United States v. State of Texas

Monitoring Team Report

Lufkin State Supported Living Center

Dates of Onsite Review: April 30 – May 4, 2012

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Submitted By: Alan Harchik, Ph.D., BCBA-D
Monitor

Monitoring Team: Helen Badie, M.D., M.P.H, M.S.
Carly Crawford, M.S., OTR/L
Daphne Glindmeyer, M.D.
Gary Pace, Ph.D., BCBA-D
Natalie Russo, R.N., M.A.
Teri Towe, B.S.

Table of Contents

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 (ICFMR) 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 onsite. 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 onsite, 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, Interdisciplinary Team (IDT) 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 from the parties to protect the confidentiality of each individual.

Substantial Compliance Ratings and Progress

Across the state's 13 facilities, there was variability in the progress being made by each facility towards substantial compliance in the 20 sections of the Settlement Agreement. The reader should understand that the intent, and expectation, of the parties who crafted the Settlement Agreement was for there to be systemic changes and improvements at the SSLCs that would result in long-term, lasting change.

The parties foresaw that this would take a number of years to complete. For example, in the Settlement Agreement the parties set forth a goal for compliance, when they stated: "The Parties anticipate that the State will have implemented all provisions of the Agreement at each Facility within four years of the Agreement's Effective Date and sustained compliance with each such provision for at least one year." Even then, the parties recognized that in some areas, compliance might take longer than four years, and provided for this possibility in the Settlement Agreement.

To this end, large-scale change processes are required. These take time to develop, implement, and modify. The goal is for these processes to be sustainable in providing long-term improvements at the facility that will last when independent monitoring is no longer required. This requires a response that is much different than when addressing ICF/DD regulatory deficiencies. For these deficiencies, facilities typically develop a short-term plan of correction to immediately solve the identified problem.

It is important to note that the Settlement Agreement requires that the Monitor rate each provision item as being in substantial compliance or in noncompliance. It does not allow for intermediate ratings, such as partial compliance, progressing, or improving. Thus, a facility will receive a rating of noncompliance even though progress and improvements might have occurred. Therefore, it is important to read the Monitor's entire report for detail regarding the facility's progress or lack of progress.

Furthermore, merely counting the number of substantial compliance ratings to determine if the facility is making progress is problematic for a number of reasons. First, the number of substantial compliance ratings generally is not a good indicator of progress. Second, not all provision items are equal in weight or complexity; some require significant systemic change to a number of processes, whereas others require only implementation of a single action. For example, provision item L.1 addresses the total system of the provision of medical care at the facility. Contrast this with provision item T.1c.3., which requires that a document, the Community Living Discharge Plan, be reviewed with the individual and Legally Authorized Representative (LAR).

Third, it is incorrect to assume that each facility will obtain substantial compliance ratings in a mathematically straight-line manner. For example, it is incorrect to assume that the facility will obtain substantial compliance with 25% of the

provision items in each of the four years. More likely, most substantial compliance ratings will be obtained in the fourth year of the Settlement Agreement because of the amount of change required, the need for systemic processes to be implemented and modified, and because so many of the provision items require a great deal of collaboration and integration of clinical and operational services at the facility (as was the intent of the parties).

Executive Summary

First, 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 extremely supportive of the monitoring team's activities throughout the week of the onsite review. The Settlement Agreement Coordinator, Sherry Roark, once again did an outstanding job in helping the monitoring team with its activities all week long, as well as the weeks prior to and after the onsite week. She was extremely knowledgeable about the facility and that experience was helpful to the monitoring team.

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, below are comments on a few general topics regarding service operations at the facility.

- Outcomes: LSSLC will need to ensure its QA program obtains and reports on important outcomes, measures, and indicators (sections E1 and E2). This will require working closely with all departments, especially medical services (section L4). For example,
  - The monitoring team noted an increase in hospitalizations and a decrease in the average age of death. These important data were not being reviewed by the facility.
  - LSSLC should examine both of these medical-related outcomes as soon as possible.

- Integration: As detailed in section G, LSSLC had worked on increasing the provision of integrated clinical services. The monitoring observed many instances, including the morning clinical meeting, morning unit meetings, IMRT, weekly home meetings, and the activities around dental desensitization.

- Projects: LSSLC continued to create and implement facility-wide projects. These resulted in good outcomes, even if more work was needed.
    - Engagement and active treatment
    - At-risk

- New ISP Process: LSSLC was implementing the recent changes to the ISP process. The QDDPs, however, had not yet received state office training on the next iteration of the process. Once done, further progress is likely to be seen, especially in sections F and T.

- Self-assessment: This was LSSLC's first try at the new self-assessment process. Overall, there was good progress. Most discipline and Settlement Agreement provision leaders spent a good deal of time talking with the monitoring team about how to make the self-assessment process valid, meaningful, and in line with the Settlement Agreement requirements. Most challenging will be developing a set of self-assessment activities for each provision that separates the fine distinction between activities to engage in to meet the requirements of the Settlement Agreement versus activities to engage in to assess whether substantial compliance is being met. More detail is provided below in each section of this report for each of the provisions of the Settlement Agreement.

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

Restraints

- DADS updated the statewide restraint policy as of 4/10/12. The policy included new definitions for each type of restraint and set new guidelines for restraint debriefing and monitoring. The director of psychology had reviewed the new policies and had begun planning for implementation.
- Between 10/1/11 and 3/22/12, there were 100 restraints used for crisis intervention. This was a slight increase in the number of restraints since the last monitoring visit when 93 restraints were reported. Twenty-three individuals were the subject of restraints. There were 130 restraints for medical and/or dental treatment.
- Some mechanical protective restraints were not routinely reviewed by IDTs or reported in terms of restraints at the facility. These included mittens and helmets. This needs to be corrected and there was a new statewide plan to do so, as part of the newly revised policies.
- Actions taken since the last monitoring visit included that psychology staff were completing the statewide section C monitoring tool monthly on a sample of restraints, all restraints were being reviewed in the daily unit

meeting, and Incident Review Team meeting, and psychology staff were working in coordination with unit directors and campus coordinators to provide additional support to DSPs in crisis situations. Also, psychology staff had completed desensitization assessments for individuals designated as high priority by the dental department.

Abuse, Neglect, and Incident Management

- DFPS confirmed four cases of physical abuse, one case of sexual abuse, two cases of emotional/verbal abuse, and three cases of neglect during the previous six months. There were investigations of 66 allegations conducted by DFPS at the facility during this period.
- An additional 49 other serious incidents were investigated by the facility, including three deaths.
- There were a total of 1754 injuries reported between 11/1/11 and 4/30/12. These 1754 injuries included 19 serious injuries resulting in fractures or sutures. The facility had begun to address some issues noted to be contributing factors to the number of incidents at the facility. This included a focus on meaningful programming and crowded living units. The facility needs to continue to aggressively address tends in injuries and implement protections to reduce the number of incidents and injuries.
- Some positive steps taken to address incidents and their management at LSSLC were:
    - Began using the new state office Avatar system for documenting investigations.
    - Creation of a database to maintain and track disciplinary action related to allegations.
    - Revising the discovered injury investigation process.
    - Improvements in the documentation of activities taken during the investigation process.

Quality Assurance

- The QA department made progress towards creating a list/inventory of all data collected at LSSLC. It was 15 pages long and was divided into 34 different sections. The QA department should consider putting the list/inventory into an electronic spreadsheet format. A QA plan narrative did not yet exist at LSSLC. The QA matrix had not progressed much, if at all, since the previous reviews.
- The facility was beginning to consider making changes to the statewide self-monitoring tools. A new tool was completed and being used for section F. Other new tools were in development.
- The data that come into the QA department (i.e., the items on the QA matrix) need to be reviewed by the QA department (probably primarily by the QA director) and they need to be summarized. This was not yet occurring. Summarizing of data is typically done in the form of a graph or a table.
- The QA report had improved, evolving into a longer document with lots of data included. The QA staff were eager for feedback and commentary on their QA report. A bulleted list of comments and suggestions are provided in the report below.

- The QAQI Council met regularly. The facility director reported that she now planned to get back onto a regular schedule of reviewing a portion of the provision items at each meeting.
- There was some progress in the development of corrective action plans. Six existed and addressed important activities. Overall, however, the CAPs system needed more definition (i.e., a plan or policy/procedure) to specifically address the requirements of this provision.

Integrated Protections, Services, Treatment, and Support

- LSSLC had begun implementation of the new ISP process, but had not yet had any follow-up training and guidance from the state. This was expected to occur over the next few months.
- A shortage of QDDPs due to vacant positions and staff on leave contributed to a delay in plan development and was a significant barrier to timely follow-up on issues identified by IDTs. QDDPs were understandably frustrated with the constantly changing ISP format.
- Many positive steps had been taken towards the development and implementation of person centered plans. It was evident that the facility had noted the many concerns expressed during the previous monitoring visit and attempts were being made to address those concerns.
- In meetings observed during the review week, the QDDPs were attempting to ensure that all necessary information was covered during the IDT meeting. The risk discussion had been moved to the annual ISP meeting, but was not an integrated part of the meeting. Teams were not adequately addressing guardianship and consent, community integration, or placement options.
- There was some progress being made on developing plans that would lead to a more meaningful day for individuals. There had been a focus on providing more meaningful active treatment in both the day habilitation and residential programs. Active Treatment Coordinators had been assigned to each program to assist staff in developing and implementing programming.
- Quality assurance activities with regards to ISPs were in the initial stages of development.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- The facility continued to make progress in the integration of clinical services (section G), but not in addressing the minimum common elements of clinical care (section H). Several steps occurred, locally, in an effort to integrate clinical services. State office developed a draft procedure for sections G and H, and the facility developed and implemented a local policy for section G.
- The monitoring team met with the facility director, medical director, chief nurse executive, and medical compliance nurse to discuss integration activities at the facility. It was clear that section G was taken seriously and, since the last onsite review, additional work had been done. It was also apparent that much work remained.

