developed a plan, or ensured the presence of a plan, to protect Individual #463 from further harm. In addition, there was no evidence of any follow-up to this significant event. • Individual #507 had a history of breast cancer with surgical removal of her left breast. On 10/14/11, she was diagnosed with a mass in her right breast. Her physician ordered that she undergo a right spot compression view of her breast. Despite Individual #507's high risk of cancer and test results indicative of a significant change from her 9/22/10 breast examination, as of 11/1/11, there was no evidence that Individual #507's physician's order was implemented and no evidence of her nurses' follow-up to this significant change in her health. <u>Regarding numerous individuals</u> A good example of an opportunity for nurses to help ensure that significant changes in individuals' health were quickly identified, their physicians were promptly notified, and appropriate care was delivered was within the realm of their role and responsibility to ensure that staff members adequately and appropriately respond to actual medical emergencies vis a vis mock medical emergency drills. A review of the LSSLC Trend Analysis for Emergency Response Drills for June 2011 through August 2011 revealed that of the 222 drills conducted, only one drill failed to pass the test. According to the report, staff members were provided inservice training, and a follow-up drill was successfully completed. Notwithstanding these positive findings, there continued to be several areas that required improvement. For example: • The monitoring team's onsite review of October 2011's Emergency Drill Checklists revealed that only nurses and direct care staff members participated in the drills. A number of other staff members who had direct contact with the individuals, such as physicians, psychologists, food service employees, etc. had not been included and/or failed to respond to any of the drills. • The review of the checklists also revealed several drills where the Drill Instructor noted that the AEDs and/or nurses were "not available." It was unclear what was done to address this problem because the sections for documenting the plans of action to address findings/problems were blank.	

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		During an interview with the Risk Management Specialist, it was reported that, since 10/1/11, the Risk Management department was assigned to "check the drill [checklists]." The Risk Management Specialist affirmed that she would address the finding referenced above and stated, "From now on, I will make sure [drills] are done [in accordance with state policy]. • According to the POI and the CNE's 10/31/11 presentation of progress since the prior review, LSSLC had implemented state's revised Emergency Response policy. Also, it was reported that, as of 10/28/11, all AEDs were received and placed across the campus and direct care staff members were in the process of receiving training on the policy and use of the new AEDs. Nonetheless, during the onsite review, the monitoring team, accompanied by the facility's Nurse Compliance Coordinator, reviewed nine areas for the presence, availability, functioning, and monitoring of emergency medical equipment. Given the focus, attention, and training directed toward improving this aspect of identifying and responding to significant/emergent changes in individuals' health, it was alarming to find (1) equipment checks were incomplete in three of the nine areas, (2) checks of equipment that revealed problems, such as no working batteries in flashlights, no water and/or containers for water for suction machines, no extension cord, etc., failed to result in corrections, (3) AEDs and other emergency equipment were stored in locked rooms and not immediately available/accessible to staff members, and (4) a number of direct care staff members reported that they were to "wait for the nurse" to bring the AED, suction machine, etc. to the scene, which was directly contrary to the state's former and current policy of "…Do not wait for the nurse…" • Also during the review of equipment, it was revealed that areas 557 and 559, where approximately 104 individuals reside, had only one emergency equipment bag, two suction machines, and two portable oxygen tanks. Thus, when/if a medical emergency should occur, according to one of the nurses, the nurse(s) must "run while carrying the oxygen tank, suction machine, emergency equipment bag, and AED to the scene." The monitoring team, with the assistance of the Nurse Compliance Coordinator, timed a very brisk walk to/from the area where the emergency equipment bag was stored to the furthest point in the area where individuals resided. Without gathering and carrying heavy equipment, it took over three minutes to briskly walk even the most direct route. Another good example of an opportunity for nurses to help ensure that significant changes in individuals' health were quickly identified, their physicians were promptly notified, and appropriate care was delivered was within the realm of their role and responsibility to provide health care to individuals who were residing in the facility's infirmary. According to the Infirmary Nurse Manager, individuals who received care and treatment in the infirmary were usually individuals discharged from the hospital and/or	

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		individuals in need of daily head to toe nursing assessments and close supervision. At the time of the review, there were eight individuals residing in the infirmary with an average length of stay of 32 days. According to the Infirmary Nurse Manager, he communicated and coordinated the infirmary individuals' care with their home charge nurses and home managers. He indicated that although he tried very hard to transfer individuals back to their homes in a safe and timely manner, "they [the Individual's PST] preferred them to be in the infirmary." The Infirmary Nurse Manager astutely pointed out that the infirmary does not provide an environment conducive to "overall participation in daily life." Unfortunately, the Infirmary Nurse Manager had not been invited or included in the PSPAs that were held to determine individuals' transfers to/from the infirmary. Given the role, responsibilities, and information that the Infirmary Nurse Manager would bring to bear on these discussions and decisions, it would seem prudent for the PSTs to include him in, at lease some of, these discussions. During the monitoring team's review of the delivery of nursing care in the infirmary, several problems were noted. • Direct care staff members who work in the infirmary were reportedly trained and competent to obtain individuals' vital sign measurements. On the day of the review, a direct care staff member obtained a high blood pressure reading on an individual who was in the infirmary while recovering from a procedure. Although the direct care staff member immediately reported this finding to one of the infirmary nurses, the infirmary nurse purposefully waited 30 minutes before re-checking the individual's blood pressure. This conduct was not what a reasonable nurse would do in a similar situation and not consistent with the state's or the facility's nursing policies/procedures. The high blood pressure reading obtained by the direct care staff member should have been immediately re-checked by the nurse on duty. • Another one of the infirmary nurses was observed conducting a post-procedure/recovery assessment of an individual in the hallway. Since there were vacancies in the infirmary and private space available, it was unclear to the monitoring team why there was no privacy afforded to the individual during an assessment of his vital signs, lung sounds, abdomen, etc. • A brief interview with one of the direct care staff members assisting individuals in the day room revealed that the staff member knew little to nothing about the health needs and risks of the individuals, including, but not limited to, the reason for why they were in the infirmary. • There was no evidence of an assessment and assignment of an acuity level of the individuals in the infirmary. One of the reasons for why the infirmary lacked an acuity measurement system was because "acuity fluctuates so much," which was	

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		exactly why it was an important and relevant to the delivery of nursing care in the infirmary. • It was reported that during individuals' infirmary stays, which, for some, lasted weeks and months, nurse case managers were rarely, if ever, observed conducting face-to-face visits of the individuals on their caseload. Of note, there was no evidence in any of the nursing reports, meetings, minutes, etc. that indicated that the Nursing Department had identified and/or addressed the problems referenced above. Although the Nurse Compliance Coordinator was present during much of this aspect of the review and aware of many of the findings, the monitoring team reported these findings and shared its concerns with the CNE and NOO during the onsite review.	
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.	According to this provision item of the Settlement Agreement, nurses are responsible to perform and document assessments that evaluate the individual's health status sufficient to identify all of the individual's health care problems, needs, and risks. The Settlement Agreement, as well as the DADS Nursing Services Policy and Procedures, affirmed that nursing staff would assess acute and chronic health problems and would complete comprehensive assessments upon admission, quarterly, annually, and as indicated by the individual's health status. Properly completed, the standardized comprehensive nursing assessment forms in use at LSSLC would reference the collection, recording, and analysis of a complete set of health information that would lead to the identification of all actual and potential health problems, and to the formulation of a complete list of nursing diagnoses/problems for the individual. Current annual and/or quarterly nursing assessments were not present in two of the 22 records reviewed. Of the 22 records reviewed, all 20 of the nursing assessments failed to provide one or more components of a complete, comprehensive review of the individuals' past and present health status and needs and their response to interventions, including but not limited to medications and treatments, to achieve desired health outcomes. Thus, the conclusions (i.e., nursing diagnoses) drawn from the assessments did not consistently capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks. This was a serious problem because the HMPs, and the selection of interventions to achieve outcomes, were based upon incomplete and/or inaccurate nursing diagnoses derived from incomplete and/or inaccurate nursing assessments. As a result, a rating of noncompliance has been given to this provision item. At LSSLC, the nursing assessment was of even greater significance because it was the only process whereby individuals' nurses' compiled, analyzed, and recorded their evaluations of individuals' health status and their responses to treatment interventions	Noncompliance

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		from "head to toe." Also at LSSLC, IPNs were episode-driven (i.e., they were notes written in response to narrow, specific, and significant changes). Across the 22 sample individuals reviewed, although they were for the most part medically-complex individuals with multiple and interrelated health needs and risks, their record notes, for days and weeks at a time, documented nothing more than the "monitoring" of one specific problem, such as a seizure episode, urinary tract infection, sunburn, scratch/bruise, etc. This type of documentation was not consistent with the state's Nursing Services policy, which stipulated that nurses must document all actions, interventions, and communication for all health issues in the IPNs. Also at LSSLC, in addition to the annual and quarterly comprehensive nursing assessments, nurses were required to complete Post Hospitalization/ER/LTAC Nursing Assessments of individuals who were re-admitted to the facility upon discharge from the emergency room, hospital, and/or LTAC. Of the 22 records reviewed, over half were records of individuals who were transferred to the emergency room and/or hospitalized during the period of 5/1/11 – 11/3/11. Almost half of these individuals' assessments were complete. But, the incomplete summaries tended to have one or more important sections pertaining to communicating the individuals' special needs to direct care staff members and initiating care plans for specified problems left blank. Other examples are given below: <u>Regarding specific individuals</u> • Individual #310 had many health needs and risks, which included a poorly controlled seizure disorder, hyponatremia secondary to seizure medications, chronic dependent edema, vitamin D deficiency, and abscess on his buttocks. Although Individual #310 was prescribed a very specific diet and restricted fluid intake, his nursing assessment of his meal was limited to his nurse's reiteration of his diet order and failed to provide any information regarding his adherence, tolerance, and response to the prescribed dietary interventions, which were in place to reduce his risks associated with edema and hyponatremia. In addition, his nursing assessment failed to reference the problems he suffered related to alteration in his skin integrity from 7/22/11-9/1/11. Neither his hyponatremia nor his alterations in skin integrity were listed among his nursing diagnoses. • Individual #507 was a 72-year-old woman with current, active medical diagnoses of organic personality disorder, bipolar disorder, intermittent explosive disorder, hypertension, osteopenia, chronic kidney disease, recurrent urinary tract infection, and right breast mass. Individual #507's nursing assessments failed to completely reference her current, active medical problems, and erroneously indicated that, "All of her medications and treatments have proved to be effective in the care of [Individual #507's] diagnoses." According to	

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		Individual #507's psychiatrist, despite her receipt of psychotropic medication, "All of her psychiatric diagnoses remain problematic." Also, according to Individual #507's bowel tracking record, there were several occasions when, despite her receipt of medications to treat her constipation, she required the use of enemas because she failed to move her bowels for four days. • Individual #102 had many health problems, which included seizure disorder, hypothyroidism, high cholesterol, constipation, degenerative joint disease, leukopenia, urinary tract infection, cataracts, and insomnia. Over the past several months, Individual #102 suffered anemia, gluteal abscess, 13-pound unplanned weight loss, and episodes of hypothermia and constipation, and she was diagnosed with **a** possible hilar mass and osteopenia. Peculiarly, her nursing assessment concluded, "[Individual #102] has had a healthy quarter." • One of Individual #502's most outstanding health problems was her fractured left femur. Nonetheless, this problem was not listed in Individual #502's nursing assessment as one of her current, active medical problems. In addition, Individual #502's nursing assessment failed to reference an evaluation of her response to other health problems, such as features of chronic COPD and vision impairment, which significantly impacted upon her health risks including her risk of falls/fractures." <u>Regarding numerous individuals</u> • Several individuals' weekly Gastrostomy Assessment and/or Aspiration Trigger Assessment reports were not completed on a weekly basis. • More than half of the individuals' nursing assessments failed to properly document an evaluation of the effectiveness of the individuals' medications and treatments. • The impact of many of the individuals' chronic conditions, usually constipation, incontinence, hyperlipidemia, osteoporosis, immobility, sensory deficits, vision and hearing impairments, and psycho-social challenges, including, but not limited to aggressive and/or self-injurious behavior, insomnia, severely limited ability to communicate, etc., on their health and wellness were either not adequately portrayed by the individuals' nursing assessments and/or not even referenced in the individuals' lists of nursing diagnoses. • When significant weight changes were documented, there were no evaluations of the nature and impact of the changes on the individuals' health status. • The results of nurses' meal monitoring activities were often limited to uninformative phrases, such as "Tolerated well," "No problems noted, " etc. This was especially problematic for individuals who were prescribed complicated dietary regimens that were likely to present challenges related to proper implementation, adherence, tolerance, etc.	

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		• Lists of nursing problems/diagnoses were almost always incomplete and usually copied verbatim from prior assessments regardless of changes suffered by the individual during the quarterly review period. • Nursing summaries, especially the annual summaries, were confusing. The summaries were usually run-on sentences and/or lists of discrete events, such as medication changes, appointments, lab test results, clinic visits, etc., which failed to provide an organized, thoughtful, recapitulation of the individuals' health status over the quarterly review period and failed to put forward nursing interventions/recommendations to address the individuals' progress/lack of progress toward the achievement of their desired health outcomes. • The Respiratory Therapists (RT) were members of the Nursing Department and under the supervision of the CNE. Over half of the 22 sample individuals suffered acute respiratory problems and/or chronic respiratory disease and severely compromised respiratory status. A review of their records revealed no evidence of the RT's involvement in their respiratory care/treatment and no evidence that the RT ensured that the individuals at LSSLC received the benefit of the RT's substantial freedom to evaluate, diagnose, and make recommendations to meet their various needs and risks. o For example, a review of Individual #419's record revealed IPNs, summaries, and reports that indicated that her "respiratory system [was] fragile" and that she had a significant history of "chronic aspiration pneumonia and multiple episodes of labored respirations with distress." Notwithstanding her significant respiratory needs and risks, there was no evidence that she was evaluated, monitored, or otherwise treated by the RTs. This finding was not anticipated given the information provided to the monitoring team during an interview with one of the three RTs at the facility. The interview revealed that the RT was a knowledgeable individual who was indeed capable of identifying and treating individuals in need of respiratory services/supports. o For example, during the interview, the RT recalled the case of an individual who required continuous oxygen, and she reported very positive outcomes of the interventions and equipment delivered by the RTs. o The RT also recalled that there were only very few occasions when she was "part of a whole picture of rehab." For example, over the past six months, the RT reported her involvement in only one collaborative process for one individual who had swallowing problems, aspiration risks, and hospitalizations for pneumonia. Thus, the problems found during the review of individuals' receipt of respiratory therapy services may have been related to the lack of evidence that the Nursing	

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		Department effectively ensured that the RTs were consistently afforded opportunities to be part of a collaborative process to meet the individuals' respiratory health needs.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	The Health Care Guidelines and DADS Nursing Services Policy and Procedures clearly called for written nursing care plans, which were based upon the nursing assessments, reviewed by the RN on a quarterly basis and as needed, and updated as to ensure that the plan addressed the current health needs of the individual at all times, to be developed for all individuals. The nursing interventions put forward in the individuals' plans were required to reference specific, personalized activities and strategies designed to achieve the individuals' desired goals, objectives, and outcomes within a specified timeline of implementation of the interventions. During the prior review, it was noted that the HMPs/ACPs were in need of substantial improvement in order to meet the provisions of the Settlement Agreement. It was also noted that the forms, processes, and plans in place at that time were problematic and in need of review and revision, especially with regard to the use of generic, that is, stock care plans and protocols, which were not individualized to address the significant health problems and risks identified vis a vis the revised integrated risk assessment process. According to the facility's POI, section M3, since the prior review, additional monitoring tools were completed, PST meetings were held to address the remaining two individuals' risk levels, summaries of health risk reviews were added to the annual nursing assessment process, and, on 10/1/11, a nursing QA plan that included monitoring tools for Health Care Plans was implemented. It was unclear to the monitoring team how the implementation of these action steps would address the deficiencies identified during the prior review and help to bring about compliance with this provision item. Currently, the monitoring review of 22 individuals' records revealed that all 22 individuals had one or more HMPs, several individuals had a MCP, and few individuals had one or more ACPs. Overall, since the prior review, there was little to no progress made in improving the presence, nature, and quality of individuals care plans. As a result, a rating of noncompliance was given to this provision item. Some general comments regarding the 22 sample individuals' care plans are below. • Generic, stock, mini-plans with various dates and time frames, some of which were reviewed at least quarterly, many of which were not, continued to be the pattern of health care planning at LSSLC. • Some care plans blatantly revealed that they were prefabricated plans that had not been tailored to meet the individuals' needs because there were highlighted	Noncompliance

#	Provision	Assessment of Status	Compliance
		areas across the document where the RN case manager had only to insert the name of the individual to complete the development of the plan. • Thus, it was not surprising that the same HMPs were used to address health problems regardless of the individual's co-morbid conditions and/or the precursors, nature, scope, and intensity of the problem. For example, the same HMP for alteration in skin integrity was used to address individuals' rashes, abrasions, avulsed toenails, surgical incisions, ostomy sites, and pressure sores. • ACPs were often not developed in response to emergent health problems. • The purpose of the MCPs was unclear. They referenced only very generic interventions, such as "physician will provide annual physical exam," "evaluate and treat as indicated," "review x-rays and labs," and "monitor treatments ordered," across a myriad of medical diagnoses. In addition, dozens of blank review forms were usually attached to the MCP, which referred the reader to "See IPN for detailed assessment data." • Not one of the 22 individuals records contained plans that addressed all of the current health needs of the individuals at all times. • Almost all HMPs and ACPs signature sheets had one or fewer signatures. • There were significant discrepancies between the interventions referenced in the plans and the actual delivery of health services and supports to the individuals portrayed by their record notes • Although there some plans with dates and signatures indicating periodic, albeit not quarterly, reviews of HMPs, changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes did not trigger or result in revisions to their HMPs. • Goals and outcomes were not specific, measurable, and person-centered. For example, there were goals for individuals to have "fewer fleet enemas this year compared to last year, " "a minimum number of episodes of hypothermia," and "improved oral hygiene over the year." Examples of problems in the HMPs and ACPs of specific individuals are presented below: • Individual #419 was a 51-year-old woman with many health needs and risks. Over the past several months, she was hospitalized for treatment of episodes of aspiration pneumonia and respiratory distress, urinary tract infection and urosepsis, constipation, etc. Although she received all medications, food, and fluids via gastrostomy tube and was designated as "NPO," meaning she was to receive nothing by mouth, her HMP to address her hypertension was the generic plan that referenced interventions that were contraindicated and harmful, to her. For example, her HMP recommended that she "eat a low fat diet." In addition, although Individual #419 was severely contracted and unable to walk, her HMP recommended that her staff members "assist her with ambulating."	

#	Provision	Assessment of Status	Compliance
		• Individual #494 was a 49-year-old man diagnosed with Down Syndrome, gastritis, osteoarthritis, inguinal hernia, high cholesterol, and history of squamous call carcinoma of his lip. In addition to these diagnoses, over the past several months, Individual #494 suffered significant, unplanned weight loss. As of the review, Individual #494 continued to refuse meals and suffer weight loss. However, his 6/8/11 HMP to address his "underweight" status, was not revised and failed to reference the current interventions/strategies to address his weight loss. Of note, there was no evidence that many of the strategies put forward in Individual #494's "underweight" plan were implemented. For example, there was no evidence that the time of day when he had the greatest appetite was determined and no evidence that meal substitutes were offered/assured. In addition, his food intake log, which indicated that he ate "good" for almost every meal, every day, was not corroborated by his direct care staff members' verbal reports that he frequently refused many meals. Nonetheless, there was no evidence that this food intake log was reviewed and that changes were made to ensure the validity and reliability of his intake data. • Individual #368 was a 63-year-old man with many health needs and risks. In addition, over the several months, he suffered an incident of choking, several head and face injuries, multiple episodes of extensive bruising and swelling reportedly due to self-injury, possible fractured clavicle, MRSA infection of his ear, hypothermia, and insomnia. Notwithstanding his many problems, needs, and risks, at the time of the review, Individual #368 had only two HMPs filed in his record – one plan was related to his unsteady gait, and the other plan was related to his poor oral hygiene. • Individual #285 was a 34-year-old man diagnosed with mental retardation, pervasive personality disorder with self-injurious behavior, hiatal hernia, GERD with ulcerative esophagitis, Barrett's esophagus (diagnosed 2/06), iron deficiency anemia (secondary to GI bleeding), constipation, and severe mobility impairment. Over the past year, Individual #285 lost 27 pounds, that is on September 2010 he weighed 126 pounds, and, as of 10/31/11, he weighed 99 pounds. He suffered almost daily episodes, with some breaks due to sedation, medication changes, etc., of self-induced vomiting, meal refusal(s), and self-injurious behaviors, which usually involved repeatedly banging his head on walls, bed frame, etc. Notwithstanding the number and complexity of Individual #285's problems, needs, and risks, there was no evidence that all members of his multidisciplinary team, including his physician and LAR, worked together to develop a comprehensive plan that addressed all of his needs and clearly communicated and closely monitored its implementation. As of this onsite review, Individual #285 languished while many of his clinical professionals recommendations were not implemented and his gastroenterologist's	

#	Provision	Assessment of Status	Compliance
		suggestion(s) were not addressed. The monitoring team raised concerns to DADS and the facility regarding this particular case. In the weeks following the onsite review, an action plan was put in place regarding this case.	
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 Specialty Nurse team, which included the Chief Nurse Executive, Nursing Operations Officer, Nurse Educator, Nurse Recruiter, Hospital Liaison, Nurse Compliance Monitor, and Infection Control Nurse, the Nurse Managers, and the RN Case Managers continued to work toward meeting this provision of the Settlement Agreement. According to the prior review, the Chief Nurse Executive (CNE) reported that the top priorities for the nursing department were to continue to assure that the facility's nurses were knowledgeable regarding the content of and expectations embedded in monitoring tools and to fully implement nursing assessment and health care planning policies and procedures that would result in complete, quality assessments and plans in a timely fashion. At that time, the activities that were underway were: (1) using the revised monitoring tools to assess compliance in the areas of urgent care/emergency care/hospitalizations, infection control, acute illness/injury, GERD, quarterly and annual nursing assessments, documentation, and seizures, (2) providing training to direct care staff members 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 individuals diagnosed with GERD and aspiration and development of a care plan template, (4) providing educational in-services to all nurses on vital sign assessment and follow-up and monitoring, and (5) lengthening and expanding the new nurse orientation and preceptor program. Since the prior monitoring visit, the Nursing Department indeed made progress toward achieving success in the areas that they targeted for improvement. In so doing, they implemented several state initiatives designed to improve the assessment and reporting of changes in individuals' health status. These initiatives included training for all non-clinical staff on observing and reporting changes in individuals' health status and implementation of the new standardized competency-based nursing orientation and training curriculum and hospital/transfer/discharge nursing protocol and forms. Notwithstanding these positive findings, the current review revealed that there was much work to be done to achieve compliance with this provision. Thus, a rating of noncompliance was given to this provision item. The Nursing Operations Officer (NOO) worked closely with the CNE and shared in her vision for a capable, adequately staffed, solid Nursing Department. As noted in the prior review, the NOO continued to manage and supervise the nurse managers and Nurse Educator. The NOO contributed to the assessment and reporting capacity of LSSLC's nurses by her daily commitment to serve as their ever-present "help desk." That is, the	Noncompliance

#	Provision	Assessment of Status	Compliance
		NOO helped solved the problems of the day, every day, and served as the Nursing Department's liaison to other departments, such as psychiatry, pharmacy, and habilitation. The NOO helped to ensure communication within the Nursing Department through the implementation of the "Weekend Coverage/24-Hour Nursing Report." The NOO was also immersed in the department's endeavor to meet its "#1 challenge" – adequate training of all staff members to implement assessment and reporting protocols within their roles, responsibilities, and scope of practice. According to the NOO, new employee orientation and annual staff training and refresher courses were "good and getting better." The Nurse Educator reported that, since the prior review, she provided training to each and every direct contact employee in identifying and reporting the signs and symptoms of change in health status, in accordance with the state's curriculum. In addition, the Nurse Educator provided the monitoring team with the Nursing Education Handbook, which had been revised in accordance with the State's standards and expectations for the training and education of its nurses. In addition, other education materials and resources supplemented the handbook for nurses. The Nurse Educator also reported that the annual nurses' competency based training program was scheduled to occur on 11/15/11-11/17/11. • LSSLC has not been scheduled to receive the statewide nurse education and training initiative, which is specifically designed to help improve the capacity of the RN case managers and RN managers in the performance of nursing assessments. This was much anticipated training given the findings, as noted in Section M2, of serious problems in the accuracy and completion of the assessments reviewed. During the interview with the Nurse Educator, the facility's Preceptor Program was discussed, and it was discovered that the Nurse Educator had little to no involvement in the program. The Nurse Educator reported that the nurse who previously held her position was involved in preceptor recruitment and training, but, currently, she had no access to the Nurse Preceptor Program outline and objectives. The Nurse Educator was also not knowledgeable of the criteria used to identify and select nurses to serve as preceptors to newly hired nurses. This was an unusual set of circumstances given that after the newly hired nurses completed their orientation, the Nurse Educator handed off the completion of their competency skill checklist to their preceptor, who was selected and assigned to the new nurse by the Nurse Recruiter and Nurse Managers, and waited on the preceptors to submit the nurses' completed competency skill checklists to her office. Upon closer review, it was revealed that, as of the review, only one of the last nine nurses hired in September 2011 had a completed competency skill checklist submitted to the Nurse Educator by his/her preceptor.	

#	Provision	Assessment of Status	Compliance
		During the monitoring team's interview with the Nurse Recruiter, some aspects of the Preceptor Program were clarified. The Nurse Recruiter reported that the Nurse Managers let the Nurse Recruiter know which nurses they identified and selected to serve as preceptors. Purportedly, not one nurse refused to participate in the Preceptor Program, which involved a commitment from the nurse to work at the side of the newly hired nurse for 12 shifts. This was commendable. However, as noted during the interview with the Nurse Educator, the Nurse Recruiter was not aware of the objectives and criteria used by Nurse Managers to select preceptors. The Nurse Recruiter reported that, currently, there were two vacant RN positions and seven vacant LVN positions. In order to ensure adequate nursing staff at the facility, contract/agency nurses were used. One agency, which "screened nurses better [than the others]," was used the most by the Nurse Recruiter. Over the past couple of months, the Nurse Recruiter's focus was on hiring LVNs, which was a challenge because their schedule permitted only one weekend off per month. The Nurse Recruiter indicated that several years ago, it was almost impossible to recruit RNs to the facility. However, through the Nurse Recruiter's efforts to build relationships with local nursing programs and spread the word that LSSLC was a good place to work for those who believed in making a difference in the lives of people with disabilities, there was significant improvement in the recruitment and retention of RNs. Since the prior monitoring review, a new Hospital Liaison was hired from within the ranks of the nurses at the facility. The Hospital Liaison's vision of her role and responsibilities was that she was the "communication hub" between LSSLC and tertiary care facilities. A review of 22 individuals' records revealed that, over the past six months, a significant minority of these individuals were hospitalized one or more times. A review of these individuals' records revealed that they all benefitted from the oversight of the Hospital Liaison and her designees, who assisted in carrying out the duties of the Hospital Liaison when she was absent or off-duty. Individuals who were hospitalized at the local hospitals were visited daily, Monday through Friday. On weekends and holidays, nursing supervisors ensured that telephone contacts were made. Daily telephone contacts were also made to tertiary care facilities on behalf of individuals who were hospitalized at facilities more than two hours from LSSLC. The Hospital Liaison communicated her assessments of individuals' hospital care/treatment and their response to treatment via written reports, which were sent to the individuals' nurse case managers, physician, pharmacist, and home managers, and were also filed in the individuals' records. A review of a number of these reports revealed that they provided the LSSLC clinical professionals with information relevant to the individuals' status, response to treatment, and needs upon discharge. In addition, the	

#	Provision	Assessment of Status	Compliance
		Hospital Liaison accompanied the physician on his/her daily rounds of the facility's infirmary. As such, the Hospital Liaison was directly involved in the daily process of nursing assessment and reporting protocols. Since the prior monitoring review, the Infection Control Nurse, who had been on the job for less than a year, had met and exceeded the expectations she set for herself during the prior monitoring review. As of the review, the Infection Control Nurse, was conducting environmental reviews, inspecting emergency medical equipment, reviewing records reviews, investigating infection episodes, and participating in the wound care team's monitoring and evaluation of individuals with wounds. Also since the prior review, on the basis of the Infection Control Nurse's analysis of infection data, she provided focused training on the prevention of urinary tract infections and provided training materials to the RN case managers to assist their efforts to train direct care staff members in the process of collecting urine specimens without contamination. This appeared to be a worthwhile endeavor and in line with the Infection Control Nurse's priority – ensuring basic hygiene. During the review, the monitoring team attended the Infection Prevention and Control Meeting chaired by the Infection Control Nurse. The agenda topics referenced all relevant areas of monitoring and surveillance of actual and potential risk of infection, and the presentation and discussion covered topics, such as pneumonias, hand hygiene, conjunctivitis, unit temperatures, labs, results of campus-wide random infection control audits, etc. During the meeting, the monitoring team noted that a number of the "plans of action" presented at the meeting were identical to the plans of action referenced in prior meeting minutes. For example, for many months, the infection control meeting minutes indicated that the physician was in dire need of a sink in his/her examination room on Home 506. Although the plan of action was to provide a sink in the examination room to ensure proper sanitary conditions, this plan was repeatedly referenced without explanation for why the plan was not implemented and the problem persisted. During the monitoring team's interview with the Infection Control Nurse, she was aware of this problem, but did not know why it had not been addressed and/or corrected, especially since, to her knowledge, water/drainage was available in the area and the sink was "do-able." During the review of 22 individuals' records, there was no evidence that the Infection Control Nurse was informed of incidents that posed risk for possible transmission of contagious disease. For example, there was no evidence that the Infection Control Nurse was notified when an individual suffered two human bite wounds, exposing himself and the other individual to possible transmission of contagious disease. This was significant because an investigation of both individuals' health/disease/immunization/etc. records for the presence/absence of blood-borne/infectious diseases should have been	

#	Provision	Assessment of Status	Compliance
		conducted. As noted in the prior review, 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. Although the QA Nurse continued to be involved in most aspects of quality oversight of the delivery of health care services to individuals at LSSLC, her relationship with the Nursing Department was unclear, especially with regard to the Quality Assurance Nurse's collaboration and coordination with the Nurse Compliance Coordinator, who was a member of the Nursing Department. Since the prior review, the QA Nurse received access to the statewide QA database. In addition, the QA Nurse completed the selected monitoring reviews required to calculate measures of the reliability between her findings and the findings of the Nursing Department using the same tools and reviewing the same individuals. The monitoring team's review of these data revealed that the QA Nurse's findings, especially her findings pertaining to the evaluation of nursing assessments, were significantly less positive than those reported by the Nursing Department. As of the review, the QA Nurse reported that there had not been an opportunity for the QA and Nursing Departments to meet and address and resolve the discrepant results. It was recommended that this problem should be addressed since it raised question regarding the validity, as well as the reliability, of the results. 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 Quality Improvement Death Reviews of Nursing care. A review of the QA Death Reviews of Nursing care conducted during the period of 6/1/11-10/30/11 revealed that some of the areas identified for improvement were addressed by the Nursing Department, but others were not. For example, in follow-up to the recommendations put forward in response to the death of Individual #552, neck-stabilizing equipment was added to the Infirmary's emergency response bag. However, the recommendation to provide training for all staff regarding falls/injuries, specifically not to move individuals who cannot move after a fall or injury, was not implemented as recommended. More specifically, for some unknown reason, nurses were not included in the training. This was a significant oversight because nurses were clearly involved in the events that occurred proximate to incident that preceded the individual's death. Of note, since September 2011, the QA Nurse was not completing the QA Death Reviews of Nursing care. Inexplicably, the Hospital Liaison and the Nurse Compliance Coordinator completed the two most recent QA Death Reviews of Nursing care. It was unclear why these reviews were not completed by the QA Nurse, who had prior experience in conducting these reviews and who was more likely to critically review the	

#	Provision	Assessment of Status	Compliance
		death from the perspective of a clinical professional who was a colleague, but not directly supervised by the NOO or CNE.	
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.	At the time of the monitoring review, LSSLC was 10 months into its implementation of the state approved health risk assessment rating tool and assessment of risk as part of the PSP process. According to the facility's POI, since the prior monitoring review, the remaining PST meetings to address two individuals' health risks were held. Also, the Infection Control Nurse provided training and education to the RN case managers regarding the prevention of urinary tract infection and combined her efforts with those of the Immunization Nurse to educate LSSLC employees and improve their compliance with TB tests and vaccinations. One of the most obvious steps taken by the Nursing Department to participate in the development and implementation of a system of assessing and documenting individuals' indicators of risk was the attendance and participation of the individual's nurse in the PST process. During the conduct of the review, the monitoring team attended two PSPA meetings, which were held as a result of significant changes in individuals' health and/or behavior status and needs. Both of the QDDPs who chaired the meetings were prepared, organized, and participated in keeping the meeting discussion focused and on track. One of the QDDPs was very knowledgeable and confident in his/her presentation and in raising her concerns and posing questions to the clinical members of the team. The other QDDP, however, appeared less comfortable with the process and in need of training and support to help guide his/her efforts in preparing for the meeting and advocating on behalf of the individual to ensure that their health and safety needs would be thoroughly discussed and addressed by all members of the PST. The conduct of the RN case managers who participated in the PSPAs was commendable. For example, during Individual #560's PSPA, the RN case manager came to the meeting very well prepared, and, almost single-handedly, reported the individual's pertinent information and data to the PST and clearly expressed the clinical basis for his/her opinions regarding the individual's level of risk for particular areas of his health status. In addition, the RN case manager frequently attempted to draw other members of the PST into the discussion to ensure multidisciplinary input on the assessment and plan. During Individual #267's PSPA, the RN case manager was very knowledgeable of the individual's history, strengths, needs, risks, and recent changes in his health, which increased his health risks and needs. All clinical professionals in attendance at the meeting provided input into the assessment of Individual #560's health risks and assumed a role/responsibility in both the development and implementation of his risk action plan. All 22 of the sample individuals reviewed had multiple risks related to their health	Noncompliance

#	Provision	Assessment of Status	Compliance
		and/or behavior, and over half of the 22 individuals reviewed were referred to as having one or more "high" health risks. Since 1/1/11, all but one of the 22 sample individuals whose records were reviewed were also reviewed by their PSTs and assigned levels of risk that ranged from low to high across several health and behavior indicators. As noted in the prior report, however, there continued to be problems with health risk ratings that were not consistently revised when significant changes in individuals' health status and needs occurred. Therefore, this provision item was rated as being in noncompliance. Examples included the following: • Over the past several months, Individual #368 suffered a number of falls that resulted in head and face injuries, extensive bruising and swelling, and possible fractured clavicle. Nonetheless, Individual #368's risk rating form indicated that he remained at "medium" risk for falls. • Over the past 10 months, Individual #494 suffered a 10-pound, unplanned weight loss, frequently refused meals, and restricted his intake to very few unhealthy foods, which caused his nurse to believe that he was malnourished. His physician ordered dietary consultations, supplements, and an appetite stimulant to treat his weight loss. Despite the presence of a pattern of frequent meal refusals and significant downward trend in weight, on his PST determined that he "…always refused anything he doesn't want…[and] still within his estimated desired weight range (EDWR)," concluded that he was a "picky eater," and at "low" risk for weight loss. • Over the past six months, Individual #502 suffered a fecal impaction and required laxatives and enemas to address her constipation. She also suffered a fractured, and, as a result, her record notes indicated that she spent a number of days in bed and immobile. Nonetheless, Individual #502's risk assessment indicated that her risks of constipation and alteration in skin integrity remained "low" because "she no longer had an HMP for constipation" and her "skin problems are generally minor." These explanations, which fell far short of the state's expectations for the implementation of its risk assessment and planning processes, were indicative of the need for additional training and support for PST members.	
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	The administration of medication and the management of the medication administration system at LSSLC continued to improve since the prior monitoring review. As indicated in more detail below, although much work still needed to be done to ensure that medications were administered and accounted for in accordance with generally accepted professional standards of care and the Health Care Guidelines, the facility had taken several steps toward identifying and measuring the nature, severity, and scope of their problems in this area. For example, since the prior monitoring review, the state's revised	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Medication Administration Policy was implemented, entire medication observations and monitoring reviews were completed, and all orders and adaptive equipment needs for individuals were reviewed by the nursing, habilitation, and pharmacy departments. This provision item, however, was rated as being in noncompliance because there continued to be a number of problems in this area. Observations of medication administration, oral and enteral, were conducted on 524, 549a, 557a, 559a, and 559b. During three of the five observations, nurses failed to administer medications in accordance with standards of practice. For example, during the three deficient medication passes, nurses did not follow proper infection control practices and precautions to sanitize their hands between their contacts with residents and/or other soiled materials, such as soiled dressings, dirty washcloths, towels, and adult protective garments; nurses left excessive amounts of liquid and/or crushed medications in discarded medication cups and failed to implement the facility's policy/procedure to ensure that all medications were given as prescribed; nurses failed to ensure that individuals were properly positioned at the time of medication administration; nurses failed to rinse and clean enteral feeding equipment after use and before the equipment was stored in plastic bags/re-used; and nurses initialed that medications were given prior to individuals' receipt of medications. Reviews of documents and observations of medication administration revealed other problems that may have contributed to medication errors. For example: • There were instructions related to the administration of individuals' medications written in permanent ink inside the bins where their medications were stored. However, these instructions, which were related to crushing, mixing, and other individual-specific suggestions for the administration of individuals' medications, were <u>not</u> consistent with the instructions printed on the individuals' MARs. Fortunately, most nurses were aware that the instructions written on the inside of the individuals' bins were not to be followed. It was unclear, however, whether or not a new and/or contract nurse would be similarly aware of this unwritten rule, which was <u>not to follow instructions</u>. • Although most nurses were counting and reconciling medications at least once a day, some were not. • The MARs were confusing. There were a number of crossed-out, re-written, and otherwise clarified medication orders on the MARs for all individuals reviewed by the monitoring team. • It was reported to the monitoring team that there were Certified Medication Aides (CMAs) at the facility that administered medications to individuals when	

#	Provision	Assessment of Status	Compliance
		they were on trips/outings. In an effort to ensure the competence of the CMAs, it was reported that each CMA administered medications at the facility at a rate of approximately four medication passes per month to keep up their skills. Upon closer review, it was revealed that there were indeed 11 CMAs at the facility who had a current license/certification to administer medications. However, only three of the 11 CMAs were reportedly observed during medication administration on only one occasion during the period of 8/11/11 – 10/3/11. In addition, a review of the three CMAs competency evaluations provided to the monitoring team revealed that one of the three evaluations failed to reference the name of the CMA who was purportedly evaluated, and one of the three evaluations noted that the CMA correctly administered medications via enteral tube, which was not permitted by state and facility policy and procedure. Although it was explained that these entries were "inaccurately marked on the form," this was not identified or clarified by LSSLC until months after the evaluation was conducted. o It was strongly recommended to the CNE that she take a very close look at the structure and implementation of this program at LSSLC to make sure that the health and safety of the individuals would not be placed in jeopardy and that the state's and facility's policies and procedures would be followed. Many of the 22 individuals reviewed had a "pre-SAM" or "SAM" (self-administration of medication) assessment and designation filed in their record. During the observations of medication administration, with the exception of one nurse, the nurses uniformly treated individuals with respect and dignity during medication administration, and either implemented or made reasonable attempts to implement the individuals' SAM program. There was generally appropriate and accurate documentation of administrations of medications as indicated by nurses' initials in the appropriate space of the MARs. The review of 22 individuals' current MARs for the period of 10/1/11 to 10/31/11 revealed much improvement with omissions and/or discrepancies in the MARs of only five of the 22 individuals reviewed. These omissions and discrepancies included several missing entries for psychotropic, gastrointestinal, bowel, antibiotic medication(s), vitamins/supplements, and/or oral, wound, and/or skin treatments during the four-week period. During the week of the onsite review, the monitoring team attended the meeting of the Medication Variance Committee meeting. As noted during the prior review, the committee continued to review reported "variances," attributed to the Nursing and Pharmacy Departments. The CNE reported to the Committee that although there were	

#	Provision	Assessment of Status	Compliance
		"no un-reconciled medications" during the review period, this did not mean that there were no medication errors. What it meant, however, was that the nurses, vis a vis daily counting and reconciling procedures, were able to identify the who, what, where, when, and how of extra and/or missing doses of medications. Thus, in the CNE's opinion, there were no un-reconciled medications. Be that as it may, all variance data presented during the meeting showed a pattern of decline in total variance, which was a positive finding. Of note, two interventions that appeared to contribute the most to the decline in medication variance were (1) the pharmacist's double check and correction of medications that were dispensed before they left the pharmacy, and (2) the nurses' close scrutiny and correction of the MARs. During a discussion of the data analyses and reporting of medication errors, several additional concerns were raised by the monitoring team members: • The total number of errors was limited to the errors committed by nurses and failed to include errors made by physicians, pharmacists, etc. • The total number of errors was based upon "episodes" of errors, versus occurrences of errors. For example, an error that went undetected and involved several nurses who committed the same error over and over during a period of time was counted and presented to the committee as only one error. • There were no systems in place to reconcile medications that were not in the form of pills, tablets, or capsules. • Unannounced observations of medication administration were not conducted during the monthly review period. A review of the prior six months' meeting minutes revealed that the committee failed to identify the above-referenced concerns. They did, however, make several important recommendations, which required follow-up by the Nursing, Medical, and Pharmacy Departments. For example, the committee recommended that the pharmacist investigate the possibility of contracting with another provider to serve as a back-up for the pharmacy and requested that the MARs include instructions for administration, physicians' orders, and revisions to orders in a more timely and accurate manner. As of the monitoring review, these recommendations had not been addressed.	

Recommendations:

1. Ensure that nurses consistently document health care problems and changes in health status, adequately intervene, notify the physician(s) in a timely manner, and appropriately record follow-up to problems once identified (M1, M4).

2. Ensure that nursing assessments are complete and comprehensive and conducted upon significant change in individuals' health status and

risks (M2, M5).

3. Communicate and clarify expectations for the conduct of the infirmary nurses and direct care staff members to ensure that all are knowledgeable of the individuals' health needs and risks. In addition, reinforce that although the infirmary is there to provide close observation and assessment, this may still be accomplished while affording privacy and dignity, and it need not imply immobility and sensory deprivation (M2, M3, M4, M5).

4. Thoroughly re-evaluate the Certified Medication Aide and Preceptor Programs. If these programs are going to continue, consider developing adequate policies and procedures that guide and direct the implementation and evaluation of the effectiveness of these programs (M6).

5. The Nursing Department should continue efforts to coordinate and collaborate with the QA Department to best utilize the QA Nurse and Program Compliance Coordinator, including addressing significant differences in findings as part of its efforts to establish reliability between auditors and ensure validity and integrity of the data (M4).

6. Consider letting the QA Death Reviews of Nursing care remain with the QA Department and QA Nurse (M4).

7. Improve the communication and collaboration with the respiratory therapists to capitalize on their skills and expertise. Also, clarify the line of supervision of the respiratory therapists, which purportedly lies within the Nursing Department (M3, M4, M5).

8. Consider developing additional strategies to improve the collaboration and cooperation between the Nursing and Habilitation Departments, especially in the domain of PNMT, to improve the coordination of individuals' health care (M3, M4, M5, M6).

9. The facility should consider re-evaluating the current healthcare planning approach including the overreliance on standardized, stock care plans versus the development and implementation of person-centered health care plans, interventions, and goals (M3).

10. Continue to ensure that Registered Nurses are visible on the homes in the locale of the individuals and their direct caregivers at different times of the day/evening every single day (M1-M6).

11. Develop strategies to ensure that clinical professionals who have contact with individuals participate in emergency medical drills to both maintain competence and set examples for non-clinical staff members to follow (M1, M4).

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 DADS Policy #009.1: Medical Care, 2/16/11 o LSSLC POI for Section N o LSSLC Organizational Charts o LSSLC Policy: #011: Pharmacy Services Policy and Procedures, 10/12/11 o LSSLC Operational Procedures Manual, Medical 15 Adverse Drug Reaction Reporting, 12/16/10 o LSSLC Policy: Drug Utilization Policy, 10/14/11 o LSSLC Lab Procedure Matrix, 12/13/10 o LSSLC Procedure for Tracking Acceptance/Rejection Quarterly Drug Regimen Reviews Recommendations o Pharmacy and Therapeutics Committee Meeting Minutes, 5/10/11, 8/17/11 o Medication Variance Committee meeting minutes: 4/6/11, 4/27/11, 5/16/11,6/8/11, 7/13/11, 8/12/11, 8/29/11, 9/22/11 o Rx Interventions Meeting Minutes, 8/15/11, o Directors Meeting Notes, 10/5/11 o Single Patient Interventions and Notes Extracts: o Adverse Drug Reactions Reports: o Quarterly Drug Regimen Reviews for the following individuals: • Individual #273, Individual #759,Individual #310, Individual #195, Individual #543 Individual #475, Individual #507, Individual #482, Individual #515, Individual #225, Individual #468, Individual #477, Individual #449, Individual #117, Individual #367, Individual #223, Individual #552, Individual #100, Individual #506, Individual #162, Individual #23, Individual #257, Individual #43, Individual #11, Individual #321, Individual #75, Individual #61 o DISCUS evaluations for the following individuals: • Individual #426, Individual #434, Individual #135, Individual #39, Individual #148, Individual #410Individual #566, Individual #301, Individual #99, Individual #279,Individual #305,Individual #479 Individual #368, Individual #261 Individual #57, Individual #380,Individual #218, Individual #555,Individual #252, Individual #273 Individual #468, Individual #492, Individual #449, Individual #472, Individual #507,Individual #321 o MOSES evaluations for the following individuals: • Individual #28,Individual #217, Individual #471, Individual #160, Individual #316,Individual #267,Individual #103 Individual #85, Individual #339 Individual #497, Individual #382,Individual #574, Individual #513,Individual #529, Individual #547

	Individual #252, Individual #273, Individual #468, Individual #492, Individual #552,Individual #507 o Drug Utilization Evaluation Summaries: • Dilantin • Olanzapine • Simvastatin <u>Interviews and Meetings Held</u>: 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 o Gail Wascom, Facility Director o Gena Hanner, RN, QA Nurse <u>Observations Conducted</u>: o Pharmacy and Therapeutics Committee Meeting o Medication Error Reduction Committee o Polypharmacy Committee meeting o Daily Morning Clinical Meetings o Pharmacy Department
	Facility Self-Assessment: LSSLC submitted its self-assessment, the POI. It was updated 10/ 17/11. The facility self-rated that it was compliant with Provisions N5 and N6 and noncompliant with Provisions N1, N2, N3, N4, N7 and N8. The POI did not provide any information on how the facility conducted the self-assessments nor did it state why the facility rated itself noncompliant with the six provision items. The POI provided a list of regular updates for several provision items, but it did not always link the action to compliance with the Settlement Agreement. For example, the POI stated that pharmacists had access to lab results. It did not state that the pharmacists actually reviewed the lab results during the prospective reviews to ensure that labs are current per protocol. The POI stated that only a small percentage of pharmacy recommendations were accepted and this information was given to the medical director. It did not provide any information on what the medical director did with this information. The facility will need to engage in a variety of actions to meet compliance with the Settlement Agreement. For the benefit of the facility, the action plans should provide a series of detailed steps for how each provision item will be met. Additionally, each provision item should be linked to a plan of self-assessment as well as an auditing tool.

	Summary of Monitor's Assessment: In order to determine compliance with this provision, interviews were conducted with the pharmacy director, clinical pharmacist, and the medical director. The monitoring team attended the Pharmacy and Therapeutics Committee, the Polypharmacy Committee, and the Medication Variance Committee meetings. Discussions were conducted with the medical staff during various formal and informal meetings. Pharmacy policies and procedures, meeting minutes, active integrated records, and multiple data sets were reviewed. At the time of the onsite visit, the pharmacy department was staffed with a pharmacy director, clinical pharmacist, and four technicians. A full time pharmacist retired at the end of August 2011. Additional help was provided through the use of contract pharmacist who worked two days a week. Another contract pharmacist worked approximately four days a month. The facility's current software system required that a series of checks occur prior to dispensing medication. Documentation of communication with medical providers related to the prospective review was not clearly evident. The vast majority of SPIs were retrospective. The notes extracts did not contain any information that indicated what provider was contacted or what the response was to the concern. There was improvement in the quality of the QDRRs, but it was very disconcerting to find that the recommendations were essentially being disregarded with a series of repetitive responses of "no action required." Similarly, the MOSES and DISCUS evaluations were completed, but very often the provider did not provide a response as required. ADRs were reported, but based on the facility's definition of an ADR, the size of the facility and the number of medications administered, the reporting of 10 ADRS (some duplicate) over a six-month period likely represented under-reporting. One DUE was completed each quarter and information was shared with the medical staff during the Pharmacy and Therapeutics Committee meeting. The facility maintained a system for reporting medication variances. Pharmacy and nursing maintained separate data streams. A significant concern was the fact that medication errors were reported as events and not occurrences. This introduced the ability to significantly diminish the actual medication error rate. This was disconcerting because actual error rates often are used as a quality indicator. Moreover, it was not clear that the true error rate was accurate because the facility only reported omissions related to pill medications.

#	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 medication 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. In those cases where the review of the order resulted in questions, the pharmacist contacted the provider for clarification. The clinical pharmacist and pharmacy director met with the monitoring team to discuss the prospective reviews of physician orders. According to the pharmacy director, the pharmacist entered communication with medical providers into the Single Patient Intervention section of WORx. The pharmacy technicians utilized the notes extracts. A request was made for all SPIs and an electronic copy of the notes extracts since the last onsite review. There were 137 interventions entered by the clinical pharmacist, seven interventions documented by the pharmacy director, and a total of seven interventions by two pharmacy technicians. The SPIs documented by the clinical pharmacists were quite detailed, but usually pertained to findings of the QDRRs and, as such, were part of retrospective reviews. Many of the SPIs entered by the pharmacy director were blank. Several hundred pages of note extracts were provided. The extracts included information related to therapeutic duplication, drug allergies, and drug interactions. It appeared that many of these were prospective, but the monitoring team did not find clear documentation of correspondence with the medical provider regarding important issues contained in the notes extracts, nor was there evidence of the providers' response to the issues. An additional requirement for this provision item was that "a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication." For example, when a dose of levothyroxine was changed (new order), the pharmacist would be responsible for ensuring that the TSH was monitored per protocol. According to the clinical pharmacist, all pharmacists had access to laboratory results, which could be reviewed as part of the prospective review of physician orders. It would be reasonable to consider that the facility develop a list of drugs that will be targeted for prospective laboratory review.	Noncompliance
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist	The clinical pharmacist submitted completed QDRRs to the medical director's office for distribution to the medical staff. They were required to review the QDRR, sign, and record agreement or disagreement with the recommendations of the pharmacist on the	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.</td><td>QDRR form. An explanation was required when the physician disagreed with the recommendations. The medical provider was required to document this in the IPN as well. The documents were returned to the pharmacy following completion for tracking. The pharmacy then returned the forms to the medical secretary so that they could be filed in the records. Timelines for provider completion and return were not specified in policy.

The facility submitted a sample of the most recent QDRRs to the monitoring team. The record sample included the two most recent QDRRs. Several records included in the sample omitted the QDRRs, but provided the Quarterly Personal Support Plan.

All QDRRs were reviewed for timelines for completion, content of the reviews, physician review, and responses to the recommendations. Overall, the QDRRs adequately assessed the use of drugs based on the adopted criteria. The current process of completing a review during the month following the review period will be examined during the next visit.

Examples of the content contained in several QDRRs is presented below. The PCP response was not included since the response “no action required” was noted for <u>every</u> QDRR submitted. The psychiatry response was omitted when the individual did not receive psychotropics. Comments are those of the monitoring team. Unless otherwise indicated, the monitoring team noted documentation of appropriate laboratory monitoring.

<table>
<tr><th>Individual #</th><th>Date</th><th>Comments</th></tr>
<tr><td>162</td><td>9/2/11</td><td>• Recommendations:
o Assess the need for continued use of three medications to manage constipation
o Recheck Vitamin D level due to sub-therapeutic values
• Psychiatry response: agree</td></tr>
<tr><td>477</td><td>9/2/11</td><td>• Recommendations:
o Recent MOSES is needed
• Psychiatry response: No action required
• Comments: Appropriate monitoring for medication use was documented with the exception of the need for the MOSES evaluation.</td></tr>
<tr><td>482</td><td></td><td>• Recommendations:
o DISCUS should be completed for aripirazole
o EKG with borderline QT interval; recommend monitoring and repeat EKG
• Psychiatry response: No action required</td></tr>
<tr><td>257</td><td>8/15/11</td><td>• Recommendations:
o Annual EKG due to trazodone use; annual labs due
• Psychiatry response: Agree; patient sent to ER today</td></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status				Compliance
			23		• Recommendations: o Next DISCUS due November 2011; MOSES due October 2011 o Close monitoring needed of cardiovascular status while on quetiapine and trazodone. • Psychiatry Response: Signature page missing	
			506	9/7/11	• Recommendations: o No new reactions or exceptions noted • Psychiatry response: No action required • Comments: There was no monitoring documented for the use of propanolol, simvastatin and olanzapine.	
			475	9/7/11	• Recommendations: o No new reactions or exceptions note • Psychiatry response: No action required • Comments: There was no documentation of monitoring for the use of trazodone and diazepam	
			367	9/7/11	• Recommendations: o Sertraline should be used in extreme caution with seizures. • Psychiatry response: Blank • Comments: There was no documentation of monitoring for the use of alendronate nor was there any comment related to the drug interaction	
			43	9/2/11	• Recommendations o Monitor for side effects of steroid use • Psychiatry response: No action required • Comments: There was no monitoring for the use of Vitamin D.	
			195	9/7/11	• Recommendations: o Consider a reduction in dose of apriprazole since dose prescribed is above max recommended dose. • Psychiatry Response: No signature; No action required. • Comments: Documentation of monitoring for drug use was appropriate. There was no comment provided by the psychiatrist or signature of the psychiatrist in spite of the fact that the medication was used at a dose higher than the recommended maximum dose.	
			482	9/2/11	• Recommendations: o DISCUS was not completed and should be for use of aripiprazole o Closely monitor cardiovascular status and EKG • Psychiatry Response: No action required	
			11	9/16/11	• Recommendations: o Last EKG 2004, obtain updated EKG due to use of multiple AEDs • Psychiatry Response: Page missing	
			543	9/16/11	• Recommendations: o Omega 3 fatty acids to improve lipid status o No significant interactions noted • Psychiatry Response: No action required	

#	Provision	Assessment of Status				Compliance
			223	9/16/11	• Recommendations: o Assess the need for two AEDs since the last seizure was in 2008 o Periodically monitor bicarbonate due to the use of Zonisamide • Comments: Documentation of monitoring for drug use was appropriate with the exception of the absence of monitoring of serum bicarbonate	
			321	9/16/11	• Recommendations: o Consider increasing does of levothyroxine due to elevated TSH • Comments: There was no documentation for monitoring for the use of ibandronate	
			310	9/2/11	• Recommendations: o Assess the need for use of four meds for management of constipation • Comments: There was no documentation of monitoring for the use of antihypertensives	
			75	9/15/11	• Appropriate monitoring was documented • Recommendations: o Change the administration time of statin to night o Periodically monitor CPK	
			507	10/24/11	• Recommendations: o Check DISCUS o Re-check Vitamin D level due to low value • Psychiatry Response: No action required • Comments: There were no comments related to the HTN and the use of atenolol	
			507	8/24/11	• Recommendations: o Assess the need for such a high dose of folic acid o Last documented eye exam was in 2009, Eye exam is pas due • Psychiatry Response: No action required • Comments: There were no comments related to the HTN and the use of atenolol. The PCP did not document any justification for the use of 4 mg of folic acid daily.	
			449	8/17/11	• Recommendations: o Monitor for medication side effects o Re-check EKG due to borderline QTc interval • Psychiatry Response: No action required other than ordering EKG • Comments: There was no mention of TSH and no discussion of hyperlipidemia.	

#	Provision	Assessment of Status			Compliance
		449	5/12/11	• Recommendations: o Repeat lipids in 6 -12 months for simvastatin o Re-check EKG due to borderline QTc interval • Psychiatry Response: Blank . • Comments: There was no mention of TSH and no discussion of hyperlipidemia. The QTc interval was relevant to the use of psychotropics.	
		468	8/9/11	• Recommendations: o Change indication for dilantin; Current indication for dilantin is "dilantin toxicity" o Repeat glucose and potassium	
		468	5/23/11	• Recommendations: o Need Pb level and follow-up of glucose o Dilantin level supra therapeutic at 26; needs monitoring. • Comments: Documentation of monitoring for drug use was appropriate. There was no response to the issue of sub-therapeutic dilantin.	
		273	8/24/11	• Recommendations: o No new labs or exceptions you	
		100	9/14/11	• Recommendations: o Record not available for review • Comments: There was no documentation of monitoring for drug use.	
		61	9/14/11	• Recommendations: o Record not available for review • Comments: There was no documentation of monitoring for drug use.	
		449	5/12/11	• Recommendations: o Repeat lipids due to use of quetiapine • Psychiatry Response: Blank • Comments: There was no documentation of comments related to psychotropic use.	
		Overall, the quality of the quarterly drug regimen reviews improved since the last onsite review. The criteria for laboratory monitoring included in the lab matrix was more consistently applied and recommendations were more easily discernable. A review of each individual QDRR did not allow the monitoring team to determine if lab monitoring occurred at the correct frequency because only the most recent pertinent labs were documented. Serial labs were not documented for trending. A significant concern related to this process was the fact that the primary care providers did not review and sign the documents. All QDRRs reviewed by the monitoring team were signed by the medical director and indicated that "no action was required." This was noted even in those cases were action clearly needed to occur. The failure to require			

#	Provision	Assessment of Status	Compliance
		the primary provider of record to review and sign the QDRR was a significant deficiency, which precluded achieving substantial compliance for this provision item. This deficiency is worthy of immediate corrective action. The facility should give some consideration to the following: • The lab matrix should be expanded to include other medications that require monitoring, including but not limited to, thyroid replacement hormones, statins, and diabetic agents. This will help ensure that monitoring for these drugs occurs at the appropriate intervals. • Serial labs should be presented in tabular format. This will allow the medical providers and pharmacists to determine if the frequency of monitoring is appropriate. Additionally, it will allow for easy detection of trends in lab values. • The QDRR should be reviewed by the providers responsible for care of the individual. The providers should thoughtfully review the recommendations and respond appropriately. When the recommendations are rejected, a reasonable explanation should be provided. The PCP serves as the physician ultimately responsible for all care of the individual. Recommendations related to the use of psychotropics cannot be considered solely the responsibility of the psychiatrist.	
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	The monitoring team attended the Psychoactive Polypharmacy Review Committee meeting. This meeting was usually conducted as a joint review by the psychiatry director and clinical pharmacist. The meeting attended by the monitoring team was essentially a review of specific cases relative to the use of psychoactive drugs. Lab reports, diagnostics, adverse drug reaction, and follow-up consults were reviewed during this meeting. It was good to see that this type of intense case review was being completed. The purpose of a polypharmacy committee is to review individuals who receive multiple psychoactive agents and to provide clinical justification for the use of the multiple agents. That did not occur during the conduct of the reviews. Psychoactive polypharmacy is discussed further in Section J. The lab matrix contained the monitoring parameters for the new generation antipsychotics and other medications. It was evident that monitoring for adverse effects of these medications occurred at the facility: • The QDRRs reviewed provided nice commentary on the various monitoring parameters. • The MOSES and DISCUS evaluations captured a variety of side effects including weight gain. • A DUE was completed for the drug olanzapine.	Noncompliance

#	Provision	Assessment of Status	Compliance
	antipsychotic medications.	Because the QDRRs did not include any tables with sequential labs, it was difficult to determine if overall the timelines for monitoring labs was in compliance with the protocols. Notwithstanding the provision of good information related to the use of psychotropics, there was little response to the QDRR recommendations generated by the clinical pharmacist on the part of the primary care physicians. Response from the psychiatrist was more appropriate when the recommendations were related to the use of psychoactive agents. The use of stat drugs and restraints was reviewed during the P&T committee meetings. Although the laboratory worksheet contained data on the use of benzodiazepines and anticholinergic burden, that information was not included in the actual report.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Responses to the recommendations of the pharmacists occurred prospectively and retrospectively. During the prospective pharmacy review, the pharmacist documented the response of the provider in the Interventions section of WORx. The clinical pharmacist reported that a quarterly report was sent to the medical director for review and corrective action, if deemed necessary. Prospective reviews are discussed in N1 above. Retrospectively, the clinical pharmacist tracked the responses of the providers to the recommendations generated by the QDRRs. In order to determine compliance, the 31 QDDRs discussed in item N2 were assessed to determine the adequacy of the responses from both the primary providers and the psychiatrists. Data related to the primary provider response showed: • 31 of 31 (100%) documents included signatures of the medical director indicating that review occurred • 26 of 31 (84%) documents had recommendations made by the clinical pharmacist • 31 of 31 (100%) documents indicated "no action required" by the primary provider The psychiatric provider was also required to review the QDRRs: • 21 of 31 (68%) reviews involved the use of psychotropics • 6 of 21 (29%) reviews did not have recommendation related to the use of psychotropics • 15 of 21 (71%) reviews included recommendations related to the use of psychotropics o 8 of 15 (53%) reviews indicated no action necessary by the psychiatrist	Noncompliance

#	Provision	Assessment of Status	Compliance

- 3 of 15 (20%) indicated agreement
- 3 of 15 (20%) were blank
- 1 of 15 (7%) had a missing signature sheet

As noted in Provision N2, the medical director reviewed all QDRRs and consistently documented "no action required." No other explanations were provided. The monitoring team discussed this finding with the medical director who indicated that although he reviewed the QDRRs, he did not know those individuals who were not in his caseload and, therefore, responded "no action was required."