- Little activity was directed to section H. The monitoring team found for every provision item, that the CNE had accurately reflected the facility's position of having nothing new to present. In some cases, this represented a failure to comply with some basic requirements to complete assessments in a timely manner. Having made no progress following the fourth compliance visit, the facility will need to devote resources to understanding this provision and how to move forward.

At-Risk Individuals

- Some positive steps LSSLC had taken towards compliance with this provision included:
  - A medical resource manual was developed and distributed to each residence that included clinical indicators for assessing risk in a number of areas.
  - Changes in risk status were being reviewed in the Morning Daily Clinical Meeting.
  - Risk Rating Forms and Risk Action Plans were placed in the front of individual notebooks for easy access by DSPs.
  - Posters had been placed around the facility defining the risk process.
- While progress had been made, teams were still not accurately identifying risk factors. Risk plans were not being reviewed and updated as changes in health or behavioral status warranted. Risk plans did not include clinical indicators to be monitored or specify the frequency of monitoring and review.
- Assessments were not being consistently completed prior to ISP meetings. Teams could not adequately discuss risk factors without current, accurate assessments in place.
- The facility was awaiting the next round of consultation and training on the new ISP and risk identification process from the state office. This training should move teams further towards integrating the risk process into the ISP development process.

Psychiatric Care and Services

- There was limited availability of clinical resources with 1.1 total FTE. The four part time physicians and the physician's assistant were qualified and individuals received basic psychiatric services.
- Any integration of psychiatry, beyond what could be accomplished in psychiatry clinic, was delegated to the psychiatric nurse and psychiatric assistant. For example, attendance at morning clinical medical meeting. The psychiatric nurse and psychiatric assistant alternated attending the behavioral support committee meeting.
- The psychiatric clinic was expanded to include representatives from all disciplines. This was beneficial, given that psychiatrists were not available to attend ISP meetings.
- The facility psychiatric staff made great strides with regard to the completion of comprehensive psychiatric assessments for the majority of individuals on the caseload. There was variability with regard to the quality of the documentation, which should be addressed via quality assurance and/or peer review.

- Psychiatry made gains in the area of informed consent. The psychiatrists were now obtaining informed consent for annual medication renewals.

Psychological Care and Services

- Although only two of the items in this provision were found to be in substantial compliance, there were several improvements since the last onsite review. These included an increase in the percentage of staff who wrote Positive Behavior Support Plan who were enrolled in (or completed) coursework toward attainment of board certification in applied behavior analysis and one psychologist became a certified applied behavior analyst. In addition, the facility demonstrated the use of more informative and simple graphs, initiation of the collection and graphing of replacement behaviors, initiation of the collection of data reliability, and the expansion of the collection of inter-observer agreement data. There was also the expansion of the collection of treatment integrity data, and improvements in the quality of functional assessments, the comprehensiveness of annual psychological assessments, and the quality of PBSPs.
- The areas that the monitoring team suggests that LSSLC work on for the next onsite review are to revise the method of data collection reliability, establish goals, and pilot a method to ensure that those levels are achieved. In addition, the facility should track IOA scores, establish IOA goals, and ensure that those levels are achieved; and track treatment integrity scores, establish treatment integrity goals, and ensure that those levels are achieved. The psychologists should also expand the collection of replacement behaviors to all homes, ensure that all functional assessments include direct observations of target behaviors, ensure that all Positive Behavior Support Plans are based on the hypothesized function of the target behavior, and ensure that all training of PBSP implementation includes a competency-based component.

Medical Care

- Individuals received basic medical services. When problems where brought to the attention of the medical staff, they addressed them. There were instances when follow-up care was not provided. At other times, there were failures to provide preventive services or adequate neurological care. Instability in staffing and heavy caseloads likely contributed to some of the problems that were found in this review.
- The Annual Medical Assessments now served as the lead for the new ISP, making the content and accuracy even more important. Quarterly Medical Summaries were no longer being done. The Active Problem Lists were found in the records, but were often incomplete. Consultation documentation in the IPN was improved.
- The monitoring team noted very specific patterns related to documentation, and to the provision of certain services. Those patterns have been consistently noted in external medical audits, too, and may be influenced by many factors, including fluctuating caseloads. Nonetheless, it is worth noting that compliance rates in the various areas ranged from very high to very low reflecting practitioners who consistently scored high to practitioners who consistently scored low. Those patterns should be addressed.

- Medical quality audits were completed and indicated some improvement. The medical management audits were not done. Mortality reviews were completed, but additional work is needed to improve that process.
- There had been no additional work in the development of a quality improvement program. The medical department will need to approach this with some sense of urgency. The foundation for development was created with implementation of the clinical guidelines.

Nursing Care

- The Nursing Department took several steps toward substantial compliance. They began using standardized protocols to guide and direct nursing care and its documentation, and they developed and implemented forms for documenting nursing assessments post-hospitalization and upon discharge from the facility. They also created and started using systems to track individuals' weight and their physicians' orders to help ensure that changes in their health would be detected and addressed in a timely manner.
- There were improvements to the storage and availability of emergency medical equipment, improvements in nurses' safe and sanitary administration of medications, and focused improvements in the assessment, planning, and delivery of nursing and health care services to specific individuals who were identified with high health risks during the prior monitoring review.
- There continued, however, to be problems ensuring that nurses' adequately identified of health care problems, performed complete assessments, implemented planned interventions, conducted appropriate follow-up, and kept appropriate records to sufficiently and readily identify and address the significant changes in individuals' health status and needs.
- 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. And, the overwhelming majority of the individuals reviewed failed to have specific, individualized nursing interventions developed to address all of the individuals' health care needs, including their needs associated with their health risks.
- LSSLC's nurses were working hard and were committed to meeting the provisions of the Settlement Agreement. However, with the continued vacancies, reportedly high turnover rates among the ranks of the nurses, and little to no evidence of an active and effective recruitment and retention program, nurses were often working at bare minimum staffing levels and covering for vacancies.

Pharmacy Services and Safe Medication Practices

- This review was impeded by a lack of documents. Documents usually submitted without difficulty were not made available for this review resulting in the inability to adequately assess several areas of this provision.
- The new clinical pharmacist was given the lead role in managing the issues related to the Settlement Agreement. She faced many challenges, one of which was just to understand the state system and the requirements of the Settlement Agreement. Many recent changes were made without the benefit of the appropriate historical knowledge of specific regulatory, state, and Settlement Agreement requirements. The result was a series of missteps that prevented progress. This perhaps should not be unexpected given a lack of clinical guidance.
- With regards to prospective reviews, the pharmacy department provided little documentation of communication between pharmacists and prescribers. The documentation submitted showed no evidence of resolution for the problems that were discussed. A positive finding was the implementation of the pilot of the intelligent alerts that monitored labs during prescription ordering.
- It appeared that the facility was not meeting the required timelines for completing QDRRs. The facility updated the QDRR process moving to an electronic format. While the concept was forward thinking, the process failed to capture information and present it in the most clinically relevant manner. It also presented numerous opportunities for data and information to be missed.
- The MOSES and DISCUS evaluations were completed and the physicians signed and reviewed them. There was improvement in the completion rate, but more improvement was needed. The facility did not maintain substantial compliance for completion of DUEs. The facility made no progress in the development of the ADR reporting and monitoring system.

Physical and Nutritional Management

- Key clinical indicators and health risk status should drive identification of the need for PNMT supports and services. The PNMT may want to consider initiating review of all individuals with aspiration pneumonia, bacterial/non-classified pneumonia, repeated hospitalizations, choking incidents, or significant or consistent weight loss, for example. An outline of criteria for referral had recently been developed in an attempt to address the absence of referrals.
- There was a fully-constituted PNMT, including a full time nurse. While the team met routinely, attendance was less than adequate until late February 2012. A meeting observed during this review showed some improvement since the last review. All team members participated in discussion that reflected active assessment and supports. It was of concern, however, that the team had completed only one assessment in the last six months. The assessment was very limited in content and consisted predominately of lists of medical history information.
- Extensive follow-up related to Individual #447 was noted, documents were submitted and reviewed, and an ISPA meeting was held during this onsite visit. A tremendous effort had been put forth on this individual's

behalf since the previous review. The facility is to be commended on its work and support of Individual #447. This demonstrated the ability to work collaboratively as a team to ensure appropriate and timely supports and services are provided to all individuals living at LSSLC.

- Mealtimes were observed in a number of homes. Overall, there appeared to be improvements related to the environments and implementation of the dining plans, though there were issues noted, many of which should have been identified through monitoring by PNMPCs and professional staff.
- Positioning continued to be an issue, though, in general, the wheelchairs looked better. Staff continued to need training related to understanding effective alignment and support, as well as the elements of transfers. Issues related to NEO training content were noted. The curriculum should be critically reviewed for content and the training should be audited routinely particularly when taught by non-professional staff.