During discussions with the clinical pharmacist and pharmacy director, the monitoring team was informed that the medical staff accepted very few of the recommendations from the clinical pharmacist. Data related to pharmacy recommendations were collected and reviewed quarterly with the medical director and medical staff. The discussions were documented in the Rx Intervention Meeting minutes. A table, containing QDDR data for 2011, was provided to the monitoring team during the P&T Committee meeting. A replica of the table is presented below.

Physician Response to Pharmacy QDRR Data
Year 2011

Month	No. of QDRRs	No. of Pharmacists Recommendations	No. of Recommendations Implemented/Accepted	Outcomes
April	18	44	19	65% - accepted 0% - rejected 100% - no action required
May	22	44	2	9% - accepted 90% - no action required
June	31	61	0	100% - no action required
July	21	40	1	5% - accepted 100% - no action required
August	34	53	7	53% - no action required 13% - accepted 1.9% - rejected
September	24	40	8	57.5%-no action required 22.5% - accepted 5% rejected

This facility-generated data documented that a very minute percentage of pharmacy recommendations were adopted by the medical providers. These findings were congruent with the reviews of QDRRs completed by the monitoring team. As noted in Provision N2, many relevant recommendations were provided, all of which were

#	Provision	Assessment of Status	Compliance
		responded to with "no action required" by the medical director. The practice of the medical director signing "no action required" ostensibly resulted in a lack of a medical review as there was no demonstrated response to the recommendations.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	The most recent MOSES and DISCUS evaluations included in the record sample were reviewed along with a sample provided with the document request. The findings are summarized below: Forty-six MOSES (23 individuals) tools were reviewed. The findings of the documents were: • 46 of 46 (100%) were signed and dated by the physician • 31 of 46 (67%) documented no action necessary • 15 of 46 (33%) documented no conclusion (BLANK) by the prescriber Fifty-two DISCUS (26 individuals) evaluations were reviewed and showed that: • 51 of 52 (98%) were signed and dated by physician • 33 of 52 (63%) indicated no TD • 2 of 52 (4%) indicated TD probable • 17 of 52 (33%) documented no prescriber conclusion The MOSES evaluation was completed semi-annually while the DISCIS was completed quarterly. The DISCUS was required for individuals who received antipsychotics and Reglan. The MOSES was required for any individual who received antipsychotics or AEDs. Both evaluations were reviewed by the psychiatrist prior to seeing the individual in clinic. <u>Additional Discussion</u> The detection of extrapyramidal symptoms and tardive dyskinesia are important medical issues that have the ability to significantly impact the quality of life. These data should be included in relevant documents, such as the annual medical summaries and neurology clinic notes. Although the medical providers reviewed and signed the forms, the lack of a prescriber conclusion in 33% of the MOSES evaluations and 33% of the DISCUS evaluations resulted in the monitoring team's finding of noncompliance.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>N6</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.</td><td>The facility implemented an ADR policy in December 2010. The clinical pharmacist reported that staff was re-trained in August 2011 on the importance of identifying and reporting ADRs. A total of 10 ADRs were reported since the last onsite review.

<table>
<tr><th colspan="4">Adverse Drug Reactions
April – October 2011</th></tr>
<tr><th>Reaction</th><th>Suspected Drug</th><th>Date</th><th>Outcome</th></tr>
<tr><td>Hyponatremia</td><td>Tegretol</td><td>4/22/11</td><td>ADR form indicated that tegretol was discontinued on 4/9/10. The ADR form did not provide the sodium value that resulted in generation of the ADR report. The last reported value was 132 on 4/27/10.</td></tr>
<tr><td>Diaphoresis, tachycardia</td><td>Lexapro/Wellbutrin</td><td>4/11/11</td><td>“Changes ere not made to the medication regimen as it was determined that the benefits of continuing medications outweighed the risks.”</td></tr>
<tr><td>ANC</td><td>Valproic acid</td><td>5/13/11</td><td>Valproic acid tapered and discontinued. ANC (5/11/11) was 1.2.</td></tr>
<tr><td>CPK</td><td>Zocor/Niacin</td><td>5/15/11</td><td>Zocor and Niacin both discontinued. CPK (5/12/11) was 546 IU/L</td></tr>
<tr><td>CPK</td><td>Zocor/Niacin</td><td>5/24/11</td><td>Zocor discontinued. CPK (3/23/11) was 359IU/L</td></tr>
<tr><td>Rash</td><td>Bactrim</td><td></td><td>Widespread rash that improved with antihistamines and corticosteroids. Bactrim DS flagged on the patient’s profile.</td></tr>
<tr><td>CPK</td><td>Pregablin</td><td>8/10/11</td><td>Slowly taper and discontinue drug; CPK levels decreased but there was no documentation of normal values</td></tr>
<tr><td>Cardiac arrhythmia</td><td>tropicamide</td><td>9/14/11</td><td rowspan="2">The individual received 4 mg of Ativan po for an eye appointment. The initial report cited the tropicamide as the suspected agent. The follow-up report implicated Ativan. The individual required evaluation in the Emergency Department of the local hospital.</td></tr>
<tr><td>Cardiac arrhythmia</td><td>Ativan</td><td>9/14/11</td></tr>
<tr><td>Excessive salivation drooling</td><td>Haldol</td><td>9/15/11</td><td>Individual was given Haldol in the ED for agitation following a head injury. EPS symptoms subsequently developed, but later resolved.</td></tr>
</table>

Although 10 reported ADRs demonstrated a significant improvement in reporting, various records reviewed indicated that many ADRs went unreported. The current ADR policy did not set a threshold for intense case review. The ADR involving Ativan likely warranted further review for the following reasons:
• The reaction resulted in a hospital evaluation due to a cardiac arrhythmia.
• A substantial dose of a benzodiazepine was used as a chemical restraint. The appropriateness of the use of this drug should have been reviewed and the following questions posed:
o Was Ativan given in addition to other standing psychotropics or sedating</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		medications? o Was monitoring following administration of this dose appropriate? o Did the individual receive a similar dose in the past? The ADR form did not provide information on the other medications received by the individual. The QDRR noted that the individual received trazodone 100 mg TID. The ADR forms submitted did not contain the information from the P&T review or the required signatures. <u>Additional Discussion</u> Adverse drug reactions are associated with significant morbidity and mortality. The purpose of ADR reporting is to reduce the risk associated with drug prescribing and administration to improve patient care, safety and treatment outcomes. The reporting system is a fundamental component of drug safety following release into the pharmaceutical market. ADR reporting and monitoring systems have the ability to result in changes in policy and procedures related to control of medications with a high potential for adverse effects. The facility should expand efforts at developing a more robust ADR reporting and monitoring system. Consideration should be given to the following: • The facility should ensure that direct care professionals and ancillary health care professionals receive appropriate training on recognition and reporting of ADRs. • The ease of reporting should be reviewed. • The facility should review its current system and determine if greater surveillance is needed. • In order to increase reporting, consideration should be given to developing a list of triggers or signals that would prompt the pharmacist to further explore the possibility of an adverse drug reaction. The following are examples of potential triggers: o Prescribing an anticholinergic agent to someone who receives a drug known to produce EPS o Hypokalemia noted in individual who takes a drug that is known to cause or worsen hypokalemia o Documentation of C. difficile toxin in an individual who received a drug that is known to cause pseudomembranous colitis. o Presence of supra-therapeutic drug levels, such a lithium • Thresholds for the intense case review should be established. It would be reasonable to require that any ADR that resulted in hospitalization or an emergency department evaluation require a detailed look at the event.	

#	Provision	Assessment of Status	Compliance
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 approved the Drug Utilization Policy in October 2011. The policy provided some specific guidance on completion of DUEs. One DUE was completed every quarter. DUEs were completed for dilantin, simvastatin, and olanzapine. Each of the evaluations contained: • Background information • Objective of the review • Source of data • Results of data analysis • Recommendations/Conclusions Overall, the evaluations were thorough and provided good information relevant to practices at the facility. Data analysis did not highlight any significant problems with the use of these agents. Corrective actions were targeted to deficiencies associated with systemic issues. The clinical pharmacists presented the evaluations at the Pharmacy and Therapeutics Committee Meetings.	Substantial Compliance
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	The facility maintained a system for reporting and monitoring medication errors. The monitoring team was provided numerous sets of data related to medication variances. The various tables and graphs in some instances were updated and therefore contained different values. Pharmacy and nursing reported errors separately. While the information was shared, it did not pull together in a format that lent itself to easy data analysis. The Medication Variance Committee met monthly to review variances based on discovery dates. A synopsis of this information was presented at the Pharmacy and Therapeutics Committee Meeting. Overall, the number of medication errors had decreased in recent months. Notwithstanding an overall decrease in errors, the monitoring team had numerous concerns related to safe medication practices: • The true error rate was unknown because the facility was not reconciling non-pill medication variances at the time of the onsite review. Omissions were a significant problem for the facility. Data captured pill omissions only. • Although the pharmacy director indicated there were no problems with liquid medications, audits conducted at the prompting of the monitoring team indicated that there were some issues in this area. The pharmacy and nursing departments will need to conduct regular audits to determine the extent of the problem. • The state-issued policy required that an error be captured as an episode. This translated into an event that resulted in numerous occurrences of error being reported as a single error. • The medication error data log provided inadequate and inconsistent information.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In some instances the dose of medication was reported while in other instances, it was not. An error such as "extra does of lisinopril" or "extra dose of Seroquel" had the potential to be a serious error depending on the dose given. One error was "gave two extra pills of Seroquel." The severity of this error largely hinges upon the prescribed dose. If 25 mg was prescribed, the individual would receive a total of 75 mg. If 150 mg was prescribed, the individual would have received 450 mg of Seroquel and this would have put the individual at risk for problems, such as hypersomnolence and orthostatic hypotension. The medical, nursing and pharmacy departments should work collaboratively to improve data presentation and analysis.	

Recommendations:

1. The pharmacy must document all interactions between the pharmacists and the clinicians. Documentation should include resolution of problems (N1).

2. The pharmacy and medical departments should collaborate to develop a list of drugs that will require review of laboratory data prior to dispensing (N1).

3. The medical director should regularly discuss the pharmacy intervention data with the medical staff, counsel physicians as necessary and provide educational opportunities based on data analysis and needs assessments. Systemic issues identified as a result of data analysis should also be addressed (N1).

4. The lab matrix should be expanded to include other medications that require monitoring, including but not limited to, thyroid replacement hormones, statins, and diabetic agents. This will help ensure that monitoring for these drugs occurs at the appropriate intervals (N2).

5. Serial labs should be presented in tabular format. This will allow the medical providers and pharmacists to determine if the frequency of monitoring is appropriate. Additionally, it will allow for easy detection of trends in lab values (N2).

6. The QDRR should be reviewed by the providers responsible for care of the individual. The providers should thoughtfully review the recommendations and respond appropriately. When the recommendations are rejected, a reasonable explanation should be provided (N2).

7. The facility should take multiple actions with regards to the ADR reporting and monitoring system (N2):
    a. The ADR policy should be revised to incorporate the use of an intensity scale and requirement for an intense case analysis.
    b. The ADR policy should specify how the reporting form is completed.
    c. An ADR summary log should be maintained to improve data analysis. One way of accomplishing this is to utilize a simple spreadsheet that provides data on the specific drug, drug type, and reaction type (allergic, blood dyscrasias, elevated liver enzymes, etc.), in

separate columns. Further description of the event and other comments could be put in a separate column. This would allow sorting by specific drug, drug type and drug reaction.

8. The facility must take several steps in advancing the medication variance system (N8):
    a. The facility must address assess the potential for medication errors for all forms of medications. This will require some system of reconciliation of liquid medications.
    b. The facility must implement strategies and systems that allow for detection of medication variances at every step of the medication use system.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o LSSLC Organizational Chart o Individuals Served- Alpha o Physical Nutritional Management LSSLC Policy #18 (8/30/11) o Section O Presentation Book and POI o Settlement Agreement Cross-Reference with ICF-MR Standards Section O-Physical Nutritional Management o Settlement Agreement Section O: Physical Nutritional Management Audit forms submitted o PNMT member list o CVs/resumes for PNMT members o PNMT Continuing Education documentation o PNMT meeting agendas/minutes and attendance sheets submitted o List of individuals with PNM needs o Head of Bed Elevation Assessment Protocol and Evaluation template o List of hospitalizations/ER visits o NEO training curriculum for PNM o List of Risk Levels for Choking, Falls, Skin Integrity, GERD, Constipation, Osteoporosis, Aspiration, Respiratory (Low, Medium, High) o Dining Plan template o Individuals with Modified Diets/Thickened Liquids o Individuals with diet downgrades in the past 12 months o List of individuals with poor oral hygiene o List of individuals with chronic respiratory infections in the last 12 months o List of individuals with a choking incident in the past 12 months o Follow-up documentation related to choking incidents since the previous review (Individual #460, Individual #597, Individual #342, Individual #241, and Individual #471) o List of individuals with fecal impaction in the last year o Individuals with BMI equal to or less than 20 o Individuals with BMI equal to or less than 30 o Individuals with unplanned weight loss of 10% or greater over six months o Individuals with chronic dehydration o Pneumonia Diagnosis o Drug Order Report (4/1/10 to 10/20/11) o Wound Clinic Spreadsheet (2011) o List of individuals with pressure ulcers in last 6 months and last 12 months o Fractures

	o Falls o Individuals who were non-ambulatory or require assisted ambulation o Orthotic and Assistive Brace List as of 9/15/11 o Primary Mobility Wheelchairs o Ambulation Assistive Equipment List as of 9/15/11 o Long Distance Wheelchairs o PNM Maintenance Log o PNMP Monitoring Form templates o PNMP Monitoring Results database o List of Individuals with PNM monitoring in the last quarter, Scores by Individual o PNMPs submitted o Physical Therapy Equipment List o Evaluation Trigger Database o Wheelchair Seating Database o Mealtime Assistance o Samples of Competency-based inservice training o List of individuals with enteral nutrition o List of individuals who require mealtime assistance o List of individuals receiving MBSS/VFSS in the past year o Aspiration Pneumonia/ Enteral Nutrition Evaluations for: • Individual #96, Individual #323, Individual #504, Individual #68, Individual #147, Individual #539, Individual #248, Individual #444, Individual #369, Individual #422, and Individual #321 o PNMT Evaluation for Individual #96 o PNMT documentation for Individual #232 o Information from the Active Record including: PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms and Action Plans, PSP reviews by QDDP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets, Habilitation Therapy tab, Communication Dictionary, and Nutrition tab for the following: • Individual #248, Individual #447, Individual #502, Individual #36, Individual #232, Individual #262, Individual #387, Individual #552, Individual #235, Individual #321, Individual #342, Individual #310, Individual #96, Individual #352, Individual #47, Individual #267, Individual #245, Individual #241, Individual #218, Individual #271, Individual #189, Individual #518, and Individual #77. o PNMP section in Individual Notebooks for the following: • Individual #248, Individual #447, Individual #502, Individual #36, Individual #232, Individual #262, Individual #387, Individual #552, Individual #235, Individual #321, Individual #342, Individual #310, Individual #96, Individual #352, Individual #47, Individual #267, Individual #245, Individual #241, Individual #218, Individual #271,

	Individual #189, Individual #518, and Individual #77. o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #248, Individual #447, Individual #502, Individual #36, Individual #232, Individual #262, Individual #387, Individual #552, Individual #235, Individual #321, Individual #342, Individual #310, Individual #96, Individual #352, Individual #47, Individual #267, Individual #245, Individual #241, Individual #218, Individual #271, Individual #189, Individual #518, and Individual #77. o Action Plans, Risk Rating Assessments, Plan of Correction and associated documentation submitted for Individual #447 o Documentation from PSP meeting for Individual #16 on 11/2/11 o Documentation from PNMT meeting for Individual #232 <u>Interviews and Meetings Held</u>: o Danielle Perry, AuD, CCC-A, Habilitation Therapies Director o Gail Harris, PT o Jennifer Burson, COTA o Cheryl Bennett, RN, o Candace Vieira, MS, CCC-SLP o Cheri Gonzales-Marini, MS, RD/LD. o PNMP Coordinators and Supervisor o Various supervisors, nursing and direct support staff <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs o Work areas o PNMT meeting for Individual #232 o PSP meeting for Individual #16 o Multiple PSPA meetings for Individual #447
	Facility Self-Assessment: LSSLC submitted its self-assessment for this provision (POI). In addition, the monitoring team requested that the Habilitation Director review the Presentation Book onsite and a copy was submitted for review per request. The POI did not identify what activities were conducted for self-assessment, but rather included dated statements related to a variety of tasks since completed. Also, there was no mechanism to determine how the facility had determined noncompliance with all items in this provision. The status statements did not reflect a strategic action plan, but overall, the actions appeared to be logical, and directed toward achieving

	compliance with this provision. Self-audits using the Settlement Agreement Cross-Reference with ICF-MR Standards Section O- Physical Nutritional Management tool and Guidelines were not conducted and, as such, were not used to determine compliance with this provision. Though some improvements were noted, the monitoring team concurred that LSSLC continued to be in noncompliance for each of the items in provision O.
	Summary of Monitor's Assessment: The PNMT at LSSLC consisted of only one dedicated team member (nurse) at the time of this review. While a number of meetings had been held since the previous review, the team had initiated an assessment for only one individual, yet was unable to complete it due to her transfer to a hospice facility. A second assessment for another individual had just been initiated and a preliminary meeting was held the week of this onsite review. Attendance by all core team members was inconsistent and will ultimately impact the effectiveness of this team. The facility was significantly behind in the development of this team. The PNMPs were of a consistent format and each was current within the last 12 months. LSSLC had incorporated instructions related to bathing, oral hygiene, and medication administration for most individuals. Implementation of these plans, while improved, continued to be problematic and staff did not understand the rationale for the strategies they were instructed to apply. In addition, there was no evidence that a strong skills-based competency training for elements of the plans was provided. Positioning and transfers continued to be a concern. Supervisors and monitors were not recognizing the problems and/or were not taking sufficient corrective actions to address them. PNMPCs did not consistently identify ongoing problems and admitted to not persisting with reporting issues when they were not attended to previously. PNMP monitoring must also address the question of whether interventions are effective. The PSTs will require ongoing clinical instruction regarding risk assessment to effectively implement these. A meeting related to the risk assessment process with one PST was conducted by the monitoring team during this onsite review with significant discussion about strategies for the team to consider as they implement this policy. Further evaluation of the effectiveness of this process will be necessary during future onsite reviews by the monitoring team. The refinement of this process will also greatly impact the manner in which the PNMT functions to implement interventions to mitigate identified health risks. As described in detail in Section P below there were several cases that did not reflect an effective, appropriate and timely team approach to the delivery of PNM supports and services. While these failures to address the needs of Individual #447, Individual #16, Individual #518, and Individual #77 were not directly a function of the PNMT itself, they were a clear reflection of the status of PNM services at LSSLC. Resolution to ensure a more effective team approach to these supports system-wide is critical to the achievement of compliance with this provision.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a 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	LSSLC formally initiated the new process for the Physical Nutritional Management Team (PNMT) as of 2/16/11. The nurse position was filled on 5/1/11. Core team members at the time of this onsite review were Cheryl Bennett, RN, Candace Vieira, MS, CCC-SLP; Sharon Setzer, OTR, Gail Harris, PT, and Cheri Gonzales-Marini, MS, RD/LD. Danielle Perry, AuD, CCC-A, Director of Habilitation Therapies was listed as an additional member. Minutes and sign-in sheets were submitted for organizational meetings held on 7/14/11 (two team members attended), 7/18/11 (three attended), 7/25/11 (four attended), 8/8/11 (three attended), and 8/15/11 (four attended). 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 had not met regularly since the time of the previous review. No meeting minutes or other documentation was submitted for any meetings held prior to 7/14/11, though the team had been fully identified and assigned as of 5/1/11. An assessment for Individual #96 had been initiated and several meetings were held. A report and an action plan were not completed due to her transfer to a hospice unit as of 10/1/11. Another assessment was initiated for Individual #232 and a meeting was held to review his baseline status during the week of this onsite review. This meeting was attended by the monitoring team. Resumes/CVs were submitted for the nurse and dietitian team members listed only. The resumes/CVs submitted indicated that each of these clinicians had at least three years of experience and Ms. Gonzales-Marini had previous experience with individuals who had developmental disabilities. The SLP was a new graduate and had just completed her clinical fellowship at LSSLC earlier this year. PNM-related continuing education documented since the previous review included state-sponsored webinars on 8/9/11, 8/10/11, and 9/14/11. Participation of PNMT members in one or more webinar related to the PNMT was documented by Danielle Perry, AuD, CCC-A, Candace Vieira, MS, CCC-SLP, Cheri Gonzales-Marini, MS, RD/LD, and Cheryl Bennett, RN. PNMT Core Team training in Austin was attended by each of the team members except Gail Harris, PT. She did not attend any PNMT training offered by the State and had not attended any other continuing education courses since the previous review.	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.	Based on the number of PNMPs submitted, there were 372 individuals identified with PNM needs at LSSLC, or 100% of the current census. A policy and process used to establish health risk levels was implemented statewide in January 2011. The goal was to have discussions of risk occur during each individual's PST meetings. At the time of this review, the teams were continuing to work toward integrating this into the PSP process that had been initiated in the Fall 2010. The PSTs will require ongoing clinical instruction and support regarding risk assessment to effectively implement these policies and procedures. A meeting related to the risk assessment process with one PST 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 implemented this policy (for Individual #560). Continued evaluation of the effectiveness of this process will be necessary during future onsite reviews by the monitoring team. The refinement of this process will also greatly impact the manner in which the PNMT functions to implement interventions to mitigate identified health risks. 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. The complexity of PNM-related risk indicators requires comprehensive and collaborative team assessment, intervention plan development, implementation, and monitoring. The current system of risk identification continued to be problematic and the PNMT was extremely behind in the identification and assessment of individuals who were at high risk and required more extensive PNM supports and services.	Noncompliance
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for	As stated above, there were approximately 372 individuals identified with PNM needs and provided with PNMPs. The PNMPs were generally of a consistent format and contained information related to the focus, hearing, vision, mobility, transfers, positioning, bathing/skin care, mealtime instructions, behavior concerns, precautions, risk level, and communication. Each of the plans now also referenced oral hygiene and medication administration. The monitoring team selected 23 individuals for a record sample (included in the above	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	list of documents reviewed). Comments are provided in detail below in hopes that the information will be useful to the facility. Overall, this was a very good set of PNMPs. As noted throughout this section of the report, improvements in implementation will be needed: • PNMPs were submitted for 22 of 23 (96%) individuals included in the sample. • PNMPs for 21of 23 individuals in the sample (91%) were current within the last 12 months. • In 21 of 21 current PNMPs reviewed (100%), positioning was addressed. • In 21 of 21 current PNMPs reviewed (100%), the type of transfer was clearly described or there was a statement indicating that the individual was able to transfer without assistance. • In 18 of 21 current PNMPs reviewed (86%), the PNMP listed bathing instructions and listed equipment when needed. The PNMPs consistently listed the equipment needed. • In 20 of 21 current PNMPs reviewed (95%), the PNMP listed toileting instructions. • In 17 of 21 (81%) of the current PNMPs reviewed for individuals who were not described as independent with mobility or repositioning, handling precautions, or instructions were included. • In 21 of 21 current PNMPs reviewed (100%), instructions related to mealtime were included. Dining plans were also submitted for individuals included in the sample as requested by the monitoring team. • 10 of 21 individuals (48%) received enteral nutrition. Instructions for no oral intake were clearly stated in the PNMPs for each. • In 11 of 21 PNMPs reviewed (52%), dining position for meals was provided. No positioning instructions were provided for any of the individuals who received enteral nutrition and were NPO. • In 11 of 11 PNMPs reviewed (100%), diet orders for food texture were included for those who ate orally. Assistance techniques for oral intake were consistently provided in the plan. • In 4 of 10 PNMPs for individuals who received liquids orally (40%), the liquid consistency was clearly identified. • In 11 of the 11 PNMPs for individuals who ate orally (100%), dining equipment, regular dinnerware and utensils were specified in the dining equipment section. • In 21 of 21 PNMPs reviewed (100%), a heading for medication administration was included in the plan. The content generally referred to the MARS and the eating instructions only. • In 21 of 21 PNMPs reviewed (100%), a heading for oral hygiene was included in the plan. The content provided varied from plan to plan, but was generally individualized and specific.	

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		• 21 of 21 PNMPs (100%) reviewed included a heading related to communication. The information merely was a statement of verbal or nonverbal with reference to use the Communication Dictionary. Specifics regarding expressive communication or strategies that staff could use to be an effective communication partner were provided in only four cases. There was evidence in each of the annual OT/PT assessments that the PNMPs were reviewed by therapy clinicians, however, there was no evidence of review by the PST in relation to identified risk and the efficacy of the interventions implemented. In some cases, statements from the assessments were included in the PSP, but there was no element that indicated the information was discussed or that the PNMP was reviewed by the full PST. The PNMPs were updated by the therapy clinicians based on change in status or need identification. Revised dates were not indicated in the plan, though the PSP date (annual) and highlighting of new instructions that were added to the previous plan were consistent.	
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.	PNMPs and Dining Plans were developed by the therapy clinicians with limited input by other PST members. 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 adaptive or assistive equipment as well as various positioning outlined in the plan. These pictures were large and easy to see. Wheelchair positioning instructions were generally not specific in the PNMPs. Limited instructions in the PNMP identified that individuals should remain upright, and described the angle of recline, seatbelt use, and the type of transfer to be used. General practice guidelines with regard to transfers, position and alignment of the pelvis, and consistent use of foot rests and seat belts were taught in New Employee Orientation, but not generally specified in the PNMPs. Dining Plans were noted to be available in the dining areas. Though improved since the previous reviews, errors were noted in staff implementation of interventions and recommendations outlined in the mealtime plan portion of the PNMP and/or Dining Plans. Errors in the plans themselves were also noted that had not been effectively identified through mealtime monitoring. A number of examples are presented below in hopes that this detail will be useful to the facility: • Individual #68: He was slumped in a recliner with his right leg elevated significantly while receiving enteral nutrition. Staff sitting next to him had to be	Noncompliance

#	Provision	Assessment of Status	Compliance
		prompted to reposition him. He was also noted to be very wet with urine that had gone unattended to by direct support staff and nursing. • Individual #430: Dining plan stated to cut food into nickel size pieces though he was on a ground diet. This had not been noted by the PNMPCs. Staff were pushing food off of his spoon with another spoon. This strategy was not in his dining plan. • Individual #447: Staff offered liquids before he had swallowed the food in his mouth from the previous bite. The SLP observing him did not intervene. Staff also did not consistently wait until his mouth was clear before presenting the next bite. • Individual #67: She was not seated under the table and her plate was too far away. Significant food loss was observed. • Individual #76: Staff had to remove his foot rests for the meal because his wheelchair did not fit under the pedestal table. Once the foot rests were removed, he did not have sufficient support to his feet and legs. • Individual #213 was observed to be leaning over to the left while eating. Staff did not attempt to reposition her. • Individual #33's Dining Plan listed a four ounce glass in the adapted equipment list, however, an eight ounce glass was pictured on the plan. Though improvements were certainly noted, there were a number of errors in implementation of the PNMPs, suggesting that staff did not fully understand the importance of these plans and the risks presented by the individuals they served. In particular, staff were not able to recognize when alignment was inappropriate in order to remedy or report it as a problem. When prompted, they were generally not able to make the appropriate corrections, requiring significant coaching (also see other examples in section P below). In addition, when staff were asked questions as to why an individual had honey-thick liquids or a particular spoon, they were generally not able to answer appropriately. Staff were not able to identify health risk indicators for the individuals they supported.	
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	Staff training for New Employee Orientation related to PNM included a comprehensive curriculum presented over three days. A new course taught by nursing related to clinical indicators in order to teach staff about risks and individual triggers and signs and symptoms for more timely reporting and problem resolution. An aspiration signs and symptoms iLearn course was also added as annual refresher. After participation in the training, a check-off was conducted with the staff to establish competency in some of these areas. A tremendous amount of content was to be presented with the intent of establishing competency in a short time in NEO. It will be necessary to	Noncompliance

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	to implement the mealtime and positioning plans that they are responsible for implementing.	increase the amount of time new employees have for the PNM aspects of their training and competency check-offs. There was evidence in the training documentation for Dining Plans or PNMPs that the individual-specific training that was provided was competency-based by return demonstration. Skills-based competency testing included an outline of each of the steps necessary to complete the task and each was to be checked off as it was correctly completed by the participant. Checklists were individualized and discrete, so as to ensure proper evaluation of their abilities to demonstrate and apply specific skills necessary for knowledgeable and accurate implementation of PNMPs and Dining Plans. Those conducting the training were checked off as competent in the skills themselves as well as with regard to teaching the skills and completing the check-offs to establish competency. This was a clear improvement in this area and appeared to be consistently implemented. There continued to be concerns, however, that the techs and PNMPCS were not sufficiently competent to train others to competence without an adequate system of validation, oversight, and review. Training was not consistently effective as evidenced by the implementation errors noted by the monitoring team and described above and in section P below. The current system of monitoring had recently implemented a system of targeted review of individuals at highest risk at an individually prescribed frequency to ensure appropriate implementation of supports designed to mitigate PNM risks. 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 was conducted by therapists and PNMPCs. Competency had not been clearly established via this system to date.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	There was no formalized policy related to the process of PNM monitoring (lifting, transfers, positioning, mealtime, and communication). There was no formalized curriculum for training the PNMPCs. Validation of the PNMPCs for monitoring and inservice training was not conducted at the time of this review. A monitoring form had been developed to address implementation of the PNMP, mealtime, lifting and transfers, use of AAC devices, and wheelchair and bed positioning. A prescribed schedule based on risk levels was designed to ensure that monitoring occurred during positioning, meals, medication administration, and oral care. The monitoring schedules continued to be under development with the intent to base frequency on health risk indicators. The distribution reported above was not consistent with this, however. There was no evidence that positioning monitoring had been	Noncompliance

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		conducted for Individual #447 who presented with significant issues related to position, alignment and safe transfers. He was not listed at high risk in any areas per the documentation submitted. There were at least 16 other individuals who were listed at high risk in one or more areas related to PNM. The frequency of monitoring completed based on the documentation submitted for each was not consistent with the facility's monitoring schedule, which was based on risk level. A database was under construction to aggregate data and to track compliance findings and analyze findings, issues, staff re-training, and problem resolution. There was no existing policy that outlined the process of monitoring, identifying the roles and responsibilities of monitors, training and validation of monitors, frequency, distribution, documentation, or follow-up and communication of findings. The monitoring team will further evaluate this process in the future. The PNMT did not conduct monitoring and the results obtained by the PNMPCs were not reported or reviewed in the PNMT process as only one individual had been assessed to date. There was no system implemented to address monitoring by the PNMT at the time of this onsite review. The system used to track and trend findings should be available to the PNMT and used in their assessment and follow-up on action plan elements and person-specific outcomes that are measurable, meaningful, and functional for the individual. Immediate intervention was to occur if an individual was determined to be at risk of harm. The monitor was to notify the appropriate person, such as the charge, home manager, nurse, or therapist. The forms themselves provided a mechanism to document these actions or to document follow-up, but this was not consistently noted. The PNMPCs and their supervisor admitted that the system lacked consistency with the identification of problems and follow through to resolution of reported issues.	
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.	The new health risk assessment process was introduced in January 2011 and the PSTs continued to face challenges in order to fully implement this process. Discussions with PST members were conducted with the monitoring team in an attempt to understand where the teams were with this and to hopefully move it along. Individuals with PNMPs were reviewed at least on an annual basis, or more frequently based on PST referrals, findings from monitoring and other informal observations. The system continued to need to be more fully developed and refined so as to ensure assessment of the effectiveness of the plans on a regular basis, in addition to the PNMP and dining plan monitoring conducted by the PNMPCs.	Noncompliance

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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.	There were 64 individuals (17%) who were enterally nourished, 13 of whom also received some level of oral intake as well. There were at least 10 of these individuals who were listed with aspiration pneumonia in the last year. There were approximately 44 (12%) individuals with one or more incidences of pneumonia in the last 12 months. Twelve of these were diagnosed with one or more incidences of aspiration pneumonia. There were 26 (7%) individuals listed at high risk for aspiration. Of those with aspiration pneumonia, eight were identified at high risk, two others identified at medium risk (Individual #47 and Individual #352) and two others were listed at low risk for aspiration. Individual #504 and Individual #141 each had an occurrence of aspiration pneumonia, but were not considered at risk for this significant issue. Each of these individuals was to receive an annual Aspiration Pneumonia/Enteral Nutrition Evaluation. Samples were submitted for 11 individuals. Each of these was completed as submitted and appeared to have been completed by the PST. Most had been completed in February 2011 or March 2011, though several were undated. The evaluations referred to the Risk Action Plans to address identified issues. The assessments typically documented the current interventions. Measurable outcomes were provided in a few cases, primarily that the individual would not experience aspiration or pneumonia, but without careful examination of the current plan and its effectiveness toward that end. All individuals who received non-oral intake in the selected sample had been provided a PNMP and Dining Plan that included the same elements described above. There was no formal protocol outlined for an individual to return to oral feeding. 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.	Noncompliance

Recommendations:

1. Attendance at PNMT meetings must include all core team members for each meeting to ensure a comprehensive interdisciplinary approach to assessment and intervention (O1).