Physical and Occupational Therapy

- The OT and PT clinicians appeared to be knowledgeable and enthusiastic. They conducted their annual assessments together. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment (e.g., wheelchairs), and to review other supports and services. Hab Camp was a new concept for providing competency-based training to existing staff across all aspects of PNM. It was planned to continue on an annual basis.
- The wheelchair clinic process was improved. A number of therapists attended a seating assessment workshop. The concern will be for the rotation of short term contract therapists and the continuity of knowledge and practice of this highly specialized clinical area. A plan should be developed to address this potential problem.
- Assessments were reviewed and varied in content and format. Less than a third included an analysis section, and each of these did not provide a sufficient rationale for the interventions and supports recommended. None qualified as an acceptable analysis for identifying changes in status, potentials for skill acquisition, needs, or barriers. These are essential elements of an analysis to ensure appropriate rationale for determining appropriate interventions and supports. There were no recommendations as to the needed frequency of other PNMP monitoring by the therapists, IDT or PNMPCs
- There continued to be a small number of individuals participating in direct PT and OT. Documentation was inconsistent and there was insufficient rationale provided to continue or discharge from services.

Dental Services

- The new dental clinic opened in December 2011 providing a much needed improvement for the facility. The new clinic offered ample space for two operatories and provided a soothing ambiance for treatment.
- The full time hygienist and the staff did an excellent job and had taken on numerous tasks. A full time or even part time dental director is needed in the clinic to provide oversight and address the issues of dental practice and ensure that the clinic is running as it should.
- The clinic provided basic services, but the number of clinic appointments decreased to about half of what they were one year prior to this review. Oral hygiene efforts continued and were having good impact based on improved hygiene ratings. Several individuals had poor oral health and required referral to the local oral surgeon for multiple or full mouth extractions due to decay and non-restorable teeth.
- The clinic began reporting annual compliance data with a new standard of "within 30 days." Refusals were recorded, but missed appointments were not, although staff reported they still occurred.

Communication

- Overall, the monitoring team was very encouraged by the current strategies and plans in place to address communication supports and looks forward to continued progress.
- Staffing levels were significantly increased at the time of this review and it is hoped that these levels can be maintained. These clinicians appeared to be strong in their knowledge, skills, and enthusiasm for developing effective, functional and meaningful communication supports for individuals.
- Progress with completion of comprehensive communication assessments per the Master Plan was very limited (less than 8%). The communication assessments were completed outside of the ISP schedule and, as a result, this information was not available to the team during the annual review and development of action steps.
- The clinicians continued to report difficulties with implementation of AAC related to maintenance and consistent use throughout the day. There were no Communication Plans for staff reference. A number of systems were recommended in the communication assessments, but without ongoing and consistent support provided by speech clinicians. This should not be the sole responsibility of direct support and day program staff.

Habilitation, Training, Education, and Skill Acquisition Programs

- Although no items of this provision were found to be in substantial compliance, there were several improvements. These included the initiation of SAP peer review meetings to ensure that SAPs contained all necessary components, and the reorganization of active treatment, including a new coordinator and additional staff to support individual engagement in all treatment settings. Moreover, the facility embarked on the expansion of the training methodology, the development of a new engagement tool, and the collection of inter-rater reliability for engagement. The staff established a dental desensitization area, improved the collection of

data regarding training of SAPs in the community, and continued support for individuals who were entitled to educational services and coordination with the local independent school district.

- The monitoring team suggests that the facility focus on the following over the next six months. Expand the 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 the individual's needs/preference, and ensure that each SAP has an individualized plan for maintenance and generalization. In addition, the facility should collect and track SAP integrity measures; and establish acceptable percentages of individuals participating in community activities, training on SAP objectives in the community, and demonstrate that these levels are achieved.

Most Integrated Setting Practices

- LSSLC continued to make progress towards substantial compliance. The specific numbers of individuals who were placed and who were in the referral and placement process, however, remained low. The number of individuals placed was at an annualized rate of 4% (eight since the last review) and the number on the referral list was 3% (13 individuals). This was a reverse in trend. The list of individuals not being referred solely due to LAR preference contained 107 names. This was a more accurate list than ever assembled.
- LSSLC continued to make progress in including professional determinations in ISP planning, meetings, and documentation, building from the time of the last onsite review. More detail should be included in the LOD section of the ISP so the reader has a good understanding of the IDT's opinion and how it was arrived at.
- The new style ISPs showed a number of areas of improvement. They did not, however, address obstacles to referral or to placement. The monitoring team was of the understanding that these types of obstacles were supposed to be addressed in the ISP. LSSLC was engaging in some, but not yet all, of the activities required towards educating individuals and their family members and LARs.
- CLDPs were done in a timely manner, initiated shortly after referral. IDT members actively participated in the placement process. The CLDP meeting observed by the monitoring team showed improvement from last time. In the CLDPs, more detail was needed to be specified regarding the training of provider staff, and collaboration between the facility clinicians and the community clinicians. Assessments in preparation for the individual's upcoming move needed to focus upon the new residential and day setting. If a recommendation in an assessment does not make it into the ENE supports, it should be documented as to why.
- LSSLC made progress in identifying essential and nonessential (ENE) supports, however, additional improvement was needed. Many of the ENE supports needed to be written in more measureable, observable terms. Evidence to show the provider's implementation of ENE supports needed to be shown.
- LSSLC maintained substantial compliance with item T2a. There were 28 visits required for 15 individuals and all were done timely. The residential and day sites were visited every time. The visits were documented correctly and thoroughly. The PMM did a good job of following up when there were problems.

- Of the 15 individuals who received post move monitoring, seven appeared to be doing very well and having a great life. This was well reflected in their post move monitoring reports. Two others had experienced some problems, but these were not unexpected. The other six individuals had, or were having, serious issues with their placements. Of these six, three were exhibiting serious problem behaviors and three had to be re-placed due to serious problems with the provider. Thus, 40% of the placements were very problematic. The facility needs to go back and revisit their transition planning processes as recommended in T1a, that is, to do a root cause analysis and/or sentinel event-type review.

Consent

- Some positive steps were taken in regards to consent and guardianship issues. For example, the Director of Consumer and Family Relations continued to work with families applying for guardianship and maintained contact with community resources for guardians and advocates, and he met with the QDDPs to review the requirements of section U and discuss the referral process.
- The facility had a Human Rights Committee (HRC) in place to review restrictions requested by the IDT. Membership had been expanded to include additional family members and representation from other disciplines at the facility. At the HRC meeting relevant discussion occurred, but unfortunately, did not adequately address important aspects of restrictions, informed consent, and LAR involvement.
- The facility had a self-advocacy group comprised of individuals residing at the facility.

Recordkeeping Practices

- LSSLC demonstrated continued progress with this provision item. The URC, Stormy Tullos, and the record clerks were doing good work. Overall, the active records were organized and well maintained. IPNs and observations notes had improved. Even so, there was still further improvement needed as identified in the facility's own reviews and in the monitoring team's reviews of a sample of records as per Appendix D.
- The facility should consider dating all forms so that clinicians, reviewers, readers, etc. will know if they're looking at the latest one. This may require the creation of a database of all forms to be maintained by the recordkeeping department.
- LSSLC continued to use individual notebooks exclusively for the recording of individual information throughout the day and month. Overall, this seemed to be working satisfactorily. A new master records table of contents was created in March 2012 and about half of the master records had been converted.
- Monthly audits were conducted for five to eight unified records each month. The reviews were done in a consistent and thorough manner and consisted of five components. Overall, the monitoring team was very satisfied with the audit procedures at LSSLC. Additional follow-up on items needing correction was needed.

- The monitoring team recommends that the URCs create a set of graphs as described in V3, and that these graphs be included in the LSSLC QA program. The URC recently received the list of actions and topics that were now to comprise V4. The monitoring team discussed these at length during the onsite review.

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 looks 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 DADS Policy: Use of Restraints 001.1 dated 4/10/12 o LSSLC Policy: Use of Restraint dated 7/25/11 o LSSLC FY12 Trend Analysis Report o LSSLC Self-Assessment o LSSLC Provision Action Information Log o LSSLC Section C Presentation Book o Training Curriculum for RES0105 Restraint: Prevention and Rules for Use at MR Facilities o PMAB Training Curriculum o Restraint: Prevention and Rules for Use at SSLC Facilities Training Curriculum o LSSLC New Employee Orientation Module: Positive Behavior Support 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 mechanical restraints for the past six months o LSSLC "Do Not Restrain" list o List of individuals with desensitization plans (16) o Desensitization plans for • Individual #131, Individual #450, Individual #360, Individual #286, Individual #586, Individual #101, Individual #323, Individual #488, Individual #520, and Individual #319. o Restraint Reduction Committee meeting minutes for past six months o List of all individuals who had a Safety Plan for Crisis Intervention o Training transcripts for 24 LSSLC employees o Documentation for medical restraints for: • Individual #103, Individual #516, Individual #97, Individual #447, Individual #119, Individual #203, Individual #586, Individual #562, Individual #216, and Individual #294. o ISPs, PBSPs, Safety Plans (when applicable), and ISPAs for: • Individual #410, Individual #166, and Individual #170, Individual #57, and Individual #488.