2. Ensure that the PNMT functions as an assessment team that may include collaborative interaction and observation rather than merely a meeting forum to conduct record review and history. Evaluations must be based on new data or information in order to yield a new perspective to address specific issues that drove the referral to the team (O1).

3. Identify issues that require tracking relative to individuals evaluated by the PNMT, establish the baseline, gather new data over a prescribed

period of time, then review the findings as a team in order to analyze the relevance to a problem or as evidence of a solution (O2).

4. Increase the time available for NEO training related to PNM competency check-offs and ensure that refresher courses are developed to address areas other than just lifting (O5).

5. The establishment of a more interdepartmental/interdisciplinary implementation of PNMPs and Dining Plans is indicated as well as to 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 (O6-O7).

6. Consider a system of drills for modeling and coaching with staff, perhaps a "flavor of the week" approach. Selection of a particular theme with a focus of training, coaching and review would heighten staff awareness of these concerns and would likely yield overall improvements (O7-O8).

7. Consider more immediate development of a curriculum for training PNMPCs (O7-O8).

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:** Documents Reviewed: o LSSLC Organizational Chart o Individuals Served- Alpha o Admissions list o Budgeted, Filled and Unfilled Positions o OT/PT Staff list o OT/PT Continuing Education documentation o Section P Presentation Book and POI o Settlement Agreement Cross-Reference with ICF-MR Standards Section P-Physical and Occupational Therapy o Settlement Agreement Section P: OT/PT Audit forms submitted o Occupational/Physical Therapy Services Policy (8/28/11) o List of individuals with PNM needs o Individuals receiving direct OT/PT o Head of Bed Elevation Assessment Protocol and Evaluation template o OT/PT Evaluation Instructions o OT and PT Evaluation Update template o Update Instructions o Assessment Data Base o List of hospitalizations/ER visits o List of individuals with pneumonia o NEO training curriculum for PNM o List of Risk Levels for Choking, Falls, Skin Integrity, GERD, Constipation, Osteoporosis, Aspiration, Respiratory (Low, Medium, High) o Pneumonia Diagnosis o Falls o Drug Order Report (4/1/10 to 10/20/11) o List of individuals with enteral nutrition o Wound Clinic Spreadsheet (2011) o List of individuals with pressure ulcers in last six months and last 12 months o Fractures o Individuals who were non-ambulatory or required assisted ambulation o Orthotic and Assistive Brace List as of 9/15/11 o Primary Mobility Wheelchairs o Ambulation Assistive Equipment List as of 9/15/11 o Long Distance Wheelchairs o PNM Maintenance Log

	o PNM Monitoring Form templates o PNMP Monitoring Results database o List of Individuals with PNM monitoring in the last quarter, Scores by Individual o PNMPs submitted o Physical Therapy Equipment List o Evaluation Trigger Database o Wheelchair Seating Database o Mealtime Assistance o Samples of Competency-based inservice training o NEO training curriculum for PNM o Mat Assessment for Seating and Positioning template o Plan of Correction and associated documentation submitted for Individual #447 o Action Plans, Risk Rating Assessments, Plan of Correction, and associated documentation submitted for Individual #447 o Documentation from PSP meeting for Individual #16 on 11/2/11 o Wheelchair Clinic Assessments and other documentation for: • Individual #11, Individual #137, Individual #109, Individual #599, Individual #232, Individual #225, Individual #389, Individual #174, Individual #444, Individual #14, Individual #492, Individual #407, Individual #33, Individual #308, and Individual #475 o OT/PT Evaluations for: • Individual #568**,** Individual #490, Individual #190, Individual #91, Individual #317, Individual #66, Individual #178, Individual #511, Individual #88, Individual #152, Individual #332, Individual #573, and Individual #539 o SAPs, PSPs, PSPAs, Assessments and related documentation for: • Individual #354, Individual #223, Individual #167, Individual #91, Individual #124, Individual #88, Individual #62. o Information from the Active Record including: PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms and Action Plans, PSP reviews by QDDP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets, Habilitation Therapy tab, Communication Dictionary, and Nutrition tab for the following: • Individual #248, Individual #447, Individual #502, Individual #36, Individual #232, Individual #262, Individual #387, Individual #552, Individual #235, Individual #321, Individual #342, Individual #310, Individual #96, Individual #352, Individual #47, Individual #267, Individual #245, Individual #241, Individual #218, Individual #271, Individual #189, Individual #518, and Individual #77. o PNMP section in Individual Notebooks for the following: • Individual #248, Individual #447, Individual #502, Individual #36, Individual #232, Individual #262, Individual #387, Individual #552, Individual #235, Individual #321, Individual #342, Individual #310, Individual #96, Individual #352, Individual #47,

	Individual #267, Individual #245, Individual #241, Individual #218, Individual #271, Individual #189, Individual #518, and Individual #77. o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #248, Individual #447, Individual #502, Individual #36, Individual #232, Individual #262, Individual #387, Individual #552, Individual #235, Individual #321, Individual #342, Individual #310, Individual #96, Individual #352, Individual #47, Individual #267, Individual #245, Individual #241, Individual #218, Individual #271, Individual #189, Individual #518, and Individual #77. <u>Interviews and Meetings Held</u>: o Danielle Perry, AuD, CCC-A, Habilitation Therapies Director o Gail Harris, PT o Cassidi Hairgrove, OTR o Jeremy McKnight, OTR o Jennifer Burson, COTA o Brenda Webb, COTA o PNMP Coordinators and Supervisor o Various supervisors, nursing and direct support staff <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs o Work areas o PSP meeting for Individual #16 o Multiple PSPA meetings for Individual #447
	Facility Self-Assessment: LSSLC submitted its self-assessment for this provision (POI). In addition, the monitoring team requested that the Habilitation Director review the Presentation Book onsite and a copy was submitted for review. The POI did not identify what activities were conducted for self-assessment, but rather included dated statements pertaining to a variety of tasks completed related to each of the Settlement Agreement provisions. Also, there was no mechanism to determine how the facility had determined noncompliance with each element in this provision. Settlement Agreement Cross-Reference with ICF-MR Standards Section P-Physical and Occupational Therapy self-audit tool results were submitted. Inter-rater reliability and compliance scores for 21 individuals were also submitted. Overall compliance was approximately 83%. It did not appear that the audits were used to self-rate compliance. An Action Plan was included in the POI, related to P1, P2, and P3 only. The Action Plan for P3 referenced the

	plan outlined in O6, steps one though 10. These actions were each pertinent to the provision, but did not reflect a comprehensive strategic action plan developed to guide the department through the process of achieving substantial compliance across all provisions, nor were they clearly linked to content in previous reports or specific recommendations made by the monitoring team. Twelve of the 19 action steps were listed as completed. Start dates and projected completion dates were listed, but not actual dates of completion. The other action steps listed were identified as in process with completion dates of 12/10/11 and 12/31/11. This approach did not serve as a clear, well-outlined plan to direct focus, work products, and effort by staff. Action steps should be short-term, stated in measurable terms with timelines with the evidence required to demonstrate completion of all interim steps. The monitoring team concurs with LSSLC self-assessment of noncompliance for each of the items in provision P.
	Summary of Monitor's Assessment: One individual case, Individual #447, exemplified the facility's performance for this provision. He came to the monitoring team's attention early in the week of the onsite visit because he was on extended bed rest since 9/25/11 due to the fact that he did not have an appropriate wheelchair. Over the course of that week, it was clear that he had not been provided with appropriate assessment, interventions and supports, training for staff, and monitoring; all resulting in injury and subsequently denying him access to active treatment and other favorite activities. The monitoring team observed, listened, and participated in the development of an action plan to address the issue with his wheelchair, transfers, positioning, and a number of additional issues, such as alternate positioning in his home and at work, so he could participate in activities. He did not have access to a personal television (his had been destroyed by another individual), appropriate assessment for spasticity management, mealtime assessment, communication assessment, and a program to encourage him to wear his eyeglasses. Habilitation therapists, among other team members, failed to provide him with appropriate and timely supports and services, ensure his safety and well being, promote opportunities to work and engage in activities that he enjoyed, and failed to serve as an advocate for him. There were numerous failures at many levels. As it turned out, this was not an isolated case. Individual #16 had been on extended bed rest due to delays in the provision of a new seating system. Individual #518 was on extended bed rest with delays in the provision of a new seating system. Individual #77 had experienced a significant change in her health and functional status (it was verbally reported that a stroke was suspected, though this was not confirmed in her record), so that her move to the community was postponed indefinitely. It was reported that due to a failure to provide 45 other wheelchairs in a timely manner, an ICFMR regulatory finding was made. These cases exemplified how critical it is that each and every employee, contractor, and volunteer at this facility meet their responsibility to do their job fully and completely in a timely manner and to actively advocate on the behalf of each and every individual. Failure to do so increases the risk of injury and

	seriously jeopardizes health, as well as impacts their access to and participation in activities for work, learning, and enjoyment. Habilitation therapies faces real challenges related to staffing, but having a greater number of skilled and knowledgeable clinicians on board will not ensure success.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	Danielle Perry, AudD, continued as the department director. Current staffing was one full-time physical therapist (who also served as the PT on the PNMT, Gail Harris, PT), three full-time occupational therapists (Cassidi Hairgrove, OTR, Jeremy McKnight, OTR, Sharon Setzer, OTR), and two OT assistants (Jennifer Burson, COTA, Brenda Webb, COTA). Linda Murley served as the PNMPC Supervisor, supervising nine PNMPCs. There were seven therapy technicians. Efforts to hire additional clinical staff had not been successful. Continuing education documented for these clinicians included a program related to seating and mobility assessments attended by two professional clinicians (Cassidi Hairgrove, Jeremy McKnight). Brenda Webb attended a course related to reimbursement of rehabilitation services. All of the clinicians attended a seating assessment course held at LSSLC during the September 2011 presented by Kelly Waugh, PT, based on a previous recommendation by the monitoring team. Fabrication and maintenance of seating systems and other assistive technology continued to be conducted with onsite technicians (three orthotic equipment technicians and one Tech II) and an outside vendor who attended seating clinics. The assessment process used by the therapists was expected to improve as they began to integrate new knowledge and skills acquired through continuing education. By report, seating systems for approximately 45 individuals had not been previously processed and the facility was cited in an ICFMR survey. The plan of correction required that these individuals become the highest priority and, as a result, seating systems for additional individuals were delayed. It was reported that all individuals in the current census had PNMP needs. As currently staffed, the caseloads were 1:372 for PT and 1:124 for OT. The OT assistants were not licensed to conduct assessments or develop intervention plans; they required supervision by the OT. They were able to gather specific data for assessments, provide interventions, conduct staff training, conduct monitoring, and engage in other responsibilities. Their roles were adjunct in service delivery. The therapy technicians were not licensed clinicians and, as such, were not able to provide skilled therapy interventions and required close and consistent supervision and recurring competency-based training. Clinicians were responsible for the annual assessments or annual 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 caseloads. Additional supports were available from the therapy assistants or technicians. Annual assessments	Noncompliance

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		or updates were completed by OT and PT, collaboratively. Many individuals would likely benefit from skill acquisition/enhancement programs related to movement, mobility, fine motor skills, and independence. There were only four individuals (1%) who participated in direct PT intervention and seven individuals (less than 2%) who received direct OT services. The current levels of PT staffing were inadequate and the caseloads for OT were high, especially given that one of the OTRs also had significant responsibilities with the PNMT. OT/PT assessments were submitted for 22 of 23 individuals in the sample selected by the monitoring team. Of those assessments submitted, only four were current within the last 12 months (Individual #552, Individual #245, Individual #189, and Individual #47). None of these was identified as comprehensive evaluations or updates. Though somewhat similar, none were consistent with regard to format or content. Of the remaining assessments, four were completed in 2010 and were identified as updates to previous evaluations (Individual #321, Individual #262, Individual #232, and Individual #310). These individuals had not received OT/PT assessments since 2007, though each had PNM needs. Five others were updates completed in 2009 (Individual #447, Individual #502, Individual #77, Individual #361, Individual #387, and Individual #36), in 2008 (Individual #241, Individual #218, Individual #352), and in 2007 (Individual #235). An admission evaluation was completed for Individual #96 in 2007 and for Individual #267 in 2004. Baseline updates for Individual #518 and Individual #271 had been completed in 2006 and 2004, respectively. No assessments were present in the individual record for Individual #342. There was no evidence of more current assessments for these 19 individuals, despite each presenting with PNM needs. The five most current assessments for each clinician were reviewed. The most current of these, however, was dated 8/16/11 (Individual #490), but most had been completed from 3/3/11 to 7/18/11. With 372 individuals requiring assessment, it was unclear why there were not more current assessments available for submission at the time of this review. At least 11 of the individuals were identified as having concerns related to movement, mobility, range of motion, limitations in levels of independence, and/or regression of functional skills. Most of the recommendations were for a variety of indirect services via the PNMP, the provision of assistive equipment, and/or orthotics, and dining supports. Assessments were completed for all individuals rather than screenings. Most of the assessments were completed by both OT and PT and, in some cases, the SLP. Sample admission assessments were requested. Only one individual had been admitted since the previous review, though only an OT/PT Addendum was submitted. This assessment had	

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		not been completed within 30 days of her date of admission. • No two assessments or updates reviewed were consistent with regard to format or content. Only one assessment submitted approximated the format as outlined in the template identified as current by the facility since 9/1/11, but none of the assessments submitted for review had been completed after this date. • None of the assessments provided a rationale for any of the recommendations outlined via a comprehensive clinical analysis of the objective data documented in the reports. The interval for reassessment was not specified in any of the assessments. • The health risks identified by the PST were not identified or addressed in any way in all but one assessment submitted. Health risk indicators identified by the PST were not included in the assessment reports. • There was no evidence that pertinent health and medical concerns were considered because there was no analysis of findings or documentation of clinical reasoning. A discussion of health risk issues with a description of functional limitations, skill abilities, and potentials for the development of an integrated therapy intervention plan, and to provide a foundation for non-clinical supports and programs, are essential elements to an appropriate clinical assessment. The risks addressed in the OT/PT assessment should be consistent with those established by the PST. Though if at any time there is evidence that the risk rating should be modified due to a change in status, the PST should meet to review this and the PNMP should be modified as needed to reflect these changes. This should also be reflected in the OT/PT assessments. Information contained within the OT/PT report should contribute to the team discussion to determine risk levels. If there is a rationale for a difference in these ratings identified in the annual assessment, this should be stated in the report for PST consideration. Risk levels identified by the collective PST should then in turn drive the supports and interventions via the PNMP and other more direct services provided by the therapists to assist in addressing those concerns. 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. • Individual #77 had experienced a significant change in status beginning on or around 6/17/11. She experienced vomiting, diarrhea and stomach pain on that date per nursing progress notes and was admitted to the hospital with a diagnosis of dehydration and GI bleed. She was evaluated and identified to present with an ischemic colon and pneumonia. A colostomy was placed. She was discharged to the LSSLC Infirmary on 6/30/11, returning to her home on 7/12/11. She had been scheduled for transition to a home in the community, but this was indefinitely postponed due to this significant medical event. On 7/12/11 a	

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		nursing progress note reported that direct support staff had reported that Individual #77 was having difficulty eating and drinking. She could not pick up or hold a cup or spoon and bring to her mouth by report. There was weakness and decreased range of motion in her right arm. She required assistance at meals while previously she had been independent per the OT/PT Evaluation Update on 5/27/11. An unsigned copy of this assessment was submitted. This assessment was not included in the copy of her individual record. The assessment tracking log documented an action referral request on 7/15/11 though there was no evidence of this (i.e., no written assessment or progress note). The OT and PT clinicians conducted their annual assessments together and, in some cases, the SLPs had participated in the assessment process as well, though this was unlikely to continue because there was only one SLP. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment, such as wheelchairs, and to review other supports and services, as indicated. Other issues noted in the assessments included: • Functional skill performance was not consistently addressed across the domains included in the assessment. • The clinical reasoning used by the clinician to guide the development of an intervention plan was not stated in the reports. • There was no assessment as to the effectiveness of the current interventions/supports. • There was no consistent 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. • The focus of recommendations continued to be primarily on the provision of the PNMP to the exclusion of skill acquisition strategies. 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. The assessments generally addressed range of motion and movement skills, such as transfers and ambulation. Other functional skills were not consistently addressed and improvements were still needed in this area, particularly in the area of fine motor skills and activities of daily living. In most cases, these were described in general statements rather than in the context of actual functional activities. There continued to be little consideration for the potential for learning new skills via training objectives. In the case that an update is used, a comprehensive assessment meeting the standards established per the Settlement Agreement should serve as the	

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		baseline for comparison and should be referenced in the update(s). The comprehensive assessment should remain in the individual record with subsequent updates until a new comprehensive is completed. All individuals at LSSLC should receive a minimum of a comprehensive assessment every three years with interim annual updates (because each of these individuals was identified with PNM needs, i.e., had a PNMP). An OT/PT Evaluation Triggers Database was developed and was intended to provide a list of assessments due each month based on the PSP schedule. Based on the draft of this database submitted, there were 116 individuals listed with high PNM risk. Approximately 62% of those listed did not have an OT/PT assessment or update current within the last 12 months. Action referrals or consults by OT or PT were reportedly completed in response to referrals, but a comprehensive OT/PT assessment was not conducted relative to changes in status outside of the annual PSP process. Some examples were Individual #447, Individual #77, Individual #342, Individual #235, Individual #518, Individual #321, Individual #502, Individual #361, Individual #310, Individual #267, Individual #218, Individual #232, and Individual #245. • Overall, there was a lack of evidence that supports or services had been provided by OT and/or PT for individuals included in the sample of individuals reviewed. Regarding the individuals listed above, only two had OT/PT assessments current within the last 12 months (Individual #245 and Individual #47). Two others had updates in 2010 (Individual #321, Individual #232 and Individual #310). Others were Individual #447 (2009), Individual #502 (2009), Individual #77 (2009), and Individual #361 (2009). Individual #218 had not received an assessment since 2008, Individual #235 not since 2007, and Individual #518 not since 2006. Only a baseline admission assessment was submitted for Individual #267, from 2004. More current assessments were identified in the assessment database for individuals listed with high PNM risk including Individual #235 (10/4/10) and Individual #518 (9/28/09 and 8/22/11). Individual #310 was not identified with high PNM needs per this database. Very limited integrated progress note entries were contained in the records and there was an apparent lack of follow-up or follow-through to ensure problem resolution. This was noted despite significant PNM needs for these individuals, including both chronic and acute health and medical issues. A selected sample of examples are below: • Individual #447: This case was described in Section O above and in the Monitor's Summary above. There were nearly 50 entries related to injuries associated with his wheelchair from 10/3/10 to 10/31/11, yet there was documentation by OT or PT on only three occasions (5/3/11, 7/12/11, and 7/22/11) despite repeated reports of injuries, bruises, and abrasions to legs and hips with resulting	

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		physician-ordered bed rest on 9/25/11 until wheelchair issues were resolved. There had been no comprehensive OT/PT assessment or update since 7/09. This was well outside the parameters of the generally accepted professional standard of care. The monitoring team observed direct support staff and clinical staff experience significant difficulties positioning and transferring Individual #447 on multiple occasions during this onsite review. These observations and review of records triggered a series of team meetings and action plan development. Review of the outcomes for Individual #447 will be a focus of subsequent reviews. • Individual #77: She was hospitalized on 6/17/11 for vomiting, diarrhea and hypothermia. She was discharged with resection of transverse descending colon and colostomy. On 7/12/11 direct support staff reported problems with feeding and drinking as documented by nursing. Individual #77 had not been provided an OT/PT comprehensive assessment or update since June 2009. There was no additional evidence of assessment by OT or PT until an entry on 9/9/11 when OT documented that Individual #77 had been seen for the previous two weeks for passive range of motion to her right upper extremity. There was no assessment, no baseline or rationale for this intervention. There were no measurable functional goals established. The OT reported that there had been no change in her active range of motion and she had limited range in her right shoulder. There was no data for a comparative analysis to determine efficacy of this intervention. Passive range of motion alone would not likely impact active range of movement. Timeliness of assessment and intervention, and adequacy of documentation, were outside the parameters of the generally accepted professional standard of care. • Individual #235: She had a compound tibia/fibula fracture on 9/23/10 when she caught her foot on her wheelchair. Elevating leg rests were fitted on 10/11/10 by OT, per physician order. There were no further intervention or supports documented related to this significant event by OT or PT. Individual #235 had not been provided an OT/PT comprehensive assessment or update since September 2007. • Individual #361: She had a Nissen fundoplication on 2/25/11 with no evidence of subsequent follow-up by OT or PT. A notation by PT on 4/6/11 indicated that a pressure map assessment could not be completed because the machine was broken. There was no subsequent documentation that this was ever completed. On 7/26/11, a wheelchair fitting was conducted and it was determined that the seat and back would have to be remolded, but the reason for this was not documented. On 9/13/11, edema was reported by nursing in both ankles. She was diagnosed with a distal left tibia fracture per x-ray. There was an OT evaluation related to positioning documented on 9/15/11 with subsequent follow-ups on 9/19/11 and 9/21/11. As of the time of this onsite review, Individual #361 had not yet received a completed seating system. • Individual #310: Direct support staff reported that something was wrong	

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		because Individual #310 was leaning to the side more, per a nursing note on 3/15/11. He was transferred to the emergency room, but there was no evidence of stroke or TIA. He was seen on 3/25/11 by PT to evaluate his posture. It was reported that he leaned to the right side, but there were no actions or recommendations documented. There was a note on 4/1/11 by the PTA initiating treatment, but there were no functional, measurable goals or rationale provided for intervention. On 5/31/11, the PT indicated that he was not progressing and that an SAP for direct care staff would be developed. There was no follow-up until 8/4/11 when the PT documented completing a three-year baseline OT/PT evaluation. There was no further documentation by PT through 10/30/11. The most current OT/PT assessment was an update on 7/14/10. Frequency, consistency, duration of intervention and documentation of PT was well outside the parameters of the generally accepted professional standard of care. • Individual #232: He was diagnosed with advanced Parkinson's disease and a seizure disorder. He was discharged from the hospital back to LSSLC on 4/8/11 with a diagnosis of bilateral pneumonia. There was no evidence of follow-up noted until 5/20/11 when his wheelchair was assessed per request of the Unit Director because his seatbelt was too tight. It was adjusted by OT at that time. He was transferred to the emergency room on 6/26/11 with subsequent hospitalization for ileus. When he was discharged back to LSSLC on 6/29/11, there was no evidence of assessment or review by OT or PT. He was transferred again to the ER on 7/20/11 with hospitalization for cellulitis in the right lower leg and bronchitis and discharge to LSSLC on 7/27/11 and admitted for cellulitis and pneumonia on 10/20/11 with discharge on 10/27/11. His most current PT/PT assessment was dated 10/21/08. There were no PSPAs related to PST review of his status after these hospitalizations noted in his individual record. The date of referral to PNMT was not known. A Risk Action Plan, dated 9/12/11, reviewed actions developed on 3/8/11 with no new actions initiated. Again, the lack of follow-up, intervention, and support was well outside the parameters of the generally accepted professional standard of care.	
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	Approximately 372 individuals at LSSLC were provided a PNMP, and as such, had been identified with PNM needs. These plans were reviewed by the therapy clinicians as an aspect of the annual assessment; there was no other more frequent routine review. Implementation of the plans was also monitored by the PNMPCs, though this addressed implementation only. As non-licensed clinicians, these staff were not qualified to make judgments as to efficacy of the plans. The PNMPs appeared to be updated within 30 days or less relative to the annual PSPs, but additional follow-up or response to identified needs were not consistently completed in a	Noncompliance

#	Provision	Assessment of Status	Compliance
	plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	timely manner. Other interventions were generally referral-based per physician's order and were limited with regard to minimizing regression and enhancing skills. 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. All therapy-related SAPs should be an action step in the PSP. They should also be subject to routine PST review with reported data related to progress. There was no analysis of findings in any of the assessment reports to provide a rationale for the PNMPs developed for individuals or for other interventions. The clinicians' clinical reasoning process used for the recommendations was not well documented. PSP Addendums were not consistently developed to address modifications to PNMPs and other therapy interventions. For example, in the case of Individual #218, he was participating in direct PT per the integrated progress notes, though there was no PSP addendum related to the provision of this service and there were no measurable functional outcomes or goals established. It appeared that direct therapy had been discontinued, but there was no evidence of goal attainment. The primary support provided was via the PNMPs. PNMPs provided staff instructions or precautions related to assistance and supports for mobility, positioning, and transfers. Additional areas addressed bathing and skin care, behavior concerns, communication, and precautions. Medication administration and oral hygiene were also consistently addressed in the plans. Mealtime instructions included dining equipment with diet texture and liquid consistency. Assistive equipment was included, as well. Risk levels in specific areas were identified. The focus statements were intended to identify the justification for the supports outlined in the plan, however, there was not a consistent connection between this and the interventions included in the plan. Each of the PNMPs reviewed listed specific assistive/adaptive equipment to address individual needs. The assessments inconsistently provided a rationale for the specific equipment recommended for use, though the rationale for the wheelchair seating was more consistently noted. The photographs provided were generally in color and provided visual cues and prompts related to position and alignment. There were few intervention plans and the rationale for initiation of intervention was not generally clearly established. Documentation was inconsistent, and did not address progress or status. SAPs, PSPs, PSPAs and other progress note documentation related to OT/PT services for six individuals identified as participating in direct OT and/or PT were requested. Only PSPs and PSPAs were submitted with SAP documentation unrelated to	

#	Provision	Assessment of Status	Compliance
		therapy services. Individual #502 was listed as participating in direct OT services. There was no evidence documented in her individual record. This element was not effectively evaluated and further review is indicated in six months. In a few cases, clinicians documented that an assessment had taken place in the IPNs, but there were very few entries related to routine interventions and were generally limited to PT and wheelchair seating. The documentation reviewed related to PT intervention did not identify a specific measurable outcome with a comparative analysis of progress. Reviews of the PNMP were conducted annually and upon referral. Though PNMPs for the last 12 months were requested for review, these were not submitted and, therefore, validation of this was not possible. Notes reviewed did not identify interventions based on the findings of monitoring by the PNMPCs. There was evidence of the therapists addressing some issues identified through referral, but documentation of follow-up through to resolution was inconsistent, as described above.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	There was a continued need for improved staff attention to the details of proper positioning and alignment and compliance with the PNMPs. A number of individuals were observed sitting with a posterior tilt, loose seatbelt, extremities not adequately supported, poor alignment and support, or the pelvis not well back into the seat of the wheelchair (Individual #68, Individual #447, Individual #76, Individual #546, seven gentlemen in 49 B lined up in front of TV for active treatment, Individual #599, Individual #213, Individual #151, Individual #584, Individual #88, Individual #77, and Individual #518). No one was observed being repositioned prior to his or her meal unless prompted, and a number of individuals were not appropriately aligned or supported. Staff did not demonstrate competency for repositioning. Clinicians did not provide adequate support to staff to address this and the monitoring system did not effectively identify problems in this area. NEO training related to implementation of the PNMP was offered in two days of training with an annual refresher. A written test was required for each aspect of the training, though skills based practice was built into the training in the lab area provided. Lack of competency-based training of foundational skills necessary to the appropriate implementation of the PNMP may contribute to staff weaknesses as well as their limited understanding of the rationale behind the strategies outlined in the PNMP. Individual-specific training was reported to be competency-based. Inservices sheets outlined specific competencies and these were to be checked off for each staff participating. Licensed therapy staff as well as PNMPCs provided training for home supervisors, home managers, and other staff. The staff were not confident in their responses to the monitoring team's questions and appeared to be unsure of why they were doing what they were doing in relationship to the	Noncompliance

#	Provision	Assessment of Status	Compliance
		PNMP. For example, staff were generally not able to answer questions, such as why an individual needed honey thick liquids, why a glass was only partially filled, or why a particular orthotic was required. The rationale for interventions and supports was stated in the focus statements of the PNMP, but in many cases, these were general in nature rather than specific to strategies outlined in the plan. In some cases, they did not reflect important aspects of an individual's needs. This is an important aspect of staff training. Ongoing coaching and drills with staff related to risks and the rationale for interventions and supports were indicated to ensure that they were able to discuss the rationale behind interventions and to recognize their role in management of health risk issues.	
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.	As stated above, adaptive equipment was reviewed on at least an annual basis at the time of the PSP assessments, in addition to review per referral by the PST to address fit and function. This was conducted by the licensed therapy clinicians The AT workshop technicians completed all maintenance and repairs as identified via monitoring system or as reported by direct support staff. Work orders were tracked in a log/database. By report all copies of work orders were maintained by the habilitation therapies department director and they were routed back to her upon completion. Assessments were conducted as needed for new seating systems or for modifications to existing systems. Specific mat evaluations documented this process. There were concerns, however, with the timely provision of this equipment (e.g., Individual #447, Individual #16, Individual #518). Ongoing review of this process is indicated. There were nine PNMPCs and one supervisor who conducted routine monitoring for mealtimes, communication, lifting, transfers, and positioning. PMNP Monitoring forms (three) were used to conduct monitoring by the PNMPCs and therapists. This form addressed availability of plans, use of proper lifting and transfer techniques, appropriate positioning, and condition of equipment. The individual and direct support staff were identified. The monitor was to document corrective actions taken or required. The monitors were assigned and scheduled to cover all homes across all three meals. The schedule of monitoring was based on risk level. There were, however, no policies or guidelines to address the monitoring process, though procedures were in development, as described above. There was no system to assure that those who were most at risk were assisted by competent and well-trained direct support staff only. Staff were monitored as an aspect of the individual-specific monitoring conducted by PNMPCs and therapists. There was no method to track if this covered all staff who were responsible for implementation of PNMPs. There was no system to track the findings from any monitoring for use in decision making about staff training needs or drills. There were no SAPs submitted for review that required data collection by direct	Noncompliance

#	Provision	Assessment of Status	Compliance
		support staff or validation of implementation and documentation at this this time. As described above, in the case of Individual #447, the system of monitoring did not effectively identify significant concerns evident related to his physical and nutritional management supports, and these were not appropriately addressed by OT, PT, and his PST in a timely manner.	