- A sample of restraint documentation for crisis intervention including:

Individual	Date	Type
#410	3/28/12	Physical
#410	3/5/12	Physical
#410	2/24/12	Physical
#410	1/31/12	Physical
#170	3/23/12	Physical
#170	3/22/12	Physical
#170	10/31/11	Physical/Chemical
#166	3/14/12	Physical
#166	2/8/12	Physical
#166	2/6/12	Physical
#166	1/9/12	Physical
#488	3/27/12	Physical
#57	3/23/12	Physical
#99	3/23/12	Chemical
#578	3/22/12	Physical
#420	1/31/12	Physical
#279	1/17/12	Physical
#380	12/19/11	Physical
#380	10/4/11	Physical
#74	1/19/12	Physical

Interviews and Meetings Held:
- Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs;
- Sylvia Middlebrook, Director of Psychology
- Luz Carver, QDDP Coordinator
- Mike Ramsey, Incident Management Coordinator

Observations Conducted:
- Observations at residences and day programs
- Castle Pine Morning Unit Meeting 5/2/12
- Incident Management Review Team Meeting 5/2/11 and 5/4/11
- Annual ISP meetings for Individual #252
- QDDP meeting 5/3/12
- Human Rights Committee Meeting 5/2/12
- Restraint Reduction Committee Meeting 5/2/12

	Facility Self-Assessment: LSSLC submitted its self-assessment. It was updated on 4/20/12. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The facility had implemented an audit process using the tools developed by the state office to measure compliance with the Settlement Agreement. The self-assessment indicated that the findings from the facility's monthly audit process were used to self-assess compliance. The facility self-assessment commented on the overall compliance rating for each provision item, based on the sample of restraint documentation audited, as well as, commenting on processes in place to address compliance with each item.
	Summary of Monitor's Assessment: DADS updated its restraint policy as of 4/10/12. The policy included new definitions for each type of restraint and set new guidelines for restraint debriefing and monitoring. The director of psychology had reviewed the new policies and had begun planning for implementation. Based on information provided by the facility, there were 100 restraints used for crisis intervention between 10/1/11 and 3/22/12. There was a slight increase in the number of restraints since the last monitoring visit when 93 restraints were reported. Twenty-three individuals were the subject of restraints. From 10/1/11 through 3/22/12, the facility reported 130 incidents of restraint used for medical and/or dental treatment. • 46 were chemical pretreatment sedation for dental procedures, • 84 were chemical pretreatment sedation for medical procedures. During observation at the facility, it was found that some mechanical protective restraints were not routinely reviewed by IDTs or reported in terms of restraints at the facility. These included mittens and helmets. This needs to be corrected and there was a new statewide plan to do so, as part of the newly revised policies. According to the facility self-assessment, action taken by the facility to address compliance with section C since the last monitoring visit included:

	• Psychology staff had completed the statewide section C monitoring tool monthly on a sample of restraints. • All restraints were being reviewed in the daily unit meeting, and Incident Review Team meeting. • Psychology staff were working in coordination with unit directors and campus coordinators to provide additional support to DSPs in crisis situations. • The facility had developed a "Do Not Restrain" list. • Psychology staff had completed desensitization assessments for individuals designated as high priority by the dental department. • An action plan was developed to address deficiencies noted in the last monitoring team report. The facility had made progress in meeting compliance with requirements for documenting and reviewing restraint incidents. The facility was in substantial compliance with two of the eight provision items as well as one of the items of C7.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	The new statewide restraint policy required that: • Restraints were not used unless necessary to prevent imminent physical harm in a behavioral crisis, to safely and effectively implement medical or dental procedures, or to prevent or mitigate the documented danger of self-injurious behavior that has not yet been reduced by intensive supervision or treatment. • The least restrictive effective restraint necessary to prevent imminent physical harm in a behavioral crisis, or to safely and effectively implement medical or dental procedures, or to prevent or mitigate the documented danger of self-injurious behavior was used. • Restraints were not used as punishment, as part of a positive behavior support plan, for staff convenience, or in the absence of or as an alternative to treatment. • Prone and supine restraints were prohibited. A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral crises. Sample #C.1 was a sample of 20 restraints for 11 individuals. There were 19 physical restraints and two chemical restraints (one restraint checklist for Individual #170 recorded a physical restraint followed by a chemical restraint). Three of the individuals in the sample had the greatest number of restraints. Eight others were randomly selected. The individuals in this sample were Individual #410, Individual #166, Individual #170, Individual #380, Individual #279, Individual #74, Individual #488, Individual #57, Individual #99, Individual #420, and Individual #578. • Individual #410 had the greatest number of restraints, accounting for 19 (19%) of the 100 restraints for behavioral intervention between 10/1/11 and 3/31/12. • Individual #166 had the second greatest number with 17 (17%) of the	Noncompliance

#	Provision	Assessment of Status	Compliance
		restraints; and • Individual #170 had the third greatest number with 10 (10%) of the restraints. <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 a review of 19 physical restraint records for individuals in Sample #C.1 involving 10 individuals, 0 (0%) showed use of prone restraint. <u>Other Restraint Requirements</u> 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 documentation for 20 restraints. The following are the results of this review: • In 19 of the 20 records (95%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. The exception was the chemical restraint for Individual #99 dated 3/23/12. Staff did not describe behavior exhibited prior to the restraint. • In 11 of 20 (55%) restraints, staff documented events leading to the behavior that resulted in restraints. Exceptions included restraint checklists for: o Individual #99 dated 3/23/12, Individual #74 dated 1/9/12, Individual #380 dated 12/19/11, Individual #279 dated 1/7/12, Individual #578 dated 3/22/12, Individual #166 dated 2/8/12, Individual #170 dated 3/23/12, and Individual #410 dated 2/24/12 and 1/31/12. • Some examples where staff adequately described events leading to the behavior: o The restraint checklist for Individual #410 dated 1/31/12 noted he became upset when staff asked him to eat at the table. o The restraint checklist for Individual #170 dated 3/22/12 indicated that he became aggressive towards staff when staff intervened and prevented him from throwing his roommates things away. o Staff documented that Individual #166 became physically aggressive on 3/14/12 after staff told her that she could not have a graham cracker. • Some examples where events leading to restraint were not adequately documented included:	

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		○ The restraint checklist for Individual #99 did not describe events occurring that led to the restraint. ○ Restraint checklists for Individual #410 dated 3/5/12 and 3/28/12 described his behavior prior to the restraint, but did not document what events led to the behavior. ○ In the area for the description of events on the restraint checklist for Individual #170 on 3/23/12, staff documented "hitting, kicking, and spitting at staff after verbal and physical aggression were unsuccessful." There was no documentation of the events leading up to his aggressive behavior. • In 19 of 20 the records (95%), 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. The restraint checklist for Individual #99 indicated that a chemical restraint was administered after verbal prompts were unsuccessful. During the onsite monitoring visit, the monitoring team raised some concerns over individuals who were wearing protective equipment (helmets). The facility was not consistently documenting and monitoring these restraints. IDTs were not addressing alternate strategies to reduce the use of protective equipment. There was no indication that plans to reduce the amount of time spent in restraint were addressed by the IDT. Examples noted during observation at the facility are below. • A helmet was being used for protective restraint for Individual #357 to prevent self-injurious behaviors. • Individual #27 was wearing a helmet to address his risks for falls. Staff were not clear how often the helmet should be removed and were not documenting when it was removed. His record did not include instructions for monitoring its use. State policies identified a list of approved restraints techniques. Based on the review of documentation for 20 restraints, 20 (100%) were documented as approved restraints techniques. <u>Dental/Medical Restraint</u> The facility provided a list of pretreatment sedation and medical restraints between 10/1/11 and 3/22/12: this included • 130 instances of pretreatment sedation, and • One use of mechanical restraint described as wristlets/anklets. Additionally, a list of individuals with medical or dental desensitization plans was requested from the facility. The facility reported that there were 16 desensitization plans	

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		in place. The facility had completed desensitization assessments for individuals designated as high priority by the dental department. Progress had been made on developing desensitization plans and/or strategies to minimize the use of medical and dental restraints. The facility was not yet in compliance with provision C1. To do so: • Restraint documentation needs to clearly indicate what was occurring prior to the behavior that led to restraint, and all interventions attempted prior to restraint. • The long term use of mechanical restraints should be reviewed periodically by the IDT and strategies should be developed to reduce the amount of time in restraint. • A schedule for monitoring the restraint and directions for the frequency of release from restraint should be included in ISPs, for protective restraints. • Desensitization strategies should be developed for all individuals requiring the use of pretreatment sedation for routine medical appointments.	
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 for 11 individuals in Sample #C.1 were reviewed. Of these, five of the individuals had a Safety Plan for Crisis Intervention (SPCI). They were Individual #410, Individual #166, Individual #170, Individual #488, and Individual #57. Overall, eight individuals at the facility had an SPCI in place at the time of the review. The SPCI for Individual #488, Individual #166, and Individual #170 were reviewed. All three gave direction for the use of restraint and included release criteria. See further comments regarding the quality of SPCIs in C7. The Sample #C.1 restraint documentation for 19 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. • 18 of 19 (95%) restraints reviewed indicated that the individual was released immediately when no longer a danger. • One restraint checklist indicated that the individual was released because staff could not maintain the restraint correctly (Individual #166 dated 1/9/12). • The longest restraint in the sample was 78 minutes for Individual #410 on 1/31/12. Ten (53%) of the restraints in the sample lasted three minutes or less. The facility was in substantial compliance with C2.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	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 training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that • 22 of 24 (92%) had current training in RES0105 Restraint Prevention and Rules. • 16 of the 18 (89%) employees with current training completed the RES0105 refresher training within 12 months of the previous training. Four of the employees had been hired in the past year. • 23 of 24 (96%) had completed PMAB training within the past 12 months. • 17 of the 19 (89%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. In addition to the state mandated restraint training, LSSLC psychology staff provided a two hour training module to all new employees regarding intervention with challenging behaviors and restraint prevention. LSSLC was in substantial compliance with this provision item.	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 20 restraint records (Sample #C.1), documentation in 19 (95%) 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 treatment strategies for all individuals who required the use of restraint for routine medical or dental care. There had been 130 instances of medical or dental pretreatment sedation restraint in the past six months. According to a list provided to the monitoring team, a desensitization program had been developed for 16 individuals who needed pretreatment sedation or restraint to have routine medical or dental care completed. Ten desensitization plans were reviewed. All plans in the sample included individualized strategies (also see S1 below). Dental staff were using informal desensitization plans with a number of other individuals at the facility.	Noncompliance