Recommendations:

1. Consider a reference to the baseline/comprehensive assessment and updates in subsequent updates. In other words, the therapist should clearly cite the date of the previous assessment in the current one. It may make sense to maintain the comprehensive assessment with the subsequent updates in the active record until a new comprehensive was completed. Clear statements as to when the next assessment or update was to be completed should be included in the recommendations (P1).

2. Consider the integration of risk information in NEO training as well as more hands-on practice for skills based competencies (P2).

3. 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 (P2).

4. Integrate direct and indirect supports into the PSP through the development of SAPs that include 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 are used to justify initiation, continuation, and/or termination of interventions (P2).

5. Consider the strategy of observation rounds with professional staff, technicians and PNMPCs to conduct drills for additional training for PNMPCs and to assist staff in recognizing when realignment is indicated (P3-P4).

6. Establish a formal curriculum and competencies for training the PNMPCs (P4).

7. Create a system to analyze databases to ensure accuracy of calculations of compliance. Set goals and benchmarks for improvement (P4).

8. Review the existing OT/PT assessment format to address summary/analysis. As currently written these were not consistently sufficient to establish the rationale for the recommendations. The development of a framework that included more specific guidelines for therapists in their treatment of the analysis of findings and justification for supports and interventions in the PNM clinic and the written reports would be useful, particularly with the addition of new therapy clinicians. 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, services and interventions were indicated. These should then be listed as recommendations (P1).

9. Urgently address issues related to Individual #16, Individual #447, Individual #518, and Individual #77 (P1-P4).

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o LSSLC Policy and Procedure: Facility Operational Dental Services Policy, 5/1/11 o LSSLC Organizational Charts o LSSLC POI for Section Q o Presentation Book, Section Q o Procedure for Oral Suction toothbrush o Dental Clinic Attendance Tracking Data o Dental Data: Refusals, missed appointments, extractions, emergencies, preventive services and annual exams o Monthly Oral Hygiene ratings, o Dental records for the individuals listed in Section L o Oral surgery consults and progress notes for the past six months: • Individual #43, Individual #13, Individual #520, Individual #221, Individual #388, Individual #148, Individual #188, Individual # Individual #, Individual #, Individual #, Individual #, Individual #, Individual # Annual Dental Summaries for the following individuals: • Individual #339, Individual #484, Individual #328, Individual #252, Individual #310, Individual #351, Individual #357, Individual #41, Individual #215, Individual #326, Individual #208, Individual #4, Individual #549, Individual #466, Individual #190, Individual #93, Individual #525, Individual #401, Individual #546, Individual #132, Individual #127, Individual #383, Individual #159, Individual #22, Individual #447, Individual #361, Individual #570, Individual #177, Individual #236, Individual #431, Individual #471, Individual #285, Individual #39 o Documentation of strategies for dental refusals the following individuals: • Individual #105, Individual #323, Individual #229, Individual #469, Individual #190, Individual #93, Individual #504, Individual #216, Individual #170, Individual #91, Individual #424, Individual #74 o Desensitization plans for the following individuals: • Individual #597, Individual #360, Individual #450, Individual #294, Individual #527, Individual #437 Interviews and Meetings Held: o Tina Murray, DDS, Staff Dentist o Russell Reddell, DDS, State Office Dental Services Coordinator 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 <u>Observations Conducted</u>: o Dental Department o Informal interviews with clinic staff
	Facility Self-Assessment: The facility updated the POI on 10/17/11 and determined that it was not in compliance with either of the provision items for Section Q. This assessment was congruent with the findings of the monitoring team. The POI did not provide information on what activities the facility engaged in to determine its self-rating on noncompliance. The POI did provide information related to several aspects of the Settlement Agreement such as the oral hygiene program, staff training, and the overall provision of services. The self-assessment process will require numerous activities and utilize information from multiple sources and departments. These activities will include auditing of records, completing peer reviews, and generating data on attendance and provision of services and observations.
	Summary of Monitor's Assessment: The dental department continued to make progress towards substantial compliance with the Settlement Agreement. The loss of the full time dental director in August 2011 was a significant setback for the department because it reduced the number of available clinic hours. Services continued to be provided as the part time dentist continued and the oral hygiene program continued. Individuals received frequent dental care and oral hygiene ratings appeared to be improving. The home oral hygiene maintenance program expanded and all individuals had undergone evaluation. The use of chemical restraints continued, but a significant achievement for the facility was the implementation of a multidisciplinary workgroup, which was charged with developing a formal desensitization strategy for the facility. Since the last onsite review, eight plans were developed.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide	The dental clinic staff was comprised of a part-time dentist, full time hygienist, two part time hygienists, and a full time dental assistant. The full time dental director resigned in August 2011. At the time of the onsite review, a dental director had been hired and was in pre-service training. Dental clinic continued to be conducted five days a week with the	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.</td><td>dentist providing services for half a day.

<u>Provision of Services</u>
The dental clinic provided basic dental services, including prophylactic treatments, restorative procedures, such as resins and amalgams, and x-rays. The facility maintained a contract with a board certified dental anesthesiologist. Individuals who required more extensive treatment were referred to a local oral surgeon. The total number of clinic visits and key category visits are summarized below.

<table>
<tr><td></td><td>April</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Sept</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Preventive Care</td><td>32</td><td>36</td><td>59</td><td>48</td><td>38</td><td>6</td></tr>
<tr><td>Restorative</td><td>5</td><td>2</td><td>3</td><td>1</td><td>1</td><td>2</td></tr>
<tr><td>Emergency Care</td><td>7</td><td>2</td><td>8</td><td>4</td><td>3</td><td>7</td></tr>
<tr><td>Extractions</td><td>8</td><td>5</td><td>3</td><td>2</td><td>1</td><td>0</td></tr>
<tr><td>Total Clinic Appointments</td><td>137</td><td>119</td><td>146</td><td>107</td><td>80</td><td>50</td></tr>
</table>

The number of visits decreased significantly following the resignation of the dental director in August 2011. The number of restorative appointments remained consistently low.

<u>Emergency Care</u>
Emergency care was available during normal business hours. The part time dentist worked until noon. During other hours, the primary care physician made the determination about the need for emergency care. The resignation of the dental director in August 2011 resulted in the loss of on-call dental coverage. Records related to provision of emergency care indicated that appropriate care was provided.

<u>Oral Hygiene</u>
The Oral Health Maintenance Program, implemented in February 2011 continued to make progress. This program promoted optimal oral health by providing oral hygiene care and instruction to individuals in their home environments. Training was also provided to the direct care professionals as part of this program. Baseline oral hygiene needs assessments were completed for all individuals by August 2011. These assessments identified the preferences, strengths, and needs of each individual. Following assessment, oral hygiene supports were implemented. Special equipment was issued by the two hygienists who administered the program. Each individual's supplies were maintained in their own tooth case. The hygienists were responsible for replenishing the required supplies such as toothbrushes and toothpaste.</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		Oral hygiene for individuals at risk for aspiration was augmented with suction toothbrushing. Oral hygiene ratings were documented at each annual assessment. Those ratings are summarized in the table below. Oral Hygiene Ratings 2011 % Apr / May / June / July / Aug / Sep Good: 7 / 21 / 27 / 18 / 36 / 62 Fair: 57 / 21 / 55 / 55 / 28 / 23 Poor: 36 / 37 / 18 / 27 / 36 / 15 Undetermined: 0 / 21 / 0 / 0 / 0 / 0 Generally, there was improvement in ratings evidenced by a decrease in the percentage of individuals with poor hygiene ratings and an increase in the individuals with good ratings. These data will become more meaningful once the annual hygiene status is recorded for all individuals. It should be noted that hygiene status can fluctuate significantly based on the daily hygiene provided. The facility should give consideration of documenting quarterly hygiene assessments given the significant resources invested in the oral health program. <u>Staff Training</u> In March 2011, the facility implemented a very ambitious training program to ensure that direct care professionals were adequately trained in the provision of oral hygiene. New and current employees participated in didactic sessions that included classroom instruction and hands on training in the facility's training lab. All training was competency based and was conducted by the dental clinic hygienist in collaboration with CTD staff. The data provided did not provide information on the percentage of staff that received training. Given the considerable resources invested in this program, the percentage of staff trained over time should be documented in addition to the number of staff trained.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current	<u>Policies and Procedures</u> The facility maintained a current set of comprehensive polices and procedures which were consistent with state issued dental policy. <u>Annual Assessments</u> The facility provided a list of all annual assessments completed during the six months prior to the onsite review. The dates of the current and previous assessment were provided for comparison. The assessment was considered timely if it was completed no later than the calendar month of the previous year's assessment.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.		

Annual Assessment Compliance Rates 2011 (% Compliance)					
April	May	June	July	Aug	Sept
100	100	86	53	13	40

Compliance rates were noted to decrease in June 2011 although the reason was not clear. Further decreases in compliance were noted during the month that the full-time dental position was vacated.

The annual dental summaries were reviewed for 10% of individuals. Overall, the summaries provided information on oral hygiene status, last annual exam, last prophylaxis, x-rays done, and overall exam. Additional information, such as number of appointments, types of appointments, medication used, and effectiveness would be helpful for PSTs.

Dental Records

Dental records consisted of initial/annual exams, dental progress treatment records and documentation in the integrated progress notes. Providers documented in the integrated progress notes. An entry was also made in the dental treatment record. This entry pointed the reader to the dated progress note. Copies of these documents were placed in the dental clinic's records.

Failed Appointments

The facility reported data on missed appointments, refusals and failed appointments. Failed appointments were determined by adding missed appointments and refusals.

Missed appointments were appointments not kept, but were not the fault of the individual. This included appointments missed due to lack of staff, off campus appointments, etc. Refused appointments were appointments where the individuals refused to receive treatment in clinic.

Dental Data 2011						
	Apr	May	June	July	August	Sept
Total Visits	137	119	146	107	80	50
Total Failed	51	66	53	42	38	19
Missed	24	24	21	5	2	0
Refused	27	42	32	37	36	19

Overall, a downward trend was noted in the number of failed appointments. Based on these data:

370 of 639 (58%) of appointments were completed

#	Provision	Assessment of Status	Compliance
		269 of 639 (42%) of appointments failed The completion rate was slightly, however not significantly, decreased from the six month reporting data seen during the last visit which showed completion and failure rates of 66% and 33%, respectively. The facility had taken steps to reduce failed appointments. The dental clinic sent a formatted note, by email, to the QDDP and psychologist as notification of failed dental clinic appointments. Teams were expected to respond with possible solutions. The dental clinic provided the monitoring team with copies of the document Report of Missed Dental Appointments, emails, and progress notes to document strategies to overcome barriers to treatment. There were multiple examples where communication with the PST resulted in successful completion of a dental appointment. <u>Desensitization</u> The facility continued to utilize oral sedation and TIVA to facilitate dental treatment. The use of both modalities required the approval of the Human Rights Committee. The dentist contacted the LAR when the use of TIVA was proposed. A board certified dental anesthesiologists conducted TIVA monthly.	

Use 2011						
	April	May	June	July	Aug	Sep
Sedation	4	2	4	9	1	1
TIVA	7	7	5	6	5	6

Overall the utilization of sedation and TIVA remained low. The facility had a significant number of individuals who refused treatment or were not able to cooperate.

During the April 2011 onsite review, more than 150 individuals were enrolled in the desensitization program which was essentially developed by the dental clinic staff. This process proved to be futile in that no individuals were identified who had successfully completed a plan that resulted in the desired outcome of receipt of treatment. In response to a lack of positive outcomes, the facility formed a multidisciplinary workgroup in September 2011 to address the issue of desensitization. Participants included representatives from psychology, nursing, QDDPs, active treatment, habilitation therapies, and dental clinic. The workgroup developed a plan to assist individuals in overcoming barriers to achieve good oral health:

- The PST identified individuals who required additional services in the area of dental desensitization. Individuals who required pre treatment sedation in the past were assessed.

#	Provision	Assessment of Status	Compliance
		• Psychology determined what plan was most appropriate for the individual. • Training options included dental education and toleration, dental simulation training and desensitization. The facility reported that eight desensitization plans were completed. Six plans were provided to the monitoring team for review. Each of the plans reviewed was individualized and targeted the primary problems identified. Since most of the plans were newly implemented, little follow-up was available. Nonetheless, this represented a notable improvement over the previous onsite review. The facility will need to continue increased efforts in this area to prioritize the approximate 120 individuals who were in need of assessment.	

Recommendations:

1. A full time dental director is needed in order to provide adequate services and ensure appropriate leadership for the department. There must also be a plan to ensure appropriate emergency services are available including on-call dental services (Q1).

2. The dental director should ensure that all individuals at the facility are receiving all necessary services, such as restorative services (Q1).

3. The facility should ensure that all individuals who would benefit from the use of suction toothbrushing receive this treatment (Q1).

4. Data should be maintained on the number of persons who have received training on oral hygiene, including the percentage of staff that have received training (Q1).

5. The facility must ensure that all individuals receive timely annual assessments (Q1).

6. Consideration should be given to expanding the annual dental summaries to include information on the total number of appointments, type of appointments (Q2).

7. The facility should continue to closely monitor the number of failed appointments and take immediate corrective action if that number increases (Q2).

8. Consideration should be given to tracking oral hygiene on a quarterly basis. Considerable resources have been invested in the home program. Tracking hygiene status more frequently will allow for ore immediate response (Q2).

9. The facility should ensure that the desensitization efforts expand. It was reported that 120 were currently in need of assessment for the appropriateness of desensitization (Q2).

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:** Documents Reviewed: o LSSLC Organization Chart Individuals Served- Alphabetical list o Admissions list o Budgeted, Filled and Unfilled Positions o AAC Services Policy #16 (10/07/09) o Communication Services Policy (7/25/11) o Section R Presentation Book and POI o Settlement Agreement Cross-Reference with ICF-MR Standards Section R-Communication Guidelines o Settlement Agreement Section R: Communication Audit forms submitted o Continuing Education documentation submitted o Current list of Speech staff o Speech Language Evaluation template o List of individuals with AAC devices at LSSLC o List of Status for AAC devices o PNMPs submitted o List of Individuals Who are Nonverbal Who Have Behavior Support Plans o List of Individuals with PBSPs and replacement behaviors related to communication o List of individuals with PBSPs o Master Plan o Screening Protocol o List of Individuals receiving direct speech therapy o Communication Monitoring Tool template o Monitoring Forms completed for the last month related to communication o SAPs, PSPs, PSPAs, Assessments and related documentation for: Individual #352, Individual #503, Individual #394, Individual #425, Individual #61, and Individual #248 o Communication evaluations, PSPs and PSPAs for: Individual #344, Individual #226, Individual #253, Individual #157, Individual #418, Individual #300, Individual #569, Individual #506, Individual #360, and Individual #248. o Information from the Active Record including: PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms and Action Plans, PSP reviews by QDDP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets, Habilitation Therapy tab, Communication Dictionary, and Nutrition tab for the following: • Individual #248, Individual #447, Individual #502, Individual #36, Individual #232,

	Individual #262, Individual #387, Individual #552, Individual #235, Individual #321, Individual #342, Individual #310, Individual #96, Individual #352, Individual #47, Individual #267, Individual #245, Individual #241, Individual #218, Individual #271, Individual #189, Individual #518, and Individual #77. o PNMP section in Individual Notebooks for the following: • Individual #248, Individual #447, Individual #502, Individual #36, Individual #232, Individual #262, Individual #387, Individual #552, Individual #235, Individual #321, Individual #342, Individual #310, Individual #96, Individual #352, Individual #47, Individual #267, Individual #245, Individual #241, Individual #218, Individual #271, Individual #189, Individual #518, and Individual #77. o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #248, Individual #447, Individual #502, Individual #36, Individual #232, Individual #262, Individual #387, Individual #552, Individual #235, Individual #321, Individual #342, Individual #310, Individual #96, Individual #352, Individual #47, Individual #267, Individual #245, Individual #241, Individual #218, Individual #271, Individual #189, Individual #518, and Individual #77. <u>Interviews and Meetings Held</u>: o Danielle Perry, AuD, CCC-A, Habilitation Therapies Director o Candace Vieira, MS, SLP o Speech technicians o PNMP Coordinators o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs o Work areas
	Facility Self-Assessment: LSSLC submitted its self-assessment for this provision (POI). In addition, the monitoring team requested that the Habilitation Director review the Presentation Book onsite and a copy was submitted for review. The POI did not identify what activities were conducted for self-assessment, but rather included dated statements pertaining to a variety of tasks completed related to each of the Settlement Agreement provisions. Also, there was no mechanism to determine how the facility had determined noncompliance with each element in this provision. Settlement Agreement Cross-Reference with ICF-MR Standards Section R-Communication self-audit tools (384) and Guidelines completed in 2011 were submitted for 212 individuals. Inter-rater reliability and compliance scores for the last quarter were also submitted. Overall

	compliance was approximately 65%. It did not appear that the audits were used to self-rate substantial compliance. A list of three Action Steps was included in the POI, related to R2 only. These actions were each pertinent to the provision, but did not reflect a comprehensive strategic action plan developed to guide the department through the process of achieving substantial compliance across all provisions, nor were they clearly linked to content in previous reports or specific recommendations made by the monitoring team. One of the three action steps were listed as completed (Develop a screening protocol). Start dates and projected completion dates were listed, but not actual dates of completion. The other two action steps listed were identified as in process with completion dates of 12/15/11 (assess referrals from the screening protocol and refer individuals requiring behavioral supports to Behavior Support Committee). This approach did not serve as a clear, well-outlined plan to direct focus, work products, and effort by staff. Action steps should be short-term, stated in measurable terms with timelines with the evidence required to demonstrate completion of all interim steps. The monitoring team concurs with LSSLC self-assessment of noncompliance for each of the items in provision R.
	Summary of Monitor's Assessment: There was one full time speech language pathologist (and two techs). She was bright, eager, and motivated. There was a very part time contract SLP (who had not been available recently). There were no additional staff available to her for collaboration on cases or to serve as a resource to the SLP as she gained on-the-job clinical experience. There was a long list of individuals who required a comprehensive communication assessment, including Individual #16 who had significant potential to benefit from communication supports. Without the presence of the monitoring team and the director of habilitation at her PSP meeting, it appeared unlikely that her PST would have obtained an assessment in a timely manner because as the sole clinician, the SLP was overburdened. She was also responsible for swallowing assessments and mealtime supports. Even though this was not her primary area of expertise, she took the initiative to seek additional training to provide specific interventions for individuals who needed them. Per the Master Plan, only 20 assessments had been completed to date. Eight of these were identified as Priority 1, five were identified as Priority 2, four were identified as Priority 3 and three were identified as Priority 4. This represented 6% of those identified as Priority 1, 4% of those identified as Priority 2, 6% of those identified as Priority 3 and 4% of those identified as Priority 4. Two assessments were identified as in progress. Of the 20 assessments listed as completed, only six (four were Priority 1 and two were Priority 2) had been completed since the previous review in April 2011, despite the availability of at least three additional speech clinicians prior to 7/1/11 and one additional therapist prior to 9/1/11. On a positive note, there were a number of individuals with communication systems (82). This represented 33% of those individuals (250) identified as nonverbal (Priority 1 and 2). The communication

	systems observed were intended to be functional and many were portable for use across a variety of settings. They appeared to be individualized and potentially meaningful to the individual. Of the 36 individuals monitored who had one or more AAC systems, 10 were reported to have systems that were broken, five individuals had systems reported to be missing and nine did not use the system at all or rarely. Based on the monitoring results during the month of August 2011, only 36% of those individuals had their devices available, in working order, and in use. Consistent use and integration across settings continued to be a concern and, as such, meaningful and functional use by the individual was often not possible. AAC was not provided to a number of individuals who would likely benefit from communication supports because most had not received a comprehensive assessment. However, despite the fact that the SLP understood functional and meaningful integration of communication across environments and settings, she cannot do this by herself. Communication is about having something to communicate about: engagement in meaningful, interesting activities. For example, I observed several individuals who had the ability to use their devices, yet the work they did was uninteresting, menial, and antiquated. 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 (also see comments about engagement in other sections of this report).

#	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 implement programs, provide staff training, and monitor the implementation of programs.	At the time of the onsite monitoring review, there was one full time SLP (Candace Crawford Vieira, MS, SLP) and a part time contract clinician (Debra Brown, MS, CCC-SLP) available less than eight hours a week in the past, but had not been providing any services for the last month or so. There were four unfilled state positions listed. The ratio, given the census at the time of this review, was 1:372 (the part-time contractor provided assessment only). Thus, Ms. Vieira was the only full time SLP and was singly responsible for communication and mealtime supports for each individual living at LSSLC. A current status of licensure was verified online for the clinicians listed above. Resumes or curriculum vitae were not submitted for either. No evidence of continuing education since the previous review was submitted. The single SLP was responsible for assessments, attending PSPs and PSPAs, the provision of supports and services, program development, and monitoring in the areas of communication and mealtimes. Ms. Vieira was identified also as a member of the PNMT. Ms. Vieira was a newly graduated clinician. She had completed her clinical fellowship year at LSSLC and appeared to be dedicated and competent. As the lone SLP, however, there were no additional staff available to her for collaboration on cases or to serve as a resource to her as she gained on-the-job clinical experience.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The LSSLC Master Plan was requested. Priorities were established as follows: • Priority 1: Individuals who were nonverbal with Behavior Support Plans (129) • Priority 2: Individuals who were nonverbal, not receiving therapy, and did not have Behavior Support Plans (121) • Priority 3: Individuals with limited speech (72) • Priority 4: Individuals who communicated without difficulty (69) Per this Master Plan, only 20 assessments had been completed. Eight of these were identified as Priority 1, five were identified as Priority 2, four were identified as Priority 3 and three were identified as Priority 4. This represented 6% of those identified as Priority 1, 4% of those identified as Priority 2, 6% of those identified as Priority 3 and 4% of those identified as Priority 4. Of the 391 individuals listed, four were deceased, 11 were placed in the community and one had transferred out of the facility prior to completion of a communication assessment. Assessments for Individual #232 and Individual #142 were identified as in progress. Of the 20 assessments listed as completed, only six (four Priority 1, two Priority 2) had been completed since the previous review in April 2011, despite the availability of at least three additional speech clinicians prior to July 1st and one additional therapist prior to 9/1/11. As of 9/1/11, Debra Brown had been directed to complete all assessments to permit Ms. Vieira to address the ongoing day to day needs related to communication, mealtime, and community integration. There was no evidence that she had completed any assessments since that time. It was of further concern that Ms. Brown had reportedly been unavailable for at least the last month. Five most current assessments for each clinician were requested and submitted for review as follows: • Candace Crawford Vieira, MS, SLP: Individual #300 (2/28/11); Individual #248 (3/3/11); Individual #360 (4/12/11); Individual #418 (4/28/11); and Individual #506 (8/31/11). • Debra Brown, MS, CCC-SLP; Individual #253 (3/14/11); Individual #157 (3/23/11); Individual #569 (4/13/11); Individual #226 (2/16/11); and Individual #344 (2/16/11). Only two of these assessments had been completed since the previous review. It was of concern that no other assessments had been completed during that period. Ms. Vieira's assessments were consistent in format with the template submitted. Though Ms. Brown	

#	Provision	Assessment of Status	Compliance
		used a consistent format for each of the assessments reviewed, they were not consistent with the format identified as valid per the documents submitted. The assessments reviewed were generally comprehensive in nature and those completed by Ms. Vieira were particularly strong with clear justification of recommendations. Additional assessments were submitted for individuals selected for the sample of individual records reviewed by the monitoring team and listed above in the Documents Reviewed section. Of those, only one assessment submitted was current within the last 12 months (Individual #310). Others were submitted as follows for 16 of the 23 records requested: 1988 (1), 1991 (1), 2004 (2), 2006 (2), 2007 (3), 2008 (4), and 2009 (3). Individual #352, Individual #267 and Individual #447 were each listed with AAC yet Individual #352 and Individual #267 had not received communication assessments since 2008 and 2004, respectively. There was no evidence of a communication assessment for Individual #447 in his individual record. It is critical to have a current assessment on an ongoing basis to appropriately identify AAC needs and to monitor that the AAC selected continued to be meaningful and effective for the individuals to whom it was provided. Of the 18 individuals identified with the greatest communication needs, there was no evidence of an assessment for two in their individual records (Individual #447 and Individual #342). Three others had not received an assessment since 2007, four had not received an assessment since 2008, and four had not received an assessment since 2009. Others had gone more than five years since their previous assessment, including Individual #518 (9/22/06), Individual #271 (9/13/04), Individual #189 (6/29/88), and Individual #387 (5/10/91). Assessments for six individuals who participated in direct speech services related to communication were also requested, though none were submitted for review. An assessment for Individual #248 was submitted as one of the most current assessments for Candace Crawford Vieira and was dated 3/3/11 and considered current. The Master Plan listed previous assessments for the other individuals as follows: Individual #61 (May 2009); Individual #425 (June 2010); Individual #394 (September 2009); Individual #503 (June 2009); and Individual #352 (December 2008). A current assessment should identify the need for direct therapy by a clinician with routine re-assessment to determine the efficacy of interventions based on objective data collected. It would not be possible to appropriately identify needs, establish measurable objectives and to develop an appropriate treatment plan without a current communication assessment. Per the list submitted there were 82 individuals with one or more AAC systems. This represented 33% of those individuals (250) identified as nonverbal (Priority 1 and 2).	