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		The facility self-assessment reported a concerted multi-disciplinary approach was being taken to develop plans to reduce the use of medical and dental restraints. The facility was making progress with addressing this requirement, particularly in regards to dental restraints. The facility had created a "Do Not Restrain" list. There were 93 individuals at the facility that had been identified for placement on this list for which restraints would be contraindicated due to medical or physical conditions. The list specified what types of restraints should not be used. There was no evidence that anyone on the "Do Not Restrain" list had been the subject of restraint in the past six months. As noted in C1, the facility did not adhere to restraint monitoring and review requirements for all protective mechanical restraints. The facility should ensure that these protective restraints are documented, monitored, and reviewed. Teams should review all uses of mechanical restraints and document attempts at reducing the use of these restraints. Although considerable progress had been made to address compliance with C4, the facility was not yet in compliance with this provision item.	
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	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 20 restraint records (Sample #C.1), a face-to-face assessment was conducted as follows: • In 20 out of 20 incidents of restraint (100%), there was assessment by a restraint monitor. • In the 20 instances of restraint in the sample, there was a face-to-face assessment form completed. The assessment began as soon as possible, but no later than 15 minutes from the start of the restraint in 20 (100%) instances. Based on a review of 20 physical and chemical restraints used for crisis intervention that occurred at the facility, there was documentation that a licensed health care professional: • Conducted monitoring at least every 30 minutes from the initiation of the restraint in 14 (70%) of the instances of restraint. The exceptions were the following restraint checklists: o Individual #410 dated 1/31/2 and 2/24/12, o Individual #170 dated 10/31/12,	Noncompliance

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	circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	o Individual #380 dated 12/19/11, o Individual #74 dated 1/19/12 (no time given), and o Individual #166 dated 1/9/12. A sample of restraints used for medical pretreatment sedation was reviewed for compliance with monitoring requirements. Eight of 10 (80%) documented monitoring by a licensed health care professional at least every 30 minutes from the initiation of the restraint. The exceptions were: • Pretreatment sedation for Individual #221 dated 3/23/12. • Pretreatment sedation for Individual #201 dated 3/17/12. The facility remained out of compliance with this provision. Monitoring by a nurse should be conducted and documented as required by state policy.	
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 20 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 20 (100%), continuous one-to-one supervision was indicated as having been provided. • In 20 (100%), the date and time restraint was begun were indicated. • In 19 (95%), the location of the restraint was indicated. The exception was the Restraint Checklist for Individual #99 dated 3/23/12. • In 19 (95%), information about what happened before, including the change in the behavior that led to the use of restraint, was indicated. The exception was the restraint for Individual #99. • Eleven (55%) indicated what events were occurring that might have led to the behavior (see C1). • In 19 (95%), the specific reasons for the use of the restraint were indicated. The Restraint Checklist for Individual #99 did not give a clear reason for the restraint. • In 19 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. The exception was the Restraint Checklist for Individual #99. • In 20 (100%), the names of staff who applied/administered the restraint was recorded. • In 19 (100%) of 19 observations of the individual and actions taken by staff while the individual was in restraint for physical restraints were recorded. • In 19 (100%) of 19 physical restraint incidents, the date and time the individual was released from restraint were indicated. • In 19 (100%) of 19 physical restraints, the results of assessment by a licensed	Noncompliance

#	Provision	Assessment of Status	Compliance
		health care professional as to whether there were any restraint-related injuries or other negative health 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 78 minutes in duration. In a sample of 20 records (Sample #C.1), restraint debriefing forms had been completed for 20 (100%). A sample of 10 restraint checklists for individuals receiving medical restraint was reviewed to ensure one-to-one supervision was provided. One-to-one supervision was documented in all 10 (100%). Although documentation of restraints had improved significantly, the facility was not in substantial compliance with this provision. Documentation of events occurring prior to the change in behavior leading to restraint should be documented. This information could be useful in modification of supports and programming to avoid further restraint incidents.	
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 four individuals were placed in restraint more than three times in a rolling 30-day period. This compares to the five individuals placed in restraint more than three times in a rolling 30-day period reported during the last review. Three of these individuals (i.e., Individual #170, Individual #166, and Individual #410) were reviewed (75%) to determine if the requirements of the Settlement Agreement were met. PBSPs, safety plans, and individual support plan addendums (ISPAs) were reviewed for all three individuals. The PBSPs reviewed were completed during the previous six months. The safety plans and PBSPs were those current at the time of the monitoring visit. The results of this review are discussed below with regard to Sections C7a through C7g of the Settlement Agreement. All three of the ISPAs reviewed (100%) appeared to be in response to more than three restraints in a 30-day period, and were organized so as to ensure that each of the issues	Noncompliance

#	Provision	Assessment of Status	Compliance
		below were discussed and documented (i.e., C7a-C7g). In order to achieve substantial compliance with C7, each individual's ISPA meeting minutes need to reflect a discussion of each of the issues presented below, and a plan to address factors that are hypothesized to affect the use of restraints. Additionally, LSSLC needs to document that each individual's PBSP has been implemented with integrity, that specific procedures for training replacement behaviors for behaviors that provoke restraint has been developed (when possible and practical), and that PBSPs have been revised when necessary (i.e., data based decisions are apparent). All three of the ISPA minutes reviewed reflected a discussion of the individuals' adaptive skills, biological/medical status, and psychosocial factors. One (i.e., Individual #166) of these discussions (33%), however, did not reflect a plan or discussion of how these variables affected the individual's target behaviors provoking restraint, and how these factors would (or could) be addressed. Simply listing these factors is not likely to be useful in better understanding, and ultimately decreasing the behaviors provoking restraint. The other two ISPAs reviewed (i.e., Individual #170 and Individual #410) did a somewhat better job of addressing the role of adaptive skills, and biological, medical, and/or psychosocial factors on the behaviors that provoke restraint. For example: • Individual #410's ISPA minutes stated that adaptive skills did not appear to be a factor in restraint. Additionally, this ISPA indicated that Individual #410 tended to get attached to some staff, and that those staff were likely future targets of his aggression. The ISPA indicated that this had been addressed by having some of these staff move to other homes. • Individual #170's ISPA indicated that psychosocial issues did not appear to affect his restraints. The ISPA also indicated that his psychiatric condition may affect the behaviors provoking his restraint, and that his psychiatric medications were being adjusted. Both of these individuals' ISPA meeting minutes, however, also included simple listings of other adaptive skills, and biological, medical, and/or psychosocial factors without indicating if they were a potential factor in each individual's restraints. For example: • Individual #410's ISPA (in the section biological/medical factors) simply indicated that Individual #410 had a diagnosis of autism. In order to achieve substantial compliance with this item, each individual's ISPA 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.	

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	(b) review possibly contributing environmental conditions;	All ISPAs should reflect a discussion of potential contributing environmental factors (e.g., noisy or crowded environments) and, if any are hypothesized to potentially affect dangerous behavior, suggestions for modifying them to prevent the future probability of restraint. One (i.e., Individual #410) of the three ISPAs reviewed (33%) indicated that environmental conditions did not play a role in his restraints. The other two IPSAs reviewed identified potential contributing environmental conditions (e.g., behavioral outburst from other individuals in Individual #170's home, another individual talking to Individual #166's boyfriend), however, no discussion of how these environmental factor could be addressed was provided. All ISPA minutes of meetings in response to more than three restraints in a 30-day period should reflect a discussion of possible contributing environmental factors and, if any are hypothesized to potentially affect dangerous behavior, suggestions for modifying them to prevent the future probability of restraint.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	This item is concerned with a review of potential antecedents to the behavior that provokes restraint. Two of the ISPAs reviewed (i.e., Individual #170 and Individual #166) indicated that the team identified no antecedents to restraint. Individual #410's ISPAs described a situation where staff providing popcorn to Individual #410 was an antecedent to restraint, but no further discussion or no action to attempt to eliminate or reduce antecedents to dangerous behavior was evident in the ISPA minutes. 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 provokes 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. All three ISPAs reviewed indicated that no variables maintaining the dangerous behaviors provoking restraint were identified. Therefore, this item is rated as being in substantial compliance. Two of the IPSAs reviewed (i.e., Individual #170 and Individual #166) had N/A in this section. Individual #410's ISPA minutes included the comment that the team had discussed the function of Individual #410's dangerous behavior but could not identify	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		any variables at this time. This is a more informative statement then simply putting an N/A in the section. To maintain substantial compliance with this provision item, when factors are determined to not affect individuals' restraints, future ISPA meeting minutes should reflect that the issues were discussed, but none identified, rather than merely writing N/A.	
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	All three individuals reviewed (100%) had PBSPs to address the behaviors provoking restraint. The following was found: • Three (100%) were based on the individual's strengths, • Three (100%) of the PBSPs specified the objectively defined behavior to be treated that led to the use of the restraint, • Three (100%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, and • Three (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. None of the three PBSPs (0%) to weaken or reduce the behaviors that provoked restraint, were determined to be adequate 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 (100%), the type of restraint authorized was delineated, • In two (i.e., Individual #166 and Individual #410) of the safety plans (66%), the maximum duration of restraint authorized was not specified, • In all (100%), the designated approved restraint situation was specified, and • In all (100%), the criteria for terminating the use of the restraint were specified.	Noncompliance
	(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	For none of the individuals reviewed (0%) were integrity data available that demonstrated 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