#	Provision	Assessment of Status	Compliance
		These had been provided as follows: • talking photo albums (4), Chattervox (2), community posters (38), personal posters or pictures (4), Dynavox (16), Communication Builder (5), communication books (12), voice output switch (1), Big Mack communicator (5), wheelchair communication boards (5), voice output devices (3), output switch (1), joystick switch (1), and an environmental control switch (1). These systems appeared to be varied, individualized, and designed to be available to individuals across environments. It was of concern, however, that very few new systems had been provided, based on recommendations from the assessments completed for individuals identified as nonverbal with and without BSPs.	
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.	As described above, a Master Plan had been developed to prioritize individuals living at LSSLC related to communication and AAC needs based on written protocol. No progress was noted in moving forward on these assessments. Individuals who had AAC and/or received direct or indirect supports and services did not receive assessments in a timely manner. Per the documents submitted, the one individual admitted to LSSLC in the last six months had merely been screened to identify her priority level and placed on the Master Plan. With one full time clinician and a part time (currently unavailable) clinician, implementation of the Master Plan and compliance with this provision was not possible. There was no policy related to the identification of individuals with behavioral challenges and related communication deficits. Lists were requested of individuals with communication-related replacement behaviors in their PBSPs (96 individuals) and also for individuals who had behavioral concerns and severe communication/language deficits (171 individuals identified). The assessment used for those who received behavioral supports was the same used for other individuals living at LSSLC. There was limited or no discussion in the assessments reviewed as to how or if limitations in communication skills contributed or exacerbated behavioral concerns. Per a list submitted, there were a number of AAC devices recommended for individuals, but not available for their use. There were four devices for four individuals that had been ordered as of April 2011 and June 2011 but had not been received. There were approximately 25 devices for 22 individuals that had been approved, some as far back as May 2011, but the orders were listed as pending.	Noncompliance
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would	There were 20 individuals listed as participating in direct programming or therapy for communication enhancement and/or AAC use. In these cases, programs, goals, and objectives related to the acquisition or improvement of speech or language were written by the SLP. Documentation for six of these was requested and submitted:	Noncompliance

#	Provision	Assessment of Status	Compliance
	benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	• Individual #248: There was a SAP developed related to use of his Dynavox. This had been identified in a Communication Skills Evaluation dated 3/3/11. Recommendations included his participation in direct intervention for skill acquisition. While the device was referenced in his PSP dated 3/9/11, this provision of direct services was not. No SLP attended this meeting. There were objectives identified for an outcome in his PSP to improve his expressive communication skills, though these addressed only charging the device and obtaining it each morning. There were no objectives for use of the device in this PSP. Nearly four months later, a PSP Addendum was held to initiate the skill acquisition plan. Though documentation related to his progress with this SAP was requested, none was submitted. As such there was no evidence that this intervention had been provided or that he had made any progress in the last four months. • Individual #61: There was a SAP developed related to the use of her AAC system. A communication assessment dated 5/22/09 identified the need for assessment for a voice output device in addition to the communication board on her wheelchair tray. There was no evidence that this assessment had been completed. She had been provided a Communication Builder device that was mounted to the left of her wheelchair tray. Without an appropriate assessment, selection of an appropriate device and optimal access points would not be possible. There was no SAP in her PSP dated 5/16/11, to address enhancement of her communication skills. An objective listed was not measureable in that it stated she would use the Communication Builder to communicate in her home and program areas. There was no program or documentation related to this submitted. A PSPA dated 6/30/11 indicated that a SAP would be developed to enhance skill acquisition in the area of communication and using her AAC device. The SAP submitted was dated 7/1/11, but documentation submitted indicated that the plan was not actually implemented until 9/13/11. Individual #61 was seen on two occasions in September 2011, though she refused to participate during the second session. In October 2011, it was documented that she was seen one time only. Without significant efforts to integrate use of AAC throughout her day, it is unlikely that she will make progress in this area. • Individual #425: There was a SAP developed related to the use of his AAC system. There was no evidence of a communication assessment. He was provided a voice output device and was reported to be involved in direct intervention to enhance his ability to use it for communication. Documentation related to this SAP reported that his AAC device was broken since 9/13/11, the date of initial program implementation, through 10/31/11 and programming was not conducted. • Individual #394: A SAP was developed with a PSPA conducted on 9/16/11.	

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		There was no evidence of a communication assessment. It was documented that the program was not implemented one of four sessions because the technician was reprogramming a device for another individual. There was no evidence that the session was to be rescheduled. This was not an acceptable rationale for canceling this session. • Individual #503: A SAP was developed with a PSPA conducted on 6/30/11. There was no evidence of a communication assessment. Documentation did not pertain to the identified goals and no data were collected. An additional objective related to independence with charging the palmtop device had been developed with documentation submitted for the last quarter. Per the data sheets submitted, the program was often not implemented due to the device being broken or unavailable. • Individual #352: A SAP was developed but as of 9/3/11 it had not been implemented as the device has not been ordered. There was no evidence of a communication assessment or PSPA. The communication systems observed were intended to be functional and many were portable for use across a variety of settings. They appeared to be individualized and potentially meaningful to the individual. Consistent use and integration across settings continued to be a concern. Thus, meaningful and functional use by the individual was often not possible. AAC was not provided to a number of individuals who would likely benefit from communication supports because most had not received a comprehensive assessment. While the interactions of staff with the individuals they served were generally positive, 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. 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. Adequate SLP support was not available to ensure sufficient supports for appropriate and routine implementation of the recommendations addressed in the communication assessments. As observed during the previous review and again during this review, the position of many individuals was not optimal to promote visual or physical participation in communication activities.	

#	Provision	Assessment of Status	Compliance
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	There were no policies related to a monitoring system for AAC, though an outline related to PNMPC responsibilities had been developed. The Comprehensive Communication Monitoring Form was used to monitor communication. Completed forms for the last month were requested and 300 forms for approximately 90 individuals were submitted for August 2011. These forms were completed by PNMPCs and, as such, it was not possible to determine the effectiveness of the devices for these individuals. Only 40% of the individuals monitored had AAC devices. Others either were identified as verbal or did not have an AAC system. As there were 82 individuals at LSSLC listed with AAC, there were at least 46 individuals who had not been monitored during the month of August 2011 while 54 of those with no AAC or who were verbal were monitored that month. Of the 36 individuals monitored who had one or more AAC systems, 10 were reported to have systems that were broken, five individuals had systems reported to be missing, and nine did not use the system at all or rarely. Thus, during August 2011, only 36% of those individuals had their devices available, in working order, and in use. There was no analysis of the monitoring data or process to inform and direct staff training or system change. By report, emails were sent by the PNMPC supervisor to inform the speech clinician of issues identified. There was no mechanism to document the need for action based on monitoring results or to make a referral on the monitoring form itself. The PNMPCs reported that often they reported issues on the monitoring form that were not addressed in a timely manner and, in some cases, they stopped documenting the same problem. The PNMPCs did not appear to be adequately trained to conduct this monitoring based on their reported findings: • Item: The individual is able to use the AAC/device? PNMPC answer: NA, uses communication poster. The PNMPC was not aware that the poster was AAC. • Item: The rationale and description of intervention regarding the use and benefits of the AAC are integrated into the PSP? PNMPC answer: PSP states that Individual #253 uses a voice output device at LISD school classroom, but does not use in the dorm. This statement did not identify any rationale, but rather described how the individual communicated. This was noted in a number of cases. • Item: Staff understands how the individual communicates? PNMPC answer: point, pull, use noises. Individual #542 had a Communication Builder and a book, but staff did not identify these as communication methods. It was also reported that the Communication Builder was broken and the book was lost. There was no evidence of validation monitoring conducted with the PNMPCs related to communication at the time of this review. There was no formal system to validate communication programs and data collection implemented by therapy technicians.	Noncompliance

Recommendations:

1. Address the barriers to the successful staffing of an adequate number of qualified speech clinicians. In addition, consider the addition of Speech Assistants to enhance and expand service provision (R1).

2. Establish a clearly outlined strategic plan to direct the activities of the speech clinicians that will focus on those actions necessary to make progress toward and achieve substantial compliance with each item of this provision. The development of the POI should be clearly related to activities conducted to assess status based on record review, observations, training drills, and so forth, and the actual implementation of actions in the strategic plan with documentary evidence. These should be reported in the POI and serve as the foundation for the assignment of compliance or noncompliance status by the facility (R1-4).

3. Review the current format and content of NEO staff training. Revise as indicated to ensure that the focus is for new staff to develop skills as effective communication partners. This should by interactive and dynamic with opportunities for role playing and practice. A refresher for existing staff is also indicated (R1).

4. For those receiving direct services, well defined, measurable, meaningful, and functional goals or outcomes must be clearly stated as determined via an appropriate assessment. Indices of progress should be 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 (R3).

5. Provide competency-based training for PNMPCs to improve their understanding of the communication process and AAC use in a general manner as well as providing task-specific training related to monitoring communication programs and AAC (R4).

6. PNMPs should include descriptions of expressive communication as well as strategies for use by staff (R3).

7. There is an urgent 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 (R1).

8. Establish an effective system to ensure that AAC systems are available and in good working order. Monitoring by the PNMPCs occurs across the month and an individual could potentially go without their communication system before a problem was identified. This system should also include back-up systems for individuals when their higher tech systems are not working as well as a system to ensure that repairs/replacement are completed in a timely manner (R3-R4).

9. Ensure improved consistency of how communication abilities and effective strategies for staff use are outlined in the PSPs and in the PNMPs (R3-R4).

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 #23, Individual #431, Individual #305, Individual #101, Individual #76, Individual #549, Individual #194, Individual #192, Individual #401, Individual #39, Individual #134, Individual #424, Individual #102, Individual #484, Individual #43, Individual #317, Individual #506, Individual #294, Individual #511 o Skill Acquisition Plans (SAPs) for: • Individual #67, Individual #76, Individual #192, Individual #431, Individual #101, Individual #23, Individual #305, Individual #549, Individual #194, Individual #401 o SAP data for past 6 months for: • Individual #23, Individual #305, Individual #549, Individual #194, Individual #401 o Dental Desensitization Plans for: • Individual #360, Individual #294 o Quarterly reviews of SAP data for: • Individual #23, Individual #431, Individual #305, Individual #101, Individual #67, Individual #76, Individual #549, Individual #194, Individual #401, Individual #192 o Plan of Improvement, 10/17/11 o Skill training in the community, undated o Community outings for the last six months o A list of Individuals who are employed on- and off-campus, 9/21/11 o New SAP format, undated o Action Plan for improvements in Active Treatment Engagement, 10/12/11 o Dental Desensitization Plan outline, undated o Section F and S Presentation Book, undated o Sample of a basic SAP using Forward Chaining, 5/26/11 o Skill Acquisition Plans, proposed by DADS Consultants, dated 8/21/ o A list of all Individuals with dental desensitization plans, undated o List of individuals who lived at LSSLC and received services from LISD, dated 10/27/11 o List of individuals returned to LSSLC from LISD, including date and reason, 8/23/11-10/31/11 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 #395, and Individual #402 Interviews and Meetings Held:

	o Luz Carver, QDDP Coordinator and LSSLC Liaison to LISD o Delaina Dearing, RTT IV o Barbara Draper, Active Treatment Director o Robin McKnight, M.A., Associate Psychologist V o Mike Fowler, M.A., Associate Psychologist V o Lisa Curington, Director of Employment and Day Services o Ric Savage, DADS Consultant o Ms. Antley, LISD classroom teacher at LSSLC <u>Observations Conducted</u>: o Dental and Medical Desensitization Solution Group meeting • Staff Present: - Robin McKnight, Psychologist; Rosie Christian, Psychology Assistant; Jeremy McKnight, OTR; Donna Kimbrough, Psychologist, Kenny Elerson, Psychologist; Joanne Lancaster, Dental Hygienist 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 o LISD classroom on the LSSLC campus
	Facility Self-Assessment: LSSLC submitted its Plan of Improvement (POI), dated 10/17/11. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the facility identified what tasks have been completed and the status of each provision item. The POI did not indicate how the findings from any activities of the self-assessment were used to determine the self-rating of each provision item. 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. 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 throughout the facility, and because it will likely take some time for LSSLC to make these changes, the monitoring team recommend that the facility establish, and focus their activities, on selected short-term goals. The specific provision items the

	monitoring team suggests that facility focus on in the next six months are summarized below, and also discussed in detail in this section of the report.
	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 the SAP format to include a rationale for SAP selection and the inclusion of several necessary components for learning • Addition of a new position to oversee the SAP process • Increased use of data based decisions of the continuation, modification, or discontinuation of SAPs • Development of a data system to track and improve training of individuals in the community The monitoring team suggests that the facility focus on the following over the next six months: • Expand new SAP format to all SAPs written at LSSLC • Ensure that the rationale for each SAP clearly states how acquiring this skill is related to each individual's needs/preferences • Ensure that all of the components necessary for learning new skills are included in each SAP • Continue to expand the methodology used to teach SAPs • Collect and track SAP integrity measures • Ensure that Individual engagement is monitored and improved on evenings and weekends • Address the public school related comments in S1

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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	This provision required an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at LSSLC. As indicated below there have been improvements, however, 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 QDDPs (qualified developmental disabilities	Noncompliance

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	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.	professionals). QDDP assistants trained direct care professionals (DCPs) in the implementation of SAPs, and monitored progress. Vocational SAPs were written and monitored by employment services personnel. 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. As discussed in the last report, it was not obvious that the SAPs reviewed were developed to address individual preferences and needs. The facility had, however, made progress in this area since the last (i.e., April 2011) review. The facility had recently modified the SAP format to include a rationale for each specific acquisition plan. This appeared to be a very direct way to ensure that SAPs were developed to address individual preferences and needs. No SAPS in the new format were available at the time of the review. It is recommended that the rationale for the selection of each individual's SAP be specific enough for the reader to determine if the SPO was practical and functional for that individual. Once identified, skill acquisition plans need to contain some minimal components to be most effective. The field of applied behavior analysis had 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 included many of these components, such as task analysis, behavioral objectives, operational definitions, specific	

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		training instructions, the documentation methodology, and the use of consequences for incorrect responses. None of the SAPs reviewed, however, contained the use of relevant discriminative stimuli, specific consequences for correct responses, or a plan for maintenance and generalization of skills. This is another area where the new SAP format represented an improvement over the current SAPs. The new SAP format included a description of the discriminative stimuli, consequences for correct responses, and a plan for maintenance and generalization of skills. The monitoring team was encouraged by the introduction of the new SAP format that attempted to ensure that the SAPs at LSSLC are based on each individual's preference and needs, and included all the components necessary for learning. The monitoring team looks forward to seeing actual SAPS in the new format during the next onsite review. The monitoring team had the opportunity to review a proposed SAP format prepared by DADS consultants. The monitoring team found the proposed SAP format to be compatible with the recommendations provided in this provision item. As this new format is developed, the monitoring team hopes that another problem at LSSLC can be addressed, that is, the wording of objectives within the action plans of the PSP. In many LSSLC PSPs, 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. Finally, the facility has begun to expand the methodology used to teach SAPs. LSSLC had begun to experiment with the use of forward and backward chaining. No SAPs utilizing these new training procedures were available at the time of this review, however, the monitoring team looks forward to seeing them during the next review. <u>Desensitization skill acquisition</u> LSSLC had begun to make substantial improvements in this area. An interdisciplinary team consisting of dentistry, psychology, and rehabilitation was formed and met regularly. They developed an assessment tool to determine if refusals to participate in dental exams were primarily due to general noncompliance or to fear of dental procedures. An action plan is then developed based on the results of the assessment. A spreadsheet of dental desensitization plans indicated that 118 individuals at the facility had these plans at the time of the onsite review. Two of the most recent dental desensitization plans were reviewed. The monitoring team was encouraged to find that the plans were written in the new SAP format discussed above. Both dental	

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		desensitization plans, however, were identical; suggesting that the dental desensitization plans were not individualized. It is critical that dental desensitization plans are individualized. Outcome data (including the use of sedating medications) from desensitization plans, and the percentage of individuals referred from dentistry with desensitization plans, will be reviewed in more detail in future site visits. <u>Replacement/Alternative behaviors from PBSPs as skill acquisition</u> As discussed in the last report, LSSLC included replacement/alternative behaviors in each PBSP. Several of the PBSPs reviewed indicated that training of replacement/alternative behaviors would be incorporated into the facility's SAP methodology. The monitoring team did not encounter, however, any examples of a replacement behavior found in the PBSP included as a SAP. It is recommended that the facility incorporate alternative/replacement behaviors that require the acquisition of a new skill into SAPs. <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 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 QDDPs. 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	

#	Provision	Assessment of Status	Compliance
		listed in the table below. The facility had instituted several initiatives just prior to the last review (April 2011) to improve individual engagement at the facility. The monitoring team was, therefore, very optimistic that tangible improvements in engagement would be observed during this review. Those expectations were not, however, realized. There were some good examples of engagement, such as in home 523 where several individuals were engaged in a lively group game, and 557A where several individuals appeared to enjoy knitting with the staff. 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 consistently high level of productive engagement in the workshop. The overall impression, however, was that the level of engagement, particularly in the homes in the evening, was disappointing. The monitoring team observed many examples of individuals sitting idly. In some cases, staff appeared to be trying to engage individuals in activities, but in many other cases, staff did not appear to be attempting to promote engagement at all. The monitoring team also observed several examples of staff attempting to engage individuals in activities and discussions that did not appear to have relevance or interest to the individuals. The active treatment coordinators continued to monitor engagement, develop activities schedules, and provide activity boxes to the DCPs. One likely reason that these efforts had not resulted in improved engagement was that none of the active treatment coordinators worked evenings or weekends and, therefore, were not available to the DCPs for guidance and monitoring of engagement. Even engagement data collected by the facility was restricted to first shift. It appears unlikely that the facility will improve engagement in the homes in the evenings unless engagement data are monitored, and DCPs provided feedback. The average engagement level across the facility was 38%, a considerable decrease in that observed during the last two reviews (i.e., 48% and 46%). 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 recommends that engagement data during evenings and weekends be collected, and goal levels of engagement be established and maintained.	

#	Provision	Assessment of Status	Compliance

Engagement Observations:

Location	Engaged	Staff-to-individual ratio
549 A	2/5	2:5
549 A	1/6	1:6
549 B	1/4	4:4
549 B	1/7	2:7
549 D	3/3	1:3
549 D	1/3	1:3
549 C	1/3	1:3
557 A	4/6	3:6
557 A	2/3	2:3
557 B	1/8	1:8
559 B	0/3	1:3
523	4/4	3:4
523	2/4	2:4
520 A	0/2	1:2
506	2/7	2:7
Workshop	20/25	2:25
Workshop	5/8	2:8
510	1/3	2:3
510	3/6	2:6
550	1/3	1:3
550	1/5	1:5
550	2/10	2:10
560	1/3	1:3
560	0/3	1:3

Educational Services

The facility liaison with LISD reported that LSSLC had maintained a great working relationship with the school district. This was good to hear. Students continued to attend LISD schools and the on campus classroom was more active than during the previous review. The liaison reported that an LSSLC psychologist was going to be assigned to being a primary contact with LISD regarding psychology and behavior intervention related activities.

The facility continued to maintain data on student returns from public school (e.g., due to illness). Overall, it appeared to be decreasing. These data might be graphed to show trends.

#	Provision	Assessment of Status	Compliance
		Some, but not all, of the recommendations made in the previous report were addressed. The following paragraph is repeated from the previous report. • 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 following are again recommended. LSSLC should be: • Working on carryover from LISD instructional activities to the individuals' homes at LSSLC. o The new PSP had a section specifically addressing this need. • Conducting some sort of review of the LISD progress reports, perhaps during quarterly PSP reviews. • 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. Advice from DADS central office should be sought by the LSSLC liaison.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	LSSLC conducted annual assessments of preference, strengths, skills, and needs. As discussed in S1, the facility was beginning to make improvements in the documentation of how this information impacted the selection of specific program objectives. Overall, however, more work is needed to achieve substantial compliance for this item. At the time of the onsite review, the facility was beginning the use of the Functional Skills Assessment (FSA) to replace the Positive Adaptive Living Survey (PALS) for the assessment of individual skills, and as part of the method of identifying skills to be trained. The monitoring team looks forward to learning how this new assessment is combined with the results from clinical assessments (e.g., nursing, speech/language pathology) and individual preference, to identify meaningful individualized skill acquisition programs. Finally, while the PSP attempted to identify individual preferences, no evidence of systematic preference and reinforcement assessments (when potent reinforcers or preferences are not apparent) were found. Subsequent monitoring visits will continue to evaluate the tools used to assess individual preference, strengths, skills, needs, and	Noncompliance

#	Provision	Assessment of Status	Compliance
		barriers to community integration.	
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 has made progress on this provision item. More work, however, in the areas of integrity of the implementation, and the demonstration of practicality and function of SAPs is needed. Therefore, this item was rated as being in noncompliance. QDDPs at LSSLC summarized SAP data monthly and presented those data at quarterly meetings. The QDDPs graphed SAP outcome data to improve data based decisions regarding the continuation, modification, or discontinuation of SAPs. Reviews of SAP data revealed that skill acquisition plans were producing meaningful behavior change for 17 of 32 SAPs reviewed with at least three months of data (53%). Examples included: • Identifying items which do not belong to him for Individual #431 • Pressing a button to activate a talking book for Individual #101 There were also several examples of no improvement, resulting in a modification, or discontinuation of the SAP. For example: • Modifying the task for putting left leg in pants for Individual #67 • Discontinuation of a Individual #76's SAP of applying deodorant due to the absence of progress These examples of data based decisions concerning the continuation, discontinuation, or modification of SAPs represents a substantial improvement from the last review. The evaluation of the practicality of SAPs at LSSLC is difficult without a clearly stated rationale for the plan. The recent addition of the rationale on the SAP training sheet, however, will reveal if SAPs are practical and functional for each individual. The monitoring team will be reviewing those SAP rationales during the next onsite review to ensure that SAPs are consistently practical and functional.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 reviewed to evaluate if data were completed as scheduled. The results from those observations were mixed. For example: • Individual #77 was working on her SAP of calling the operator on the phone. The DCP implemented the acquisition program, however, the training level appeared unclear to the DCP in that Individual #77 was physically guided on one trial, but allowed to refuse on two other trials. The DCP could not explain what level of physical guidance was specified in the SAP. • Data were present in seven of eight SAP data sheets reviewed (87%). These observations suggested that SAPs were being conducted as scheduled, however it questions if they were consistently being implemented as written. The only way 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, the monitoring team was encouraged by the facility's addition of a QDDP Assistant Supervisor to oversee the monitoring and implementation of SAPs at LSSLC. The addition of this position should result in an improvement in the use of data based decisions and treatment integrity.	
	(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 training in the community. More work, however, is necessary to achieve substantial compliance. Please see detailed examples provided in section F1e of this report. The facility began tracking of community training prior to the last onsite review. The documentation, however, did not clearly allow for the tracking of community outings that included the implementation of SAPs. The community outing form had recently been modified to better track training of SAPs in the community. The monitoring team will review these data from the new form in future reviews. At the time of the onsite review, five individuals at LSSLC worked in the community. This represented a slight increase in the number reported during the last onsite review (i.e., four). The monitoring team was encouraged by the facility's progress on this provision item and looks forward to seeing continued progress at the next review.	Noncompliance

Recommendations:

1. Extend the new SAP training sheet to all SAPs throughout the facility (S1)
2. Ensure that the rationale for the selection of each individual's SAPs is specific enough for the reader to determine if the SAP was practical and functional for that individual (S1)
3. Ensure that dental desensitization plans are individualized (S1)
4. It is recommended that the facility incorporate alternative/replacement behaviors that require the acquisition of a new skill into SAPs (S1)
5. Engagement data during the evening should be collected, and goal levels of engagement be established and maintained (S1)
6. The facility should expand the number of communication SAPs for individuals with communication needs (S1).
7. Ensure that SAPs are consistently practical and functional (S2)
8. It is recommended that a plan be developed to collect and graph integrity data to ensure that SAPs are conducted as written (S2)
9. Address the four recommendations regarding public school related activities (S1).

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 LSSLC facility-specific policy, Client Management-38, Most Integrated Setting Procedures, 9/20/11 o Organizational chart, undated o LSSLC policy lists, dated 9/16/11 o List of typical meetings that occurred at LSSLC, undated o LSSLC POI, 10/17/11 o LSSLC Quality Assurance Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 10/31/11 o Community Placement Report, last six months, through 10/31/11 o List of individuals who had been placed since last onsite review (13 individuals) o List of individuals who were referred for placement since the last review (14 individuals) o List of individuals who were referred and placed since the last review (4 individuals) o List of total active referrals (17 individuals) o List of individuals who requested placement, but weren't referred, (6 individuals) • Monthly report of activities taken by facility regarding these cases, called APC review and status update o List of individuals who requested placement, but weren't referred solely due to LAR preference, (6 individuals, however, this list was incomplete) o List of rescinded referrals (4 individuals) and PSPA notes regarding each rescinding o List of individuals returned to facility after community placement (0 individuals) o List of individuals jailed or psychiatrically hospitalized at some point after placement (1 individual) o List of individuals who have died after moving from the facility to the community since 7/1/09 (1 individual totals, 1 since the last review) o List of individuals discharged under alternate discharge procedures and related documentation (1 individual) o LSSLC Admissions and referrals weekly report to senior management (9/13/11-11/1/11) o Statewide one-page weekly enrollment report, September 2011 o Root cause analysis of 1 case (return from community in 12/10), 5/10/11 o Description of how the facility assessed an individual for placement o List of all individuals at the facility, indicating the PST's recommendation, if any, for movement to the community o Variety of documents regarding trainings and educational opportunities for individuals, LARs,

	families, MRAs, and facility staff. o Document titled: Obstacles to moving to a community placement, July 2011 o List of individuals who had a CLDP completed since the last review (13 individuals) o Completed checklists used by APC regarding assessment submissions for CLDP (attached to CLDP) o DADS central office written feedback on CLDPs (2 individuals) o Documentation on follow-up to Individual #283 concerns from previous monitoring report o Completed statewide self-monitoring tools for section T, three different tools, 13 completed o Graphs of admissions placement department data o PMM tracking sheet listing post move monitoring dates due and completed o Draft new PSP format blank form o Draft/working new format PSPs for • Individual #309, Individual #558, Individual #555 o PSPs and associated assessments for: • Individual #132, Individual #102, Individual #540, Individual #43 o CLDPs for: • Individual #491, Individual #434, Individual #379, Individual #557, Individual #233,Individual #21, Individual #565, Individual #41, Individual #476, Individual #208, Individual #335, Individual #590 o In-process CLDPs for: • Individual #498, Individual #92, Individual #244 o PFA used during the CLDP meeting for: • Individual #198 o Pre-move site review checklists (P) and Post move monitoring checklists (7-, 45-, 90-, and/or 120-day reviews) conducted since last onsite review for: • Individual #378: 120 • Individual #398: 90 • Individual #283: 90 • Individual #538: 45, 90 • Individual #534: P, 7, 45, 90 • Individual #335: P, 7, 45, 90, 120 • Individual #590: P, 7, 45, 90 • Individual #41: P, 7, 45, 90 • Individual #21: P, 7, 45 • Individual #233: P, 7, 45 • Individual #557: P, 7, 45 • Individual #565: P, 7, 45 • Individual #491: P, 7 • Individual #434: P, 7 • Individual #379: P, 7 • Individual #208: P, 7, 45, 90 (completed by Denton SSLC) • Individual #476: P, 7, 45, 90 (completed by Denton SSLC)

	Interviews and Meetings Held: o Lisa Pounds Heath, Admissions and Placement Coordinator o Leigh Anne Hall, Post Move Monitor o Ric Savage, DADS consultant, and Luz Carver, QDDP Coordinator o Shawn Madison and other direct care staff, American Community Living, community provider o Eileen Shore, DADS state office community placement staff o Adam Parks, Mary Pat McGehee, QDDPs o Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs Observations Conducted: o CLDP Meeting for: • Individual #198 o PSP Meeting for: • Individual #309, Individual #558, Individual #50, Individual #116 o Community group home visit for: • Individual #491, Individual #434, Individual #379 o Many residences and day programs at LSSLC
	Facility Self-Assessment: LSSLC submitted its self-assessment, called the POI. It was updated on 10/17/11. In addition, during the onsite review, the APC reviewed the presentation book for this provision and discussed the POI at length with the monitoring team. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision (other than some mention of the statewide self-monitoring tools). Instead, in the comments section of each item of the provision, the APC wrote a sentence or two about what tasks had been completed and/or the status of each provision item, usually there was an extra every month or every other month. In future POIs, to present a more complete description of the self-assessment process the facility should describe what actions it took, such as observation, interview, and review of a sample of documents. These are the types of activities taken by the monitoring team as part of this compliance review. The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The APC self-rated the facility as being in substantial compliance with 10 provision items: T1b2, T1c2, T1c3, T1d, T1e, T1g, T1h, T2a, T2b, and T4. The monitoring team was in agreement with some (six), but not all of these self-ratings, though again, it was unclear from discussions with the APC and from a review of the POI how LSSLC came to any of the self-ratings in the POI. The monitoring team did not rate T1b2, T13, and T1g in substantial compliance. Further, for this review, T2b was not rated because an actual post

	move monitoring was not conducted during the week of this onsite review and, therefore, could not be observed by the monitoring team. The action steps included in the POI were written to guide the department in achieving substantial compliance. The action steps addressed some of the items of provision T. A full set of action plans should help LSSLC move towards substantial compliance. The action steps should be (a) revised based upon this most recent onsite monitoring report, and (b) prioritized with target dates for each.
	Summary of Monitor's Assessment LSSLC continued to make progress towards meeting provision T of the Settlement Agreement. The number of individuals referred and placed remained low, given the size of the facility, however, there was an increasing trend in placement activity since the baseline review in April 2010. Since the last onsite review, 13 individuals were placed, including four who were both referred and placed within the past six months. Individuals involved in the referral and placement process were of all ages and level of disability. The APC had made progress in summarizing and graphing some of her department's data. This effort should be continued and expanded. More work should be done on failed placement activity, such as a root cause analysis for rescinded referrals, post placement psychiatric hospitalizations or deaths, and returns the facility. These did not happen very often, but each occurrence should be evaluated for possible future improvements in the placement process. A new PSP process was being developed by DADS. It planned to address some continued inadequacies, such as including the opinions of the professionals on the PST, identifying needed supports and services, and identifying obstacles to referral and placement. A number of activities were occurring to educate individuals and their LARs, however, this needs to be individualized and incorporated into the PSP. Feedback obtained from some of these activities (e.g., provider fair, community tours) should be used by the APC for future planning. PSTs were becoming more involved in the referral process and in the selection of providers. LSSLC had good working relationships with the local MRAs and local providers. CLDPs were recently initiated at the time of referral. This was likely to improve the comprehensiveness and usefulness of the document. Additional work needed to be done regarding transition activities and staff training. Further, there continued to be serious problems with the facility's ability to develop an adequate list of essential and nonessential supports in the CLDP. Instead, most focused primarily on the provision of inservices, the scheduling of appointments, and the presence of items and plans rather than their use and implementation. There were few supports that were directly related to actions that were to occur day to day for each individual, such as implementation of preferred activities,. 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.

	Post move monitoring continued to be in substantial compliance. This was particularly noteworthy given that a new post move monitor had been hired mid-way through the past six month period. A new post move monitoring form was being used that included many improvements from the old form. The new form, however, no longer contained the brief descriptions of each essential/nonessential support, or a closing set of paragraphs that gave the PMM's overall opinion of the placement.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with 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.	LSSLC continued to make progress towards meeting the many items of this provision. The admissions and placement department staff engaged in a number of activities to encourage and assist individuals to move to the most integrated setting. The department continued to be led by Lisa Pounds Heath. The monitoring team continued to be impressed by her knowledge of the details of the lives, histories, and transitions of every individual in the referral process. Further, the monitoring team appreciated her responsiveness to the recommendations in the previous monitoring report. Ms. Pounds Heath was assisted by a newly appointed Post Move Monitor (PMM), Leigh Anne Hall. The specific numbers of individuals who were placed and who were in the referral and placement process remained low given the size of the facility (an annual rate of less than 6 percent), however, an increasing trend was evident across the four monitoring reviews. Below are some specific numbers and monitoring team comments regarding the referral and placement process. • 13 individuals were placed in the community since the last onsite review. This compared with 9, 8, and 5 individuals who had been placed during the periods preceding the previous three reviews. o This demonstrated an increasing trend. • 14 individuals were referred for placement since the last onsite review. o 4 of these 14 individuals were both referred and placed since the last onsite review. o 1 of these 14 was both referred and rescinded since the last onsite review • 17 individuals were on the active referral list. This compared with 20, 25, and 17 individuals at the time of the previous three reviews. o This was a relatively stable number and indicated continued referrals by the PSTs. • 6 individuals were described as having requested placement, but were not	Noncompliance

		referred. This compared with 6 and 9 individuals at the time of the previous two reviews. o The APC ensured that each of these six cases was reviewed. o All 6 were not referred due to LAR preference. o LSSLC had a very good process for reviewing those individuals who requested placement, who did not have an LAR, and who were not referred. It was called Placement Review Team. None were identified at the time of this review. During the past six months, two individuals were ultimately referred due to this process. ▪ Two individuals who had previously requested placement, but were not referred were identified in May 2011 by the APC. As a result, their PSTs met to re-visit the possibility of referral. One individual was referred and the other reported that he no longer wanted to move to the community (therefore, neither case required review by the Placement Review Team). • The list of individuals not being referred solely due to LAR preference contained these same 6 individuals listed immediately above (compared to 3 and 17 individuals at the time of the previous two reviews). There were, however, likely many other individuals at the facility (e.g., those who did not or could not make a request themselves) who were not referred solely due to LAR preference. o The data for this listing needs to be corrected. This was noted in the previous monitoring report, please see the previous report for details. • The referrals of 4 individuals were rescinded since the last review. This compared to 4 at the time of the previous review. o Each individual's PST met and a PSPA report was issued that provided information indicating that the decision to rescind was reasonable. One was rescinded by the LAR, one by the individual himself, and two by the PST due to increased behavioral and psychiatric problems. o The APC should do a detailed review (i.e., root cause analysis) of each of these rescinded cases to determine if anything different could have been done during the time the individual was an active referral. Note that the PSPA provided a lot of detail regarding the PST's decision to rescind. The purpose of the APC review is to assess the referral and placement processes. • 0 individuals were returned to the facility after community placement. This compared with 2 individuals at the time of the previous review. o The APC conducted a detailed review of one of these cases, as recommended in the previous monitoring report. The detailed review (i.e., root cause analysis) summarized the events leading to the return to the facility, conclusions made by the reviewer, and four recommendations. For this type of analysis, recommendations should	

relate to the admissions and placement system at LSSLC rather than solely for future services for the individual.

- 1 individual was hospitalized for psychiatric conditions after moving to the community.
  - A detailed review/root cause analysis should be conducted for this (Individual #283)), and any similar type of significant post-move events.
- 1 individual had died since being placed since the last onsite review.
  - The individual was placed approximately two years ago, however, a review of this case should occur. In this case, the individual (Individual #564) was reported to have died from cardiac arrest after/during a choking incident.
- 1 individual were discharged under alternate discharge procedures (see section T4 below).

Each of the above 10 bullets should be graphed separately and LSSLC had made good progress in doing so since the last review. A number of bar graphs were presented to the monitoring team and represented the beginning of a data set for the department. A full set of graphs, representing all of these bullets should be created. The monitoring team also recommends using to line graphs rather than bar graphs because line graphs present a better picture of trending over time. These data should be submitted and included as part of the facility's QA program (see sections E above and T1f below).

<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 assessment process, during the annual PSP meeting, and be documented in the written PSP.

LSSLC had made progress in doing so. First, facility administration began to require that each discipline's annual assessment include a statement of the opinion of the assessor regarding community placement and whether supports could be provided in a less restrictive setting. This was discussed at QAQI Council in August 2011 and training was conducted in September 2011 for clinicians. Statements from clinicians were included in the PSPs reviewed by the monitoring team for many, but not yet all disciplines. Second, discussion during the PSP meeting regarding the determinations of professionals was just beginning to occur and these discussions were observed by the monitoring team at four PSP meetings during the week of the onsite review. Across the four meetings, the depth of the discussion ranged from solely asking each clinician to state his or her opinion to deeper discussion about referral (also see section F1e of this report). Third, some of the PSP documents contained a section regarding these facility discipline clinician determinations. Fourth, the very new updated PSP process included the

		determinations of professionals as part of the standard structure of the new meeting format and the standard structure of the new written PSP document format. <u>Preferences of individuals</u> The preferences of individuals appeared to be important to LSSLC PST members. LSSLC should be very thoughtful about how it determines the preferences of individuals for community placement. For most individuals, merely asking whether he or she wants to move to a group home is insufficient (e.g., Individual #309). Therefore, an individualized plan to educate and assess preference will be needed (see T1b2). <u>Preferences of LARs and family members</u> LSSLC attempted to obtain the preferences of LARs and family members and took these preferences into consideration. <u>Senior management</u> The APC continued to keep facility senior management well informed of the status of all referrals in two ways. First, she submitted a detailed report each week. Second, once each month, she made a 15-30 minute presentation to senior management.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	The monitoring team looked to see if policies and procedures had been developed to encourage individuals to move to the most integrated settings. The state policy regarding most integrated setting practices was numbered 018.1, dated 3/31/10. A revision was being developed over the past months and was expected to be disseminated soon. The APC reported that the facility followed the state's policy. Moreover, the APC had written a facility-specific policy that she described as being in line with the new (and soon to be disseminated) state policy. Regarding the facility-specific policy: • It is likely that once the state policy is officially disseminated, some edits may be required. • The policy should include the requirement for having an item in the PSP related to educational activities of the individual and his or her LAR related to community living options. This should include activities engaged in over the previous year, the individual's response to these activities, and the plan for activities for the upcoming year. • It should be subjected to the state office process described in V2 below.	Noncompliance
	1. The IDT will identify in each individual's ISP the	This provision item was found to be in noncompliance based upon the need to adequately identify the protections, services, and supports that need to be provided to	Noncompliance

	protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	the individual, as well as the identification of obstacles to movement to the most integrated setting and a plan to overcome those obstacles. Even so, DADS and the SSLCs were making continued progress towards substantial compliance with this important provision item. DADS and the SSLCs were embarking on another revision to the PSP process. This was the third (or so) revision to the process since the initiation of the Settlement Agreement, however, this was not unexpected because revisions to such a major part of service provision often require repeated revisions, modifications, or even overhauls. The monitoring team wishes to acknowledge DADS' efforts to continue to work to improve the PSP process so that it meets the needs of the individuals while continuing to progress towards meeting substantial compliance with the Settlement Agreement. To this end, DADS recently brought in three consultants to work on developing a new PSP format, new expectations, and updated training for staff. The consultants will learn about the current system, develop a new PSP document format, revise the way the meeting is conducted, and provide training to staff. Moreover, the consultants were working with the DADS central office coordinator of most integrated setting practices to ensure that the many requirements of provision T would be addressed. One of the consultants had started working at LSSLC. The monitoring team had the opportunity to meet with him and the LSSLC QDDP Coordinator. To briefly summarize, there will be a new PSP meeting format, and a new PSP written document format. All relevant staff had received training. New procedures were modeled by the consultant. This was followed by observation, coaching, and corrective feedback during both mock and actual PSP meetings led by QDDPs. Overall, the new PSP was designed to address the many items that are required by the Settlement Agreement, ICFMR regulations, and DADS central office. Further, the consultants planned to include items that had been missing from previous PSP formats, such as professional's opinions, and the identification of obstacles. The new process was too new to be fully evaluated by the monitoring team, however, it appeared promising and to be headed in the right direction. • All annual PSP meetings observed during the week of the onsite visit were in the new style format. Each was only the first or second time the QDDP used the new format. • All written PSPs reviewed for this monitoring visit were in the old style format. The monitoring team, however, was given a blank PSP format, a sample completed PSP, and two PSP in-process documents that were used during the PSP meetings for Individual #309 and Individual #558.	

		Protections, Services, and Supports The PSP meetings observed during the week of the onsite review were well attended and there appeared to be more participation than observed during previous onsite reviews (i.e., the old style PSP meeting). In general, the QDDPs stood up during most of the meetings, wrote on poster boards, and were more engaging. Time was spent on risk identification and planning, community living, and development of action plans. This was an improvement from the old style meetings during which a lot of time was spent merely providing information about the individual that was already known to all those in attendance. A family member at one of this week's meetings stated that she thought this was one of the best meetings she'd attended. Given that a major process change was underway regarding both the PSP meeting and the PSP document, the monitoring team will not provide detailed commentary on the PST's identification of protections, services, and supports at this time because there was not yet a set of new PSPs for review. Two general comments, however, are provided below (also see section F of this report): • During the PSP meetings that were observed, there was frequent mention of ensuring that there would be action plans for important preferences and important safety supports. • This comment is repeated from the previous monitoring report: 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. Obstacles to Movement Obstacles to referral and placement were not adequately identified or addressed on an individual basis in the PSPs in any type of consistent manner across the facility. 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 to be more successful in identifying and addressing obstacles. It may be that PSTs will need to differentiate between obstacles/reasons to making a referral, and obstacles to making the placement occur. The identifying and addressing of obstacles on an individual basis, as required by this provision item, were part of the new style PSP meeting and PSP document and, as such, were undergoing major changes. As a result, detailed commentary on this aspect of this provision item will not be provided at this time because there was not yet a set of new PSPs available for review.	

	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.	The monitoring teams and DADS central office are working towards agreement on the specific criterion for this provision item. Once established, it will provide more specific direction to the APC and the facility regarding achieving substantial compliance. LSSLC had not yet addressed education of individuals and their families on an individual basis. The old style PSP template required a comment about the education of the individual and LAR, however, as exemplified in each of the written PSPs reviews, the PSP provided very little information and no details. Some PSPs described what the individual had done, whereas others described what the individual might do during the upcoming year. • 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. The new PSP format included a series of questions for the PST regarding these two aspects of education. • The quality of the discussion regarding referral needs to improve. Detailed examples are provided in section F1e of this report. Tours of community providers are an important aspect of educating many (but not all) individuals about community options. No progress had been made in improving this process at LSSLC since the last onsite review. It appeared that only four individuals had gone on a community tour since the last review and that another 10 were scheduled, but had not yet occurred. At the time of the last two reviews, 39 and 40 individuals, respectively, had gone on community tours. The system of community tours needs to be addressed by the APC. The annual provider fair occurred in March 2011 and was discussed in the previous monitoring report. The CLOIP process continued to be implemented by the local contracted MRA. The transition home, described in the previous report, was made available to individuals to tour, visit, and, depending upon availability, move in. • One individual was described as having had a very successful experience. While there, she learned important self-care skills regarding her diabetes. This appeared to play a role in her transition to the community. • The facility director reported that a second transition home was being developed. LSSLC had engaged in activities to teach staff, at all levels, more about community living, options that existed in the community, and policies and practices regarding supporting individuals to live in the most integrated settings. • The APC required that all PST members review the facility-specific most integrated setting practices policy (9/21/11).	Noncompliance

		• The transition home held an open house for staff at all levels. Approximately 100 attended during the two hour period (10/25/11). • The APC continued to participate in periodic local authority meetings. The annual local authority training was held in mid-October 2011. • The new PMM received a two-hour training regarding most integrated setting practices and her new job responsibilities (9/2/11).	
	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 individuals were assessed during the living options discussion at the annual PSP meeting, or at any other time if requested by the individual, LAR, or PST member. In addition, a listing was given to the monitoring team showing every individual and whether the PST referred the individual for community. The monitoring teams have been discussing this provision item at length with DADS, especially regarding whether the determinations of professionals in their discipline-specific assessments, a well-conducted living options discussion, and similarly well-done documentation in the written PSP, would meet the requirements for this provision item. This question will be resolved by the time of the next onsite review at LSSLC.	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 coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	As noted in section T1b above, the DADS policy on most integrated setting practices was being revised. This included development of a new CLDP document format, and the process for managing the CLDP. Twelve CLDPs were reviewed by the monitoring team. <u>Timeliness</u>: The 12 CLDPs reviewed indicated that they were developed in a timely manner. <u>Initiation of the CLDP</u>: Rather than waiting until right before the individual moved, the CLDP document was to be created at the time of referral with an expectation that its contents would be developed and completed over the months during which referral and placement activities occurred. The APC and the QDDP were the primary writers of the CLDP. This process had only just begun. Three of these in-process CLDPs were reviewed and, as somewhat expected, the amount of information corresponded with the length of time since the individual had been referred. <u>PST members visits to group homes</u>: PST members were to visit group homes and be more active in supporting the individual to choose a home and provider that would best	Noncompliance

		support his or her preferences and needs. This appeared to be occurring for most, but not all individuals. Post post-move monitoring PST meetings: PST meetings were occurring after every post move monitoring visit, even if there were no problematic issues. CLDP meeting prior to move: CLDP meetings should be as efficient and useful as possible. The APC led the CLDP meeting observed by the monitoring team for Individual #198. The APC did a good job of giving each PST member a chance to speak about the supports that he or she felt were most important for this individual. Further, the APC fostered a very good discussion with the individual's mother regarding ways she could best be involved during the day of his transition and the subsequent weeks and months. For future CLDP meetings, however, the APC should be particularly attentive to statements made by any PST member about what's "most important" or "key" for the individual. For example, the monitoring team heard a PST member say that it was most important for the individual to "trust somebody." Another spoke about the importance of him having two sandwiches to take to work each day. These two very different examples (i.e., one very broad and one very specific) should have been pursued in more depth by the APC. This is also directly related to identifying essential and nonessential supports for alter in the CLDP (see T1e below). Further, the APC should consider handing out the in-process CLDP to participants to help them in their participation during the meeting. During this meeting, only the five-page PFA was given to participants. The monitoring team wishes to acknowledge the community provider's complete flexibility and willingness to do whatever the PST asked (e.g., data collection, activities, supports). The monitoring team has found community providers to be extremely receptive to PST requests for actions, activities, training objectives, and so forth.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	Twelve completed CLDPs were reviewed by the monitoring team. The CLDP document contained a number of sections that referred to actions and responsibilities of the facility, as well as those of the MRA and community provider. Implementation of the new CLDP policy, utilization of QA processes, and greater involvement of the PST will likely bring the facility closer to substantial compliance with this provision item. Some comments regarding the actions in the CLDP are presented below. • The CLDPs identified the need for training for community provider staff. They did not define o Which community provider staff needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and	Noncompliance

		vocational staff), and/or what level of mastery of the information was required (e.g., classroom training, demonstration of competence). o The method of training, such as community provider staff shadowing facility staff, and/or showing competency in actually implementing a plan, such as a PBSP, nursing care plans, etc. • Actual implementation of these supports by staff should be required in the essential and nonessential support sections, not only inservicing. • Collaboration between the facility clinicians and the community clinicians (e.g., psychologists, psychiatrists, medical specialists) was not addressed. • Also see comments in T1e below. DADS central office was reportedly still conducting reviews of each of LSSLC's CDLPs, however, documentation was provided for only two (Individual #335, Individual #590). The monitoring team reviewed this feedback. The comments addressed all aspects of the CLDP, were excellent, and should continue. • State office should consider developing a metric to determine if facilities are making progress, that is, whether the feedback from state office is helping to reduce errors and improve content of the CLDPs. This is important to do because changes in the training and supervision of APCs will likely be required if no progress continues to be made regarding these important aspects of the CLDP, especially those regarding assessments and essential/nonessential supports.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDPs indicated the staff responsible for certain actions and activities and the timelines for these actions.	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 CLDPs contained evidence of individual review and LAR review. This was also evident during observation of the CLDP meeting.	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	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. The APC created, and used, an assessment checklist to track submissions and updates of professional discipline assessments. The checklist included the date of the assessment	Substantial Compliance

	individual's leaving.	was completed (for most of the assessments). This date could then be compared to the individual's move date to ensure it was no older than 45 days. The monitoring team's review of the 12 CLDPs indicated that the sets of assessments of all were within 45 days prior to the individual leaving the facility. The quality and content of the assessments, however, needed improvement as detailed in section F1c. In order for LSSLC to maintain substantial compliance with this provision item, the quality of PST assessments will need to improve.	
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.	Twelve CLDPs were reviewed along with their attachments, typically assessments, PSPA meetings, and PSPs. There were a number of good actions evident, and some are noted below: • A variety of individuals across the entire facility were placed, including those under age 18, those who had lived at LSSLC for many years, and those with multiple severe and profound disabilities. • CLDP documents indicated that numerous meetings and activities had occurred related to placement. • It appeared that extra efforts were given to those referrals that were more than 180-days old. • There appeared to be good involvement by PST and family members in most transitions. For example, there was consideration of multiple providers for almost every individual. Further, in a number of cases, individuals from LSSLC moved together to an existing provider home, or to a new home that was created by the provider. • Individualization in pre-placement planning was evident, such as having provider staff meet the individual prior to his visit, waiting for a new home to be ready rather than selecting a home that might have been less adequate, and/or only doing day visits rather than overnight visits. • Almost every CLDP included a support for there to be skill acquisition training for a number of different skills. • Although the list of essential and nonessential supports were overly weight to inservicing, there was individualization in the content listed for each individual in regards to PNMP and nursing details. On the other hand, little progress was made on the most important part of the CLDP, that is, the identification and definition of essential and nonessential supports (ENE). This was very surprising given the findings and feedback provided in the previous three monitoring reports. The monitoring team had the opportunity to discuss this issue at great length with the APC, the PMM, and the DADS central office staff member during the week of this onsite review. This discussion included a detailed review of the ENE	Noncompliance

		support examples that the monitoring team presented in the previous monitoring report as well as the ENE supports that were in some of the CLDPs completed since the last onsite review. Below are comments that applied to the current set of 12 LSSLC CLDPs: • Histories of serious behavioral or psychiatric problems were given scant attention, such as failed placements, psychiatric hospital admissions, and running away. Even if these had occurred many years prior to admission to LSSLC, the issues might still be relevant to the individual and should receive specific attention in the list of ENE supports. • Recent behavioral and psychiatric issues also received little attention other than references to provider staff receiving inservices on the individuals PBSP. Examples of recent behavior problems were aggression, self-injury, hoarding, and being 100 pounds overweight. • There were no specific references to the use of positive reinforcement, incentives, and/or other motivating components to an individual's success. • In only a few cases, was there a requirement to monitor the implementation of PNMP, PBSP, nursing, etc. plans (rather than only the inservicing of staff). This was more evident in the most recent of these CLDPs. o The importance of this cannot be overstated. For example, during the monitoring team's visit to a group home (see T2b below), the PMM (fortunately) asked for the actual weekly blood pressure results for one individual. It turned out that this was not being done, even though the community provider had completed the only requirement in the CLDP, that is, to have done staff inservicing. • The ENE supports were almost identical across this set of 12 CLDPs. The APC and PST should ensure that what's important for the preferences and safety of the individual are included, rather than merely including the same set of items in each CLDP. In contrast to previous monitoring reports, comments on the individual ENE supports in each of the 12 CLDPs are not provided here. Problems with the (a) identification, (b) definition, and (c) specification for monitoring of ENE supports were detailed in those previous reports and were discussed at length with the APC and PMM during this onsite review. Further, as noted in T1c above, DADS central office commented on ENE supports in their reviews of two LSSLC CLDPs (and perhaps others). The examples were similar to what the monitoring team has commented upon in previous reports and in the monitoring team reports for other SSLCs. Thus, over the past year, the facility had received frequent, detailed, and consistent feedback regarding the development of an appropriate list of ENE supports from the monitoring team and from DADS central office. This provision item also requires that essential supports that are identified are in place	

		on the day of the move. For each of the individuals, the pre-move site review was conducted by the LSSLC PMM and indicated that each essential support was in place.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	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. The monitoring team recommends that the APC take a close look at all three self-monitoring tools to ensure they contain the proper content, that the instructions for completion of self-monitoring are adequate, and that the criterion for scoring is valid. The set of completed tools reviewed by the monitoring team all indicated scores of 100%. Proper, reliable, and valid (i.e., correct content) self-monitoring will be required if LSSLC is to achieve and maintain substantial compliance with all of section T. Since the last onsite review, the APC began to collect and graph some data from her department's activities. The APC was at the initial stages of developing these graphs and, although improvements were needed (and were discussed with the APC and were noted in T1a above), it was a very good initial effort.	Noncompliance
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with	At the facility level, LSSLC was not in compliance with this provision item. Although LSSLC was beginning to gather relevant information regarding obstacles across the facility (as evidenced in a document that listed a variety of obstacles with some un-percentages, also see F1e above), 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. The proposed statewide obstacles report was described in the previous monitoring report for LSSLC. As of the time of this review, it had not yet been issued and, therefore, the same comments from the previous monitoring report continued to be relevant and are not repeated here. It appeared, however, that the new PSP process might provide valuable information that can contribute to LSSLC's ability to achieve substantial compliance with this provision.	Noncompliance

	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.		
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	The monitoring team was given a document titled "Community Placement Report." It was for the previous six months, through 10/31/11. Although not yet included, the facility and state's intention was 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.	Substantial Compliance
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 continued to meet substantial compliance with this provision item. This was especially noteworthy given the recent change in PMM staff. The previous PMM left her position in August 2011 and the new PMM began at that time. The first PMM did a very good job at post move monitoring (as reported in the previous monitoring report) and the new PMM appeared to have continued to provide the same high quality post move monitoring, as evidenced by a review of post move monitoring forms and her interactions during the home visit described in T2b below. The new PMM received a special two hour training from the state office coordinator for most integrated services practices. Moreover, she was regularly supervised by, and worked closely with, the APC. Since the last onsite review, 29 post move monitorings had occurred for 15 individuals (plus another six post move monitorings were conducted for two individuals by the Denton SSLC PMM because the individuals had moved to a location near the Denton SSLC). Of these 29, 13 were completed by the previous PMM, the other 16 were completed by the new PMM. This appeared to be 100% of the post move monitoring required, based upon the individuals who were reported to have moved to the community. LSSLC, however, did not have a tracking sheet that listed all individuals and their required post move monitoring dates. This would be helpful to the facility (and to the monitoring team) for future onsite reviews. All 29 post move monitoring reports were reviewed (as well as the six completed by Denton SSLC). For all, the day and the residential sites were visited by the PMM. All used a form consistent with Appendix C, however, the three most recent post move monitorings were completed on a new form. Although the new form included many improvements compared to the old form, the monitoring team was disturbed by the loss of narrative information that was evident in every one of the 26 old style forms. That is, in the old format, the PMM wrote a brief objective description of her findings for each of the ENE supports (a couple of sentences) as well as an overall summary of the post move monitoring, including important subjective impressions, at the end of the form (a couple of paragraphs). These sentences and paragraphs made for easy reading and were very useful in understanding the post move monitoring visit and the overall experience of the individual in his or her new day and home environments. This appears to have been lost in the new form and should be re-visited by state office. Overall, most individuals appeared to be happy and doing well in their new homes and day programs. Progress in communication and independence were reported, as well as improvements in some long-standing behavior disorders, such as hoarding. For seven of	Substantial Compliance

		these individuals, problematic issues were identified. The PMMs did not hesitate to be assertive in requiring the provider to do follow-up, provide additional information, and receive an additional post move monitoring visit (e.g., 120-day reviews were conducted for two individuals). Further, the PMMs did not hesitate to bring the LSSLC PST into any relevant discussions. Some of these individuals were having difficulties at around the time of their 45-day review. In some cases, additional clinical supports were needed; in others, there were problems with provider actions, such as follow through on agreed-upon ENE supports, providing the PMM with evidence of medical appointments, or responding to needs of the individual's public school teachers. It appeared that the PMM played a key role in getting these issues resolved, such that improvements were noted at the time of the 90-day review (e.g., Individual #41). Below are additional comments regarding LSSLC's post move monitoring. • The PMMs took the initiative to add a Yes/No/NA line to each ENE support in the old form. The new form had a column for Yes/No/NA. • Again, the PMM should always also provide her overall subjective opinion about the placement. Remember, the PMM is acting as the "eyes and ears" of the PST (and the facility). Her opinions will be valued by the PST, will enhance the quality of the post move monitoring report, and be useful to DADS, the monitoring team, and any other reviewers. • Although many ENE supports merely required an inservice to occur, the PMMs often sought out additional information, such as staff knowledge, or observation of implementation. • PST review of post move monitoring appeared to have only recently been initiated. This should continue. • There were occasional typographical errors regarding dates, and in one case the 90-day information was not included for all ENE supports.	
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 monitoring team had the opportunity to accompany the PMM and APC on a visit to the home of Individual #491, Individual #434, and Individual #379. They had moved into the home about 10 days prior to this visit. The 7-day post move monitoring had been conducted as per schedule and the 45-day was not yet due. This was, therefore, not an official post move monitoring visit and, as such this provision item was not rated. The purpose of this visit was to see the post-move monitor demonstrate some of the ways she did post move monitoring, see the community home, meet the individuals, 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, one staff from DADS central office also attended this home visit. Further, during the time of the home visit also present were two staff from the local MRA, and the mother of one of	Not Rated

	the 90th day following the move date.	the individuals. In other words, there were quite a few people in the home at this time. The three individuals handled the resulting disruption to their evening very well. The provider was American Community Living. The co-owner of the company, Shawn Madison was also there. The PMM did some follow-up to her official 7-day visit from just the week before, including one of the bedrooms having a urine smell, absence of chairs on the back deck, and staffing. Apparently, the PMM had had a number of conversations with Mr. Madison and these issues had been addressed. As noted above, the PMM inquired about one individual's blood pressure checks. It turned out they were not being done weekly as required. Note, however, that the CLDP only required there to be inservicing of staff. The PMM took the extra initiative to find out about implementation. As noted in T1e, PSTs, the APC, and the PMM should ensure that implementation is included in the list of ENE supports during the development of the CLDP.	
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:	One individual was reported to have been discharged under this T4 provision. It was done so properly as per the requirements of this provision item as evidenced by documents submitted to the monitoring team. The individuals and the reason for discharge are below: • Individual #600: discharged to another SSLC due to court order, based on psychiatric, behavior, and forensic reasons.	Substantial Compliance

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

Recommendations:

1. Update facility policies to make them in line with the new state policy, and subject the facility-specific policies to the requirements of section V2 (T1b).

2. Conduct a detailed review, such as a root cause analysis, for any failed or problematic outcomes of the placement process, such as rescinded referrals, post placement psychiatric hospitalization or death, returns to the facility, and so forth (T1a).

3. Identify those individuals who would have been referred except for the preference choice of the LAR; this list should include not only those who themselves requested referral, but those individuals who themselves cannot express a preference but whose PSTs would otherwise have referred. Add this list to the Community Placement Report (T1a, T1h).

4. Continue with the development of a revised PSP process; ensure that the PSP meeting and the PSP document address :
    a. The inclusion of professional determinations regarding most integrated setting,
    b. The identification of protections, services, and supports, and
    c. Obstacles to referral and placement (T1a, T1b1).

5. Identify and address obstacles to referral and placement across all individuals at the facility by conducting a comprehensive assessment and analyzing the information (T1g).

6. Assess implementation instructions, content, and scoring criterion for the three self-assessment tools being used for this provision; implement them in a reliable and consistent manner; and utilize the results (T1b1).

7. In the PSP, describe what activities were taken over the past year, and what activities are to be taken during the upcoming year, to educate the individual and/or his or her LAR regarding community placement (T1b2).

8. Summarize and graph all relevant data from the Admission and Placement department's activities. Some good first steps had already been taken (T1a, T1f).

9. Improve the CLDP to address the transition and staff training issues noted in T1c1 (T1c1).

10. Address the many comments in T1e above regarding the determination and definition of essential and nonessential supports (T1e).

11. Revisit the new post move monitoring format as per the comments in T2a regarding comments, sentences, and paragraphs (T2a).

12. DADS CLDP reviews might be done at various stages of CLDP development, not only immediately prior to the move date. In addition, consider creating a metric to measure the quality of the CLDPs (T1c1).

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o LSSLC Plan of Improvement updated 10/1/11 o LSSLC Guardianship Policy dated 3/31/11. o List of individuals for whom LAR has been obtained in the past six months (7) o List of individuals for whom the process to seek guardianship has been initiated (14) o Human Rights Committee Minutes for the past six months o LSSLC Priority List for Adults without Guardians o Customer Satisfaction Survey Family/LAR graphed report o Personal Support Plans: • Individual #387, Individual #285, Individual #504 Interviews and Meetings Held: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Luz Carver, QDDP Coordinator o Jason Peters, Human Rights Officer o Royce Garrett, Director Consumer and Family Relations Observations Conducted: o Observations at residences and day programs o Oak Hill Morning Unit Meeting 11/1/11 o Incident Management Review Team Meeting 10/31/11 and 11/3/11 o Annual PSP meetings for Individual #116, Individual #321, and Individual #50 o Personal Focus Meeting for Individual #560 o Human Rights Committee Meeting 11/2/11 o Self Advocacy Meeting
	Facility Self-Assessment: LSSLC submitted its self-assessment, called the POI. It was updated on 10/17/11. In addition, during the onsite review, the Director of Consumer and Family Relations reviewed the presentation book for this provision. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, the comments section of each item of the provision included a statement regarding what tasks had been completed or were pending.