#	Provision	Assessment of Status	Compliance
	targeted behavior; and		
	(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.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	According to the facility self-assessment, restraint incidents were reviewed on the first working day following the restraint in the daily Unit Morning Meeting by the home psychologist and unit director, and again at the IMRT by the Director of Psychology. Twenty (100%) restraints in the sample indicated review of the restraint within three days of restraint incident. A sample of Face-to-Face Debriefing and Review Forms related to 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 IMT. Nineteen restraints in the sample (95%) were signed by both the Unit Director and IMT within three days. The exception was the restraint for Individual #99. All restraints for crisis intervention were being reviewed in the daily unit meeting, and Incident Review Team meeting. Observation of both of these meetings confirmed that restraint incidents were reviewed and recommendations were made regarding follow-up. The facility did not have a system in place to comment on errors or to track follow-up recommendations made during the review. Comments regarding findings were not found on any of the restraint checklists signed off on by administrative staff. For example, it was noted that some of the restraint checklists in the sample did not document adequate monitoring by nursing staff. Restraint monitors, unit directors and the director of psychology had signed the Restraint Review form without noting errors in monitoring by the nurse and there was no indication that errors would be addressed with nursing staff. Restraints were also referred to the IDT for review and follow-up. See section C7 for additional comments on the adequacy of review by the IDT. The Restraint Reduction Committee reviewed restraint trends for the facility and for individuals with the most restraints. The facility will need to develop a restraint review system that documents follow-up to any issues identified during the review process.	Noncompliance

Recommendations:

1. The long term use of mechanical restraints should be reviewed periodically by the IST and strategies should be developed to reduce the amount of time in restraint. A schedule for monitoring the restraint and directions for the frequency of release from protective restraint should be included in ISPs (C1, C2, C4).

2. Desensitization strategies should be developed for all individuals requiring the use of pretreatment sedation for routine medical appointments.

3. 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).

4. IDTs should discuss the need for restraints during medical and dental procedures and strategies should be developed to try to reduce or eliminate the need for restraint (C2, C4).

5. Monitoring by a nurse should be conducted and documented as required by state policy (C5).

6. Each individual's ISPA meeting minutes, for those ISPA meetings for review of more than three restraints in any 30-day period, should reflect a discussion of each of the issues presented in C7a-d, and a plan to address factors that are hypothesized to affect the use of restraints. Additionally, there should be evidence that each individual's PBSP has been implemented with integrity, that specific procedures for training replacement behaviors for behaviors that provoke restraint has been developed (when possible and practical), and that PBSPs have been revised when necessary (i.e., data-based decisions are apparent).

7. Each individual's ISPA meeting minutes, for those ISPA meetings for review of more than three restraints in any 30-day period, should reflect a discussion of each of the issues presented in C7a-d, and a plan to address factors that are hypothesized to affect the use of restraints. Additionally, there should be evidence that each individual's PBSP has been implemented with integrity, and that PBSPs have been revised when necessary (i.e., data-based decisions are apparent).

8. The facility will need to develop a restraint review system that documents follow-up to any issues identified during the review process (C8).

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 LSSLC Section D Self-Assessment 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 MH&MR Investigations Handbook Commencement Policy Effective 8/1/11 o LSSLC Client Management Procedure: Investigations of Client Abuse/Neglect/Exploitation date 10/11/11 o LSSLC UII Action Plan Tracking o Abuse and Neglect: Identification, Reporting, and Prevention Training Curriculum o Comprehensive Investigator Training Curriculum 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 Human Rights Committee meeting minutes for the past six months o Three most recent five-day status reports o Training transcripts for 24 randomly selected employees o Acknowledgement to report abuse for 24 randomly selected employees o Acknowledgement to report abuse for all employees hired in the past two months (38) o List of staff who failed to report abuse, neglect, or exploitation (1) o Training and background checks for the last three employees hired o Training transcripts for facility investigators (14) o Training transcripts for DFPS investigators assigned to complete investigations at LPSSLC (7) o Abuse/Neglect/Exploitation Trend Reports FY12 o Injury Trend Reports FY12 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 ISPs for: • Individual #494, Individual #166, Individual #430, Individual #322, Individual #167, Individual #136, Individual #290, Individual #156, Individual #238 and Individual #119 o Injury reports for three most recent incidents of peer-to-peer aggression incidents o ISP, BSP and ISPA 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 injuries for the past six months
- List of all A/N/E allegations since 10/1/11 including case disposition
- List of all investigations completed by the facility since 10/1/11
- List of employees reassigned due to ANE allegations
- Injury reports for the past six months for:
  - Individual #598, Individual #137, Individual #517, and Individual #74.
- Documentation from the following completed investigations, including follow-up:

Sample D.1	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#41533992	Physical Abuse	Unconfirmed	3/15/12 3:42 pm	3/16/12 11:00 am	3/25/12
#41399464	Exploitation Sexual Abuse	Confirmed Confirmed	2/28/12 6:13 pm	2/29/12 6:00 pm	3/29/12
#41399477	Neglect (4)	Confirmed (2) Other (2)	2/28/12 5:00 pm	2/29/12 5:30 pm	3/9/12
#41376093	Neglect	Unconfirmed	2/25/12 4:46 pm	2/27/12 11:00 am	3/6/12
#41350592	Physical Abuse (3)	Unconfirmed (2) Inconclusive (1)	2/23/12 7:48 am	2/24/12 10:55 am	3/14/12
#41281356	Neglect Physical Abuse	Other Confirmed	2/9/12 9:15 pm	2/10/12 3:06 pm	2/29/12
#40999856	Neglect	Inconclusive	1/2/12 12:04pm	1/5/12 10:20 am	1/12/12
#40446936	Physical Abuse	Inconclusive	10/29/11 5:13 pm	11/1/11 6:45 pm	11/18/11
#40450217	Physical Abuse	Inconclusive	10/30/11 4:54 pm	11/1/11 7:00 pm	11/9/11
#40300419	Neglect (2) Physical Abuse	Confirmed Other Inconclusive	10/6/11 7:58 am	10/7/11 4:20 pm	10/26/11
Sample D.2	**Type of Incident**	**DFPS Disposition**	**Date of DFPS Referral**	**DFPS Completed Investigation**	**Facility Completed Investigation**
#4055680	Neglect	Clinical Referral	11/11/11	11/11/11	1/9/12
#41329692	Physical Abuse	Clinical Referral	2/21/12	2/21/12	2/28/12
#41461607	Neglect	Clinical Referral	3/7/12	3/8/12	3/27/12
#41494733	Theft	Administrative Referral	3/11/12	3/12/12	3/26/12

Sample D.3	Type of Incident	Date/Time of Incident Reported	Director Notification		
#41	Theft of personal property	10/18/11 7:15 pm	10/18/11 9:45		
#59	Serious Injury	11/7/11 7:30 pm	11/7/11 10:15 pm		
#73	Sexual Incident	12/2/11 6:35 pm	12/2/11 7:13 pm		
#74	Serious Injury Peer to Peer Aggression	12/5/11 11:55 pm	12/5/11 12:00 am		
#96	Serious Injury	1/25/12 12:50 pm	1/25/12 12:50 pm		
#106	Sexual Incident	2/2/12 10:35 am	2/2/12 2:08 pm		
#129	Serious Injury	2/29/12 1:00 pm	2/29/12 7:45 pm		
#135	Sexual Incident	3/15/12 12:45 pm	3/15/12 1:02 pm		
#141	Sexual Incident	3/25/12 7:50 am	3/25/12 8:03 pm		
#147	Serious Injury	4/1/12 4:45 pm	4/2/12 1:40 am		

Interviews and Meetings Held:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs;
- Sylvia Middlebrook, Director of Psychology
- Luz Carver, QDDP Coordinator
- Mike Ramsey, Incident Management Coordinator
- Mary Bowers, CNE

Observations Conducted:

- Observations at residences and day programs
- Castle Pine Morning Unit Meeting 5/2/12
- Incident Management Review Team Meeting 5/2/11 and 5/4/11
- Annual ISP meetings for Individual #252
- QDDP meeting 5/3/12
- Human Rights Committee Meeting 5/2/12

	o Restraint Reduction Committee Meeting 5/2/12 o ISPA for Individual #191 following a serious injury
	Facility Self-Assessment: LSSLC submitted its self-assessment. It was updated on 4/20/12. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The facility had implemented an audit process using the tools developed by the state office to measure compliance with the Settlement Agreement. The self-assessment indicated that the findings from the facility's monthly audit process were used to self-assess compliance. The self-assessment did not describe criteria used to evaluate compliance for each item, and did not provide comment on specific findings. There were numerous problems with the three tools being used by the facility to self-monitor (i.e., self-assess) substantial compliance with provision D. These problems included content, administration and implementation, interpretation of data, and reliability. The state office was aware of these problems and reported that new tools were being developed. It will be necessary to use these tools in conjunction with other forms of assessment. Overall, the self-assessment should look at the same types of activities, actions, documents, and so forth that the monitoring team looks at. This can be determined by a thorough reading of the report. The self-assessment completed by the IMC for this review relied heavily on the current self-monitoring tools. In some cases, the audit tool alone was not sufficient for determining compliance. For example, the self -assessment indicated that the facility was in substantial compliance with the requirements of D3g based on 100% compliance rate with the requirement for review of investigations by the IMC and facility director. The monitoring team did not find substantial compliance given that, although all investigations had been reviewed, reviews did not occur in a timely manner. The facility needs to not only assess whether or not a system is in place to address each provision item, but also assess the quality of that system for producing desired results. For example, not only should the facility have a system in place to collect and trend data related to incidents, trend identification should be used by the facility to develop action steps to put measures in place to prevent similar incidents. Further trending should than be used to measure the effectiveness of those preventative measures. The facility was moving in the right direction with the new self-assessment process. It will be important to

	look at the self-assessment activities in more detail and determine if the audit process is an effective way to assess compliance. The facility assigned a rating of substantial compliance to 18 of 22 provisions in section D. The monitoring team found substantial compliance in 16 of 22 provisions. Although considerable progress had been made, the monitoring team rated provisions D2a, D2b, D2i, D3e, D3g, and D3i in noncompliance.
	Summary of Monitor's Assessment: According to a list of abuse, neglect, and exploitation investigations provided to the monitoring team, investigation of 51 cases involving 66 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility since the last monitoring visit. Of the 66 allegations, there were four confirmed cases of physical abuse, one confirmed case of sexual abuse, two confirmed cases of emotional/verbal abuse, and three confirmed cases of neglect. An additional 49 other serious incidents were investigated by the facility including three deaths. There were a total of 1754 injuries reported between 11/1/11 and 4/30/12. These 1754 injuries included 19 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 large number of injuries were resulting from behavioral issues including peer-to-peer aggression. The facility had begun to address some issues noted to be contributing factors to the number of incidents at the facility. This included a focus on meaningful programming and crowded living units. The facility needs to continue to aggressively address tends in injuries and implement protections to reduce the number of incidents and injuries. The facility had taken steps to address concerns related to incident management at the facility. Some positive steps taken to address the provision items of section D included: • Creating a database to maintain and track disciplinary action related to allegations of abuse, neglect, and exploitation. • Began using the new state office Avatar system for documenting investigations. • Revising the discovered injury investigation process. • The DADS Section D Monitoring Tool was implemented. • Improvements were made in the documentation of activities taken during the investigation process. As noted below in the findings for section D, it was not apparent that some of these steps had adequately addressed concerns noted in previous monitoring reports. The facility needs to focus next on: • Ensuring investigation files include documentation of follow-up to all recommendations and concerns. • Ensuring IDTs are adequately addressing all incidents and putting necessary protections in place. • Ensuring that the facility audit system accurately identifies areas of needed improvement.

#	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 all employees who suspect or have knowledge of, or who are involved in an allegation of abuse, neglect, or exploitation, must report allegations immediately (within one hour) to DFPS and to the director or designee. 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. • 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. o 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. o Signed forms were provided for all employees hired within the past two months. The facility provided a copy of the signed acknowledgement for 71 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, 23 (96%) had completed the course ABU0100 in the past 12 months. Documentation of disciplinary action was reviewed for three cases in which DFPS substantiated an allegation of abuse or neglect and the AP was known. In all cases (100%), disciplinary action was documented in the investigation file. • In DFPS case #40300419, one allegation of neglect was confirmed. The employee was retrained prior to returning to her previous position. • In DFPS case #41281356, one allegation of physical abuse was confirmed. The staff involved resigned his position. • In DFPS case #41399464, DFPS confirmed allegations of sexual abuse and exploitation. The perpetrator was terminated.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		For cases where disciplinary action was warranted, it appeared that the facility was taking a position of "no tolerance" for abuse and neglect. The facility reported that evidence had been found that an employee had failed to report abuse or neglect in one case since the last monitoring visit. The employee received performance counseling regarding reporting procedures. The facility remained in substantial compliance with this provision.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	According to DADS Incident Management Policy 002.3, staff were required to report abuse, neglect, and exploitation within one hour by calling DFPS. With regard to other serious incidents, the state policy addressing Incident Management required that all unusual incidents be reported to the facility director or designee within one hour of witnessing or learning of the incident. This included, but was not limited to: • Allegations of abuse, neglect, or exploitation, • Choking incidents • Death or life-threatening illness/injury • Encounter with law enforcement • Serious injury • Sexual incidents • Suicide threats • Theft by staff, and • Unauthorized departures. The policy further required that an investigation would be completed on each unusual incident using a standardized Unusual Incident Report (UIR) format. This 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 51 cases involving 66 allegations of abuse, neglect, or	Noncompliance

#	Provision	Assessment of Status	Compliance
		exploitation were conducted by DFPS at the facility since the last monitoring visit. From these 66 allegations, there were: • 27 allegations of physical abuse; o 4 were confirmed, o 21 were unconfirmed, and o 2 were inconclusive. • 3 allegations of sexual abuse; o 1 was confirmed, and o 2 were unconfirmed. • 13 allegations of verbal/emotional abuse, o 2 were confirmed, o 5 were unconfirmed, o 5 were referred back to the facility for further investigation, and o 1 was inconclusive. • 21 allegations of neglect; and o 3 were confirmed, o 7 were unconfirmed, o 9 were referred back to the facility for review, o 2 were inconclusive. • 2 allegations of exploitation; o 1 was unconfirmed, and o 1 was referred back to the facility for review. The facility reported that there were 49 other investigations of serious incidents not involving abuse, neglect, or exploitation. A breakdown of incident type was not provided. There were three deaths and 18 serious injuries involving fractures or sutures in the past six months. From all investigations since 10/1/11 reported by the facility, 24 investigations were selected for review. The 24 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 (10 cases). • Sample #D.2 included a sample of facility investigations that had been referred to the facility by DFPS for further investigation (four cases). • Sample #D.3 included investigations the facility completed related to serious	

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		incidents not reportable to DFPS (10 cases). Based on a review of the 10 investigative reports included in Sample #D.1: • Eight incidents occurred at an unknown time. Nine of 10 reports in the sample (90%) indicated that DFPS was notified within one hour of the incident or discovery of the incident. o In DFPS #41350592, DFPS was not notified immediately of an allegation of abuse reported by Individual #367. The nurse assessing the injury notified the campus coordinator instead of DFPS. The campus coordinator began investigating the allegation prior to calling DFPS. Two witnesses to the incident leading to the allegation also failed to report the incident. DFPS did note a concern regarding the failure of employees to report the incident. The facility documented retraining on reporting abuse and neglect immediately for the two witnesses, but did not address the nurse's failure to report. • Ten of 10 (100%) indicated the facility director or designee was notified within one hour by DFPS. • Eight of eight (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. • Five of 10 (50%) indicated that the state office was notified as required. Cases that did not include documentation of state office notification were DFPS #4153392, DFPS #41376093, DFPS #41281356, DFPS #40446936, DFPS #40450217 and DFPS #40300419. In reviewing Sample D.3 (serious incidents), documentation indicated: • Seven of 10 (70%) were reported immediately (within one hour) to the facility director/designee. o UIR #129 did not include documentation of notification to the facility director following a serious injury. The AOD was notified six hours after the injury occurred. o UIR #147 indicated that a serious injury occurred on 4/1/12 at 4:45 pm. The facility director was not notified until 4/2/12 at 1:40 am. o UIR #106 indicated that the facility director was not notified of a sexual incident that occurred on 2/2/12 at 10:35 am until 2:08 pm. • Documentation of state office notification, as required by state policy, was found in six of 10 (60%) UIRs. UIRs that did not document state office notification included UIR #41, UIR #59, UIR #74, and UIR #106. o Two cases were reportable to DADS Regulatory. Notification was made as required in one case (50%). UIR #106 did not document notification.	