	The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The facility assigned a noncompliance rating to both of the provision items in section U. It was unclear from a review of the POI how LSSLC came to this self-rating. Nevertheless, the monitoring team was in agreement with these self-ratings.
	Summary of Monitor's Assessment: LSSLC did not indicate it was in compliance with any of the provisions of this section. The facility had, however, taken some steps to address compliance. Some positive steps that the facility had taken in regards to consent and guardianship issues included: • The facility had approved a policy addressing guardianship. • The Consumer and Family Relations Director was designated as the Guardianship Coordinator. • The facility had updated a list of individuals and their guardianship status. • Information on guardianship was presented at a meeting for families. • The Human Rights Committee continued to meet and review all restrictions of rights. • The facility had a Self Advocacy group comprised of individuals residing at the facility. • The facility had made contact with advocacy and guardianship agencies in the area. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. While the facility maintained a list of individuals needing an LAR, PSTs were not adequately addressing the need for a LAR or advocate. • Provision item U2 was determined to be in noncompliance. While the facility was pursuing guardianship for a number of individuals at the facility, the efforts did not appear to be related to those individuals determined by the facility to have the greatest prioritized need. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a prerequisite. The facility had a Human Rights Committee (HRC) in place to review restrictions requested by the PST. At the HRC meeting observed, committee members did not engage in thorough discussion regarding the need for the proposed restrictions prior to giving approval. The PSTs observed were also holding minimal discussions around the need for guardians in reference to the capacity for individuals to make decisions and give consent.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The state policy to address this provision had not yet been released to the SSLCs for implementation. LSSLC had approved a facility-specific policy for developing and maintaining a list of individuals lacking both a functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision. The facility had a list of 188 individuals at the facility that did not have an LAR. This list was prioritized by need. Guardians had been obtained for seven individuals in the past six months. The guardianship process had been initiated for another 14 individuals. Guardianship was being sought for those individuals who had family that might be interested in guardianship first. A sample of PSPs was reviewed for evidence that the team had discussed the need for guardianship. PSTs were not assessing individual's ability to make informed decisions. There was no evidence in any of the PSPs reviewed that teams were discussing the need for guardianship in relation to the individual's ability to make decisions or give informed consent. For example, • Individual #387 did not have a guardian. The team acknowledged that he did not understand his rights when explained to him. He communicated nonverbally and had extensive medical needs. Sedation was used for routine appointments. His sister advocated on his behalf, but cannot legally make decisions for him. He was not considered high priority for guardianship according to the facility priority for guardianship list. • Individual #504 did not have a guardian. He had complex healthcare needs and was able to express himself verbally. The team agreed that he did not understand his rights or community living options. Guardianship information has been provided to his family. He was not listed as high priority for guardianship. PSTs need to hold more thorough discussions regarding the need for guardianship and ability to make decisions and give informed consent. Priority for guardianship should be based on this discussion. The facility was not yet in compliance with this provision.	Noncompliance
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain	LSSLC had implemented facility-specific policies to address consent and guardianship. The facility continued to make efforts to obtain LARs for individuals through contact and education with family members. The facility did have some rights protections in place including an independent ombudsman housed at the facility and a rights officer employed by the facility.	Noncompliance

#	Provision	Assessment of Status	Compliance
	LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	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. Observation of the HRC meeting indicated that the committee did not have enough information in some cases to make an informed decision. For example, a request was reviewed by the HRC for approval to begin Benadryl for Individual #562. The request indicated that Benadryl was prescribed due to the side effects of another medication. The request did not include the name of the medication causing side effects, information regarding other medications that may have been tried, a list of other medications this individual was currently taking, or an analysis of risks. The facility should consider having a PST member present information to the HRC so that the committee would have enough information to make an informed decision. 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 (U1).

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 (U2).

3. Continue to teach individuals to problem-solve, make decisions, and advocate for themselves (U1, U2).

4. The HRC should consider ways to ensure members of the committee have enough information to make informed decisions regarding rights restrictions prior to approval. (U2)

5. 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 (U2).

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, dated 9/16/11 o List of typical meetings that occurred at LSSLC, undated o LSSLC POI, 10/17/11 o LSSLC Quality Assurance Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 10/31/11 o List of all staff responsible for management of unified records o Tables of contents active records and individual notebooks, updated 9/21/11 o Table of contents for the master record, updated 5/17/11 o Email regarding individual notebook issues, 9/28/11 o Various emails regarding setting up of new master record files, through 10/14/11 o A spreadsheet that showed the status of state and facility policies for each provision of the Settlement Agreement, dated 10/17/11 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 chosen for recordkeeping audits, last six months, 14 individuals o 10 completed audits of active records, individual notebooks, and master records; June 2011 (two), July 2011 (three), August 2011 (two), September 2011 (three); included the state self-assessment form and the facility's table of contents/guidelines form. o Various emails to and from responsible managers and clinicians regarding needed corrections o Unified records audit tracking sheet (one page), for September 2011 and October 2011 o Results of two V4 interviews 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 #213, Individual #33, Individual #199, Individual #148, Individual #301, Individual #242, Individual #306, Individual #225, Individual #584 o Review of master records of: • Individual #36, Individual #300 Interviews and Meetings Held: o Sheila Thacker and Stormy Tullos, Unified Records Coordinators o Stacie Cearley, QA director o Sherry Roark, Settlement Agreement Coordinator o Home records clerks and administrative assistant

	o Unit directors and director of residential services o Numerous staff and clinicians during observations in residences <u>Observations Conducted</u>: o Records storage areas in residences o Master records storage area in administrative building
	Facility Self-Assessment: LSSLC submitted its self-assessment, called the POI. It was updated on 10/17/11. In addition, during the onsite review, the QA director and the Unified Records Coordinators reviewed the presentation book for this provision. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the URCs wrote a sentence or two about what tasks were completed. The monitoring team, however, would prefer to have an understanding of the self-assessment process used by the recordkeeping department. For instance, 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. Further, the POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The URCs self-rated the facility as being in noncompliance with all four provision items. The monitoring team agreed with these self-ratings. The action steps included in the POI should be written to guide the department in achieving substantial compliance. Four action steps were included in the POI and all were related to the master record component of the unified record. A set of actions, such as those described in this monitoring report, should be set out as actions. Certainly, these steps will take time to complete; the facility should set realistic timelines, not just for initial implementation of an action, but a timeline that will indicate the stable and regular implementation of each of these actions.
	Summary of Monitor's Assessment: LSSLC demonstrated continued progress. The two URCs continued to be very serious about their jobs and had responded to many of the recommendations and comments from the previous monitoring report. The monitoring team had the opportunity to meet with the group of five unit record clerks and their supervisor from the residential services department. Their efforts were also contributing to LSSLC's continued progress. The URCs had begun to summarize and graph data from some of their activities. These data were now

	submitted to the QA department. The active records were neat and organized. Attention was needed to address problems with use of the individual notebooks. The facility should consider forming a performance improvement team regarding individual notebooks. LSSLC had recently begun to create new master records for each individual. The new master records were a great improvement from the previous format. Tracking and management of state and facility-specific policies was done on a spreadsheet. It indicated continued progress. The tracking should also include information related to central office review. Further, a system of implementation and training of relevant staff needs to be created. The URCs conducted reviews of all three components of the unified record each month, but had not yet met the requirement to have at least five done each month. Overall, the reviews that were completed were done so in a consistent manner. Two forms were completed for each review. One was the statewide monitoring tool. The other was the table of contents for the active record and individual notebook. There was a consistency in the issues and problems identified by the URCs. Many items were marked "N/A." A brief explanation is needed in future reviews, especially for those items that are not asterisked to indicate optional. Other needed improvements to the review system are described below. All needed corrections were entered into a table called the Audit Tracking Tool. The URCs used this listing to follow-up on all of the corrections. It was a reasonable way to manage the status of corrections, however, had only been implemented for less than two months. To address the facility's use of the unified records to make treatment and care decisions, the recordkeeping staff had done two brief interviews of a PST member. More activities will need to be undertaken. Direction will likely be provided by state office in the near future.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	LSSLC demonstrated continued progress with this provision item and had made a number of improvements in recordkeeping activities and records management. State policy and facility-specific policies remained the same since the last onsite review and, therefore, no new comments are provided here. Three examples of positive practices are presented immediately below. The monitoring team met with the unit record clerks. They played an important role in the facility's recordkeeping practices. They were knowledgeable about the recordkeeping activities at LSSLC and were very serious about their work. Earlier in the month (October 2011), their supervision was moved from the unit directors to the director of residential services. This appeared to be a good change because their work could be more consistently supervised and expectations could be the same across all of the clerks. Their responsibilities were modified so that they could focus primarily upon	Noncompliance

#	Provision	Assessment of Status	Compliance
		management of the active records. Further, they were now doing quality assurance audit reviews of active records in other units as well as assisting in managing the individual notebooks. Caseloads were reallocated so that each clerk had 75 records each. To address problems in the transfer of documents at the end of each month from the individual notebooks to the active records, the URCs and unit record clerks came in after 11 p.m. to work with the overnight staff, that is, to train and model for them, the proper way to transfer the documents. This was done for the first time on 10/31/11. It was reported to be successful and the URCs and record clerks were planning to do this at the end of each month for the next few months. The URCs had begun to collect and summarize data regarding their activities, including number of reviews conducted, number of errors found, and number of errors that were corrected. This was good to see. The data were submitted to the QA department and shared at the opening session of this onsite review. The monitoring team spoke with the URCs about ways to make the data presentation even more useful (see V3 below). <u>Active records</u> The active records reviewed by the monitoring team were neat and organized. Records contained documents as per the table of contents guidelines, such as the PALS, PSP, SAPs, IEP, and IPNs. There were, however, some examples of documents filed in the wrong individual's active record (e.g., Individual #192's documents in Individual #213's active record). Also, gaps (blank spaces) still existed in a number of the IPNs. <u>Individual notebooks</u> LSSLC had chosen to keep individual notebooks for all individuals. There were, however, still many concerns and challenges in successfully implementing the individual notebooks across the facility. For example, staff reported that individual notebooks were not always where they were supposed to be and, therefore, they were sometimes unable to easily record required information. Further, in one home, the individual notebooks were in found by the URCs to be in poor condition and, as a result, a series of meetings and follow-up had to occur. Finally, some staff reported that the individual notebooks were not durable. As a result, LSSLC should form a PIT to examine the current status of the use of individual notebooks and make recommendations for how the facility should proceed. Unit record clerks were recently assigned the responsibility to review each of their individual notebooks to assess (and fix) for the presence of all required contents.	

#	Provision	Assessment of Status	Compliance
		Master records LSSLC had recently begun to improve the master records. A new table of contents was created and the staff had created the new records for about a dozen individuals at the time of this onsite review. The new master records were thinner than before. They no longer contained documents that had been unnecessarily duplicated from other records. As the URCs work on completing the creation of a new master record for each individual, they also need to determine what to do about any items that are missing (e.g., determination of mental retardation, birth certificate). The recordkeeping staff should have some sort of procedure or rubric to follow so that they are ensuring that they are doing follow-up on any documents that should be located. Perhaps state office can provide some guidance. Overflow files Overflow files were managed in the same satisfactory manner as during the previous onsite review.	
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.	LSSLC had a single spreadsheet that indicated the status of state policies and the status of facility-specific policies. This was maintained by the facility's QA director. Not all policies were yet in place, though continued progress was evident. For instance, the QA director noted that facility-specific policies for 14 state office policies were developed on since the last onsite review. The spreadsheet, however, should be expanded to include all of the aspects of the DADS memo from 3/15/11 (as detailed in the previous monitoring report), that is, a column for date submitted to state office for approval, and date the policy was approved by state office (state office might have comments or edits that require the facility to make revisions; if so, this should also be noted on the spreadsheet). To show implementation and training of relevant staff on both the state policies and the facility-specific policies, the facility should develop a policy and system with the following components: • It should incorporate mechanisms already in place, such as an email/correspondence being sent to the departments impacted by the policy, including the list of job categories to whom training should be provided. • For each policy, consideration should be given to defining who will be responsible for certifying that staff who need to be trained have successfully completed the training, what level of training is needed (e.g., classroom training, review of materials, competency demonstration), and what documentation will be necessary to confirm that such training has occurred. It would seem that	Noncompliance

#	Provision	Assessment of Status	Compliance
		sometimes this responsibility would be with the Competency Training Department, but often others would have responsibility. • Timeframes also would need to be determined for when training needed to be completed. It would be important to define, for example, which policy revisions need immediate training, and which could be incorporated into annual or refresher training (e.g., PSP annual refresher training). • Based on documentation provided, it appeared a system was available to track which staff had completed which training, and to run exception reports showing who still required training. Incorporation into this system of the training on policies would appear necessary and appropriate.	
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 URCs conducted reviews unified records, however, they did not meet the minimum requirement of five per month. Over the past six months, 14 were completed. Though the required number was not yet reached, the reviews were, overall, done thoroughly and competently. A new plan was put in place by which each of the five unit clerks were to do two reviews of the unified record for another clerk's unit each month. If so and if the records reviewed are chosen randomly, LSSLC should meet the minimum requirement. The URCs were planning to also do an interobserver agreement check on three of these reviewed records each month. Overall, the reviews were done in a consistent manner. Two forms were completed for each review. One was the statewide monitoring tool for provision V. The other was the table of contents for the active record, individual notebook, and master record. The URCs used the table of contents review to indicate whether items were or were not in the active record or individual notebook. Then, they used this information to complete the statewide form. Further, any detailed comments about the quality of the contents of the records and any needed corrections were counted for the URC's data graphs, and copied into the audit tracking system. Across the 10 audit reviews, there was a consistency in the issues and problems identified by the URCs. For almost of all of the reviews, copies of emails sent by the URCs to the relevant manager or clinician were attached. These emails showed the URCs' efforts to obtain additional information or missing/outdated documents. Below are some additional comments regarding these reviews: • A large number of items were marked "N/A," including many items that were not asterisked, or for items that did not make sense to the monitoring team (e.g., "Yes" for MOSES, but "N/A" for DISCUS). A brief two or three word explanation should be provided so that the reviewer of the audit can understand why the	Noncompliance

#	Provision	Assessment of Status	Compliance
		item was marked N/A. Further, it was not clear if N/A meant not applicable, not available, none available, or no information. • Documentation in the medical consultation sections needed to be informed by the medical director's listing of consultations. It appeared that this had been addressed by the facility, however, upon review by the monitoring team, a number of questions came up, such as the need for the listing to indicate the type of consultation (e.g., cardiology), and ensuring that all consultations were included in the listing. • A standard should be determined as to the deadline for annual and quarterly documentation to be filed in the record (e.g., annual PSPs, quarterly PSP reviews). Since September 2011, all needed corrections were entered into a table called the Audit Tracking Tool. The URCs used this listing to follow-up on all of the corrections. The data were then included in the department's data graphs. The monitoring team and the URCs talked about making four graphs: number of records reviewed, average number of errors per record, number corrected, and percent agreement with home record clerks.	
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.	Continued progress was demonstrated by the recordkeeping staff, however, more work will need to be done to determine the full set of activities the facility needs to engage in to demonstrate that records are being used as required by this provision item. Recently, the monitoring teams presented, to DADS and DOJ, a proposed list of actions for the SSLCs to engage in to demonstrate substantial compliance with this provision item. The recordkeeping staff had implemented one process towards this end. They recently began to conduct a post-PSP interview with one PST member using the new questionnaire form developed by central office (two had been completed at the time of this review). The results of these were not summarized or used by the facility in any way. Further, only talking with one PST member each month might not provide enough information for any generalizations to be made about the use of records. 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. • 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. • Since the prior monitoring review, there continued to be problems with nurses'	Noncompliance

#	Provision	Assessment of Status	Compliance
		writing over incorrect information and obliterating entries in the IPNs versus properly indicating errors with a line through the incorrect entry and the author's initials, documentation on the margins of the page versus staring a new IPN page, and notes, on the same page, that were not in chronological order. In addition, there were a number of notes that were uninformative, cryptic phrases that failed to constitute an assessment or evaluation of any sort. For example, individuals were noted to have "kinda" fallen, eaten with "no problems," and had "no significant decrease in LOC today." • Current OT/PT and speech assessments were not consistently available in the individual records reviewed. There was also a poverty of documentation by Habilitation Therapy clinicians and, as such, critical information was not readily available to all team members for making appropriate treatment and training decisions.	

Recommendations:

1. Address and solve the problems regarding the individual notebooks (V1).
2. Finish the conversion of the master records (V1).
3. Determine what to do about items missing from the master record (V1, V3).
4. Complete the development of state and facility policies for each of the provisions of the Settlement Agreement (V2).
5. Create a process for the implementation and training of relevant staff on state and facility-specific policies (V2).
6. Conduct at least five individual notebook reviews (V3).
7. Address the many N/A ratings; provide a short explanation or description of why an N/A rating was given (V3).
8. Determine what medical consultation documentation should be in each active record (V1, V3).
9. Determine the deadline/expectation for when annual and quarterly documents should be filed in the active record (V1, V3).
10. Update the URCs' graph as per discussion with monitoring team (V3).
11. Implement all procedures to address V4 when disseminated from state office (V4).
12. Summarize and use the information collected from the post-PSP meeting PST interviews (V4).

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
AACAP	American Academy of Child and Adolescent Psychiatry
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ACE	Angiotensin Converting Enzyme
ACLS	Advanced Cardiac Life Support
ACOG	American College of Obstetrics and Gynecology
ACP	Acute Care Plan
ACS	American Cancer Society
ADA	American Dental Association
ADA	American Diabetes Association
ADA	Americans with Disabilities Act
ADE	Adverse Drug Event
ADHD	Attention Deficit Hyperactive Disorder
ADL	Activities of Daily Living
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
AEB	As Evidenced By
AED	Anti Epileptic Drugs
AED	Automatic Electronic Defibrillators
AFB	Acid Fast Bacillus
AFO	Ankle Foot Orthosis
AICD	Automated Implantable Cardioverter Defibrillator
AIMS	Abnormal Involuntary Movement Scale
ALT	Alanine Aminotransferase
AMA	Annual Medical Assessment
ANC	Absolute Neutrophil Count
ANE	Abuse, Neglect, Exploitation
AP	Alleged Perpetrator
APC	Admissions and Placement Coordinator
APL	Active Problem List
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
ARB	Angiotensin Receptor Blocker
ARD	Admissions, Review, and Dismissal
ARDS	Acute respiratory distress syndrome
ASA	Aspirin
ASAP	As Soon As Possible
AST	Aspartate Aminotransferase

AT	Assistive Technology
ATP	Active Treatment Provider
AUD	Audiology
BBS	Bilateral Breath Sounds
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BID	Twice a Day
BLS	Basic Life Support
BM	Bowel Movement
BMD	Bone Mass Density
BMI	Body Mass Index
BMP	Basic Metabolic Panel
BON	Board of Nursing
BP	Blood Pressure
BPM	Beats Per Minute
BS	Bachelor of Science
BSC	Behavior Support Committee
BSD	Basic Skills Development
BSP	Behavior Support Plan
BTC	Behavior Therapy Committee
BUN	Blood Urea Nitrogen
C&S	Culture and Sensitivity
CAL	Calcium
CANRS	Client Abuse and Neglect Registry System
CAP	Corrective Action Plan
CBC	Complete Blood Count
CBC	Criminal Background Check
CC	Campus Coordinator
CC	Cubic Centimeter
CCC	Clinical Certificate of Competency
CCP	Code of Criminal Procedure
CCR	Coordinator of Consumer Records
CD	Computer Disk
CDC	Centers for Disease Control
CDDN	Certified Developmental Disabilities Nurse
CEU	Continuing Education Unit
CFY	Clinical Fellowship Year
CHF	Congestive Heart Failure
CHOL	Cholesterol
CIN	Cervical Intraepithelial Neoplasia
CIR	Client Injury Report
CKD	Chronic Kidney Disease

CL	Chlorine
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CMax	Concentration Maximum
CMP	Comprehensive Metabolic Panel
CMS	Centers for Medicare and Medicaid Services
CMS	Circulation, Movement, and Sensation
CNE	Chief Nurse Executive
CNS	Central Nervous System
COPD	Chronic obstructive pulmonary disease
COTA	Certified Occupational Therapy Assistant
CPEU	Continuing Professional Education Units
CPK	Creatinine Kinase
CPR	Cardio Pulmonary Resuscitation
CPS	Child Protective Services
CR	Controlled Release
CRA	Comprehensive Residential Assessment
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CTA	Clear To Auscultation
CTD	Competency Training and Development
CV	Curriculum Vitae
CVA	Cerebrovascular Accident
CXR	Chest X-ray
D&C	Dilation and Curettage
DADS	Texas Department of Aging and Disability Services
DAP	Data, Analysis, Plan
DARS	Texas Department of Assistive and Rehabilitative Services
DBT	Dialectical Behavior Therapy
DC	Discontinue
DCP	Direct Care Professional
DCS	Direct Care Staff
DD	Developmental Disabilities
DDS	Doctor of Dental Surgery
DES	Diethylstilbestrol
DEXA	Dual Energy X-ray Densiometry
DFPS	Department of Family and Protective Services
DIMM	Daily Incident Management Meeting
DIMT	Daily Incident Management Team
DISCUS	Dyskinesia Identification System: Condensed User Scale
DM	Diabetes Management
DME	Durable Medical Equipment

DNR	Do Not Resuscitate
DNR	Do Not Return
DO	Disorder
DO	Doctor of Osteopathy
DOJ	U.S. Department of Justice
DPT	Doctorate, Physical Therapy
DR & DT	Date Recorded and Date Transcribed
DRR	Drug Regimen Review
DSM	Diagnostic and Statistical Manual
DUE	Drug Utilization Evaluation
DVT	Deep Vein Thrombosis
DX	Diagnosis
E & T	Evaluation and treatment
e.g.	exempli gratia (For Example)
EBWR	Estimated Body Weight Range
EEG	Electroencephalogram
EES	erythromycin ethyl succinate
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
EMPACT	Empower, Motivate, Praise, Acknowledge, Congratulate, and Thank
EMR	Employee Misconduct Registry
EMS	Emergency Medical Service
ENE	Essential Nonessential
ENT	Ear, Nose, Throat
EPISD	El Paso Independent School District
EPS	Extra Pyramidal Syndrome
EPSSLC	El Paso State Supported Living Center
ER	Emergency Room
ER	Extended Release
FAST	Functional Analysis Screening Tool
FBI	Federal Bureau of Investigation
FBS	Fasting Blood Sugar
FDA	Food and Drug Administration
FNP	Family Nurse Practitioner
FOB	Fecal Occult Blood
FSPI	Facility Support Performance Indicators
FTE	Full Time Equivalent
FTF	Face to Face
FU	Follow-up
FX	Fracture
FY	Fiscal Year
G-tube	Gastrostomy Tube

GAD	Generalized Anxiety Disorder
GED	Graduate Equivalent Degree
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GM	Gram
GYN	Gynecology
H	Hour
HB/HCT	Hemoglobin/Hematocrit
HCG	Health Care Guidelines
HCL	Hydrochloric
HCS	Home and Community-Based Services
HCTZ	Hydrochlorothiazide
HCTZ KCL	Hydrochlorothiazide Potassium Chloride
HDL	High Density Lipoprotein
HHN	Hand Held Nebulizer
HHSC	Texas Health and Human Services Commission
HIP	Health Information Program
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human immunodeficiency virus
HMP	Health Maintenance Plan
HOB	Head of Bed
HPV	Human papillomavirus
HR	Heart Rate
HR	Human Resources
HRC	Human Rights Committee
HRO	Human Rights Officer
HRT	Hormone Replacement Therapy
HS	Hour of Sleep (at bedtime)
HST	Health Status Team
HTN	Hypertension
i.e.	id est (In Other Words)
IAR	Integrated Active Record
IC	Infection Control
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
ICN	Infection Control Nurse
IDT	Interdisciplinary Team
IED	Intermittent Explosive Disorder
IEP	Individual Education Plan
ILASD	Instructor Led Advanced Skills Development
ILSD	Instructor Led Skills Development
IM	Intra-Muscular

IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IMT	Incident Management Team
IOA	Inter Observer Agreement
IPE	Initial Psychiatric Evaluation
IPN	Integrated Progress Note
ISP	Individual Support Plan
IT	Information Technology
IV	Intravenous
JD	Juris Doctor
K	Potassium
KCL	Potassium Chloride
KG	Kilogram
KUB	Kidney, Ureter, Bladder
L	Left
L	Liter
LAR	Legally Authorized Representative
LD	Licensed Dietitian
LDL	Low Density Lipoprotein
LFT	Liver Function Test
LISD	Lufkin Independent School District
LOD	Living Options Discussion
LOS	Level of Supervision
LPC	Licensed Professional Counselor
LSOTP	Licensed Sex Offender Treatment Provider
LSSLC	Lufkin State Supported Living Center
LTAC	Long Term Acute Care
LVN	Licensed Vocational Nurse
MA	Masters of Arts
MAP	Multi-sensory Adaptive Program
MAR	Medication Administration Record
MBA	Masters Business Administration
MBD	Mineral Bone Density
MBS	Modified Barium Swallow
MBSS	Modified Barium Swallow Study
MCG	Microgram
MCP	Medical Care Provider
MCV	Mean Corpuscular Volume
MD	Major Depression
MD	Medical Doctor
MDD	Major Depressive Disorder
MED	Masters, Education

Meq	Milli-equivalent
MeqL	Milli-equivalent per liter
MERC	Medication Error Review Committee
MG	Milligrams
MH	Mental Health
MI	Myocardial Infarction
MISD	Mexia Independent School District
MISYS	A System for Laboratory Inquiry
ML	Milliliter
MOM	Milk of Magnesia
MOSES	Monitoring of Side Effects Scale
MOU	Memorandum of Understanding
MR	Mental Retardation
MRA	Mental Retardation Associate
MRA	Mental Retardation Authority
MRC	Medical Records Coordinator
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphyloccus aureus
MS	Master of Science
MSN	Master of Science, Nursing
MSPT	Master of Science, Physical Therapy
MSSLC	Mexia State Supported Living Center
MVI	Multi Vitamin
N/V	No Vomiting
NA	Not Applicable
NA	Sodium
NAN	No Action Necessary
NANDA	North American Nursing Diagnosis Association
NAR	Nurse Aide Registry
NC	Nasal Cannula
NCC	No Client Contact
NCP	Nursing Care Plan
NEO	New Employee Orientation
NGA	New Generation Antipsychotics
NIELM	Negative for intraepithelial lesion or malignancy
NL	Nutritional
NMC	Nutritional Management Committee
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NOS	Not Otherwise Specified
NPO	Nil Per Os (nothing by mouth)
O2SAT	Oxygen Saturation

OBS	Occupational Therapy, Behavior, Speech
OCD	Obsessive Compulsive Disorder
ODD	Oppositional Defiant Disorder
OIG	Office of Inspector General
OT	Occupational Therapy
OTD	Occupational Therapist, Doctorate
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
PCFS	Preventive Care Flow Sheet
PCI	Pharmacy Clinical Intervention
PCN	Penicillin
PCP	Primary Care Physician
PDD	Pervasive Developmental Disorder
PEG	Percutaneous Endoscopic Gastrostomy
PEPRC	Psychology External Peer Review Committee
PERL	Pupils Equal and Reactive to Light
PET	Performance Evaluation Team
PFA	Personal Focus Assessment
PFW	Personal Focus Worksheet
Ph.D.	Doctor, Philosophy
Pharm.D.	Doctorate, Pharmacy
PIC	Performance Improvement Council
PIPRC	Psychology Internal Peer Review Committee
PIT	Performance Improvement Team
PKU	Phenylketonuria
PLTS	Platelets
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
POX	Pulse Oxygen
PPD	Purified Protein Derivative (Mantoux Text)

PPI	Protein Pump Inhibitor
PR	Peer Review
PRC	Pre Peer Review Committee
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSAS	Physical and Sexual Abuse Survivor
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Patient
PT	Physical Therapy
PTA	Physical Therapy Assistant
PTPTT	Prothrombin Time/Partial Prothrombin Time
PTSD	Post Traumatic Stress Disorder
PTT	Partial Thromboplastin Time
PVD	Peripheral Vascular Disease
Q	At
QA	Quality Assurance
QAQI	Quality Assurance Quality Improvement
QAQIC	Quality Assurance Quality Improvement Council
QDDP	Qualified Developmental Disabilities Professional
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QHS	quaque hora somni (at bedtime)
QI	Quality Improvement
QMRP	Qualified Mental Retardation Professional
QPMR	Quarterly Psychiatric Medication Review
QTR	Quarter
R	Respirations
R	Right
RA	Room Air
RD	Registered Dietician
RDH	Registered Dental Hygienist
RN	Registered Nurse
RNP	Registered Nurse Practitioner
RPH	Registered Pharmacist
RPO	Review of Physician Orders
RR	Respiratory Rate
RT	Respiration Therapist
RTA	Rehabilitation Therapy Assessment
RTC	Return to clinic
SAC	Settlement Agreement Coordinator

SAISD	San Antonio Independent School District
SAM	Self-Administration of Medication
SAP	Skill Acquisition Plan
SASSLC	San Antonio State Supported Living Center
SATP	Substance Abuse Treatment Program
SETT	Student, Environments, Tasks, and Tools
SGSSLC	San Angelo State Supported Living Center
SIADH	Syndrome of Inappropriate Anti-Diuretic Hormone Hypersecretion
SIB	Self-injurious Behavior
SIG	Signature
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
S/P	Status Post
SPCI	Safety Plan for Crisis Intervention
SPI	Single Patient Intervention
SPO	Specific Program Objective
SSLC	State Supported Living Center
SSRI	Selective Serotonin Reuptake Inhibitor
STAT	Immediately (statim)
STD	Sexually Transmitted Disease
STEPP	Specialized Teaching and Education for People with Paraphilias
STOP	Specialized Treatment of Pedophilias
T	Temperature
TAR	Treatment Administration Record
TB	Tuberculosis
TCHOL	Total Cholesterol
TCID	Texas Center for Infectious Diseases
TCN	Tetracycline
TD	Tardive Dyskinesia
TED	Thrombo Embolic Deterrent
TG	Triglyceride
TID	Three times a day
TIVA	Total Intravenous Anesthesia
TMax	Time Maximum
TOC	Table of Contents
TSH	Thyroid Stimulating Hormone
TSICP	Texas Society of Infection Control & Prevention
TT	Treatment Therapist
UA	Urinalysis
UII	Unusual Incident Investigation
UIR	Unusual Incident Report
URC	Unified Records Coordinator

US	United States
USPSTF	United States Preventive Services Task Force
UTHSCSA	University of Texas Health Science Center at San Antonio
UTI	Urinary Tract Infection
VFSS	Videofluoroscopic Swallowing Study
VIT	Vitamin
VNS	Vagus nerve stimulation
VPA	Valproic Acid
VS	Vital Signs
WBC	White Blood Count
WISD	Water Valley Independent School District
WNL	Within Normal Limits
WS	Worksheet
WT	Weight
XR	Extended Release
YO	Year Old