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		The facility used the Unusual Incident Report Form (UIR) designated by DADS for reporting unusual incidents in the sample. 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. • 14 of 14 (100%) investigation files in Sample #D.2 and Sample #D.3. 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 reviewed for 71 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. Based on informal interviews of six staff responsible for the provision of supports to individuals, six (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation and other serious incidents. The facility self -assessment indicated that the facility was in substantial compliance with D2a based on audit results. The sample reviewed by the monitor's team did not confirm substantial compliance with the reporting requirements of this provision. Furthermore, it was not evident in the one case in sample D.1 where employees did not immediately report suspected abuse that the facility followed up on this concern.	
	(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 did have a policy 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 eight out of 10 cases where an alleged perpetrator (AP) was known, it was documented that the AP was placed in no contact status. Two UIRs did not document that the AP was removed. These were DPFS #40500419 and DFPS #40450217. The monitoring team was provided with a log of employees who had been reassigned since 10/1/11. The log included the applicable investigation case number and the date the employee was returned to work or in some cases discharged. The date of removal from client contact was not documented on the log. In eight out of 10 cases (80%) there was no evidence that the employee was returned to client contact prior to the completion of the investigation or when the employee posed	Noncompliance

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		no risk to individuals. The DADS UIR included a section for documenting immediate corrective action taken by the facility. Based on a review of the 10 investigation files in Sample D.1, 10 (100%) UIRs documented at least some additional protections implemented following the incident. This typically consisted of three actions, including placing the AP in a position of no client contact, a head-to-toe assessment by a nurse, and a psychological assessment. Examples of other immediate action taken included, • In DFPS #40300419, the UIR indicated that the alleged victim (AV) was taken to the hospital for x-rays and his level of supervision was increased. • In DFPS #40999856, the UIR indicated that the AV was taken to the infirmary. • In DFPS #41399477, documentation of immediate corrective action taken included retraining staff and reviewing video evidence. As noted in the last monitor's report, the facility needs to more thoroughly document all immediate corrective action taken, including but not limited to, removing APs, providing immediate medical care, discussion by the IDT, and environmental modifications. The IMC reported that more attention was being placed on ensuring that corrective action had been completed. A recent turnover in the IMC position and having only the IMC and one investigator led to gaps in tracking the completion of investigations. The facility was not in substantial compliance with this provision. All immediate corrective action should be documented in the investigation file.	
	(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. A random sample of training transcripts for 24 employees was reviewed for compliance with training requirements. This included four employees hired within the past year. • 23 (96%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 16 (84%) 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. • 17 (85%) of the 20 employees (employed over one year) with current training completed this training within 12 months of the date of previous training.	Substantial Compliance

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		Based on interviews with six direct support staff in various homes and day programs: • Six (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. The Director of Training had issued a memo dated 9/29/11 to home managers and department heads stating that staff failing to attend refresher training by the due date would be deemed no longer meeting the qualifications for their position. It further stated that staff with delinquent training would be removed from their position and reassigned to a position with no client contact until completion of training. The facility was in substantial compliance with this item.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	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 reviewed for 71 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. A sample of 10 DFPS reports included one example where employees failed to report abuse. In DFPS #41350592, appropriate steps were not taken to report an allegation of abuse. The nurse assessing the injury notified the campus coordinator instead of DFPS. The facility did not take personnel action to address the nurse's failure to report to the appropriate agency. The facility did report the allegation. The facility was in substantial compliance with this item. Appropriate personnel action should be taken in all instances where abuse, neglect, or exploitation are not reported to DFPS immediately.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual	A review was conducted of the materials to be used to educate individuals, legally authorized representatives (LARs), or others significantly involved in the individual's life. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. The guide was a clear easy to read guide to recognizing signs of abuse and neglect and included information on how to report suspected abuse and neglect.	Substantial Compliance

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	who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	A sample of 10 ISPs developed after 10/1/11 was reviewed for compliance with this provision. The sample included ISPs for Individual #494, Individual #166, Individual #430, Individual #322, Individual #167, Individual #136, Individual #290, Individual #156, Individual #238, and Individual #119. • Ten (100%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings. In informal interviews with individuals during the review week, all individuals questioned were able to describe what they would do if someone abused them or they had a problem with staff. The facility provided a list of 14 investigations since 10/1/11 where the individual self-reported abuse or neglect indicating that at least some individuals at the facility knew how to report abuse or neglect to DFPS. The facility remained in substantial compliance with this item.	
	(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. Campus Administrators monitored and reviewed postings in each living unit and day program and were instructed to report missing posters as necessary. The facility remained in substantial compliance with this provision item.	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 notified law enforcement and OIG of the allegation in eight (80%), as appropriate.	Substantial Compliance

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		The facility remained in substantial compliance with this provision item.	
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	The following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: • LSSLC Client Management Procedure: Investigations of Client Abuse/Neglect/Exploitation date 10/11/11 addressed this mandate by stating that any employee or individual who in good faith reports abuse, neglect, or exploitation shall not be subjected to retaliatory action by any employee of LSSLC, DADS, or any person affiliated with an employee of either. • Both initial and annual refresher trainer stressed that retaliation for reporting would not be tolerated by the facility and disciplinary action would be taken if this occurred. The facility was asked for a list of staff who alleged that they had been retaliated against for in good faith had reported an allegation of abuse/neglect/exploitation. The facility reported zero cases where fear of retaliation was reported. Based on a review of investigation records (Sample #D.1), there were no concerns noted related to potential retaliation for reporting. The facility self-assessment also reported no complaints of retaliation in the 42 cases audited during the past six months. The facility rated itself in substantial compliance with this item. The monitoring team agreed with that assessment.	Substantial Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The facility Client Management procedure titled Investigation of Client Abuse/Neglect/Exploitation was updated on 10/11/11. It required staff to notify the facility director and DFPS of injuries of unknown origin where probably cause cannot be determined and to DADS Regulatory if the injury was deemed serious. According to the facility action plan, the following measures had been implemented to address this provision. • The IMC had begun to utilize a new database to run trend reports on injuries on a monthly and quarterly basis to determine trends of individuals experiencing three or more injuries per rolling thirty day period. Trends were to be reviewed more frequently for individuals considered high risk. • QA staff had begun auditing 1% of all non-serious injuries. • Campus Administrators were randomly auditing individual's records for individuals that had three or more injuries in a rolling 30 day period or an increased number over a 60 day period. • Reported injuries were reviewed in daily unit meetings and IMRT meetings.	Noncompliance

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		Data from record audits using the Section D statewide audit tool completed between January 2012 and April 2012 indicated compliance ratings ranging from 91% in January 2012 to a low of 76% in April 2012 with item D2i. The audit found a number of injuries not documented and reported for review. The monitoring team observed daily IMRT meetings held the week of the onsite review. All injuries were reviewed and discussed by the team. Serious injuries, and trends of injuries were investigated further and recommendations were made by the team for follow-up. As noted in D2a, an additional sample of serious client injuries was reviewed for serious injuries occurring in the past six months to determine if injuries were reported for investigation. According to a list of all investigations completed by the facility, all serious injuries in the sample had been investigated. The facility was in the initial stages of developing an audit process that was adequate for ensuring that injuries or trends of injuries were reported for investigation. This audit system will be reviewed further at the next monitoring team visit. Continued low compliance ratings should be analyzed in terms of whether or not the current audit system was adequately identifying problems that need to be addressed by the facility in reporting injuries 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, 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,	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. Seven DFPS investigators were assigned to complete investigations at LSSLC. Two were no longer working for DFPS. The training records for DFPS investigators were reviewed	Substantial Compliance

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	including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	with the following results: • Seven investigators (100%) had completed the requirements for investigations training. • Seven DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. LSSLC had 14 employees designated to complete investigations. This included the IMC, Facility Investigator, Campus Coordinators, and Campus Administrators. The training records for those designated to complete investigations were reviewed with the following results: • Fourteen (100%) facility investigators had completed CIT0100 Comprehensive Investigator Training or CSI 0100 Conducting Serious Incident Investigations. • Fourteen (100%) had completed UNU0100 Unusual Incidents within the past 12 months. • Seven (100%) had completed Root Cause Analysis according to training transcripts reviewed. The Campus Coordinators had not completed this course. There was no evidence that they had completed any of the investigations in the sample. • Fourteen (100%) had completed the requirements for training regarding individuals with developmental disabilities by completing the course MEN0300. Trained investigators were completing all investigations at the facility. Additionally, facility investigators did not have supervisory duties; therefore, they would not be within the direct line of supervision of the alleged perpetrator. The facility was in substantial compliance with this provision.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Sample D.1 was reviewed for indication of cooperation by the facility with outside investigators. There was no indication that facility staff had failed to cooperate with investigators in any of the cases. The facility IMC continued to meet quarterly with DFPS and OIG to discuss coordination of investigations between agencies. The facility was in substantial compliance.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not	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	Substantial Compliance

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	to interfere with such investigations.	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), eight 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. • There was no indication that the facility had interfered with any of the investigations by OIG in the sample reviewed. The facility was found to be in substantial compliance with this provision.	
	(d) Provide for the safeguarding of evidence.	The LSSLC policy on Abuse and Neglect mandated staff to take appropriate steps to preserve and/or secure physical evidence related to an allegation. Documentary evidence was to be secured to prevent alteration until the investigator collected it. Based on a review of the investigations completed by DFPS (Sample #D.1) and the facility (Sample #D.3): • There was no indication that evidence was not safeguarded during any of the investigations. Video surveillance was in place throughout LSSLC, and investigators were regularly using video footage as part of their investigation. The facility remained in substantial compliance with this item.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or	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. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • Investigations noted the date and time of initial contact with the alleged victim. o Contact occurred within 24 hours in eight of 10 (80%) investigations. The two cases in which contact did not occur were DFPS cases	Noncompliance

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	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.	#40450217 and #40999856. In both cases, it was determined that the alleged victim was unable to participate in the investigation process. In one case, the alleged perpetrator was unknown. In the second case, the alleged perpetrator was not interviewed until the 8th day of the investigation. • Ten (100%) investigations indicated that some type of investigative activity took place within the first 24 hours. For the two investigations in which initial contact was not made with the alleged victim, this included gathering other documentary evidence and making initial contact with the facility. • Seven of 10 (70%) were completed within 10 calendar days of the incident. o Extensions were filed in three cases that were not completed within 10 calendar days. Extension requests seemed to be reasonable in these cases. o OIG was involved in the investigation in three of four cases that were not completed by DFPS within 10 days. o Investigation #41399464 was the lengthiest investigation in the sample. It was completed on the 30th day. Documentation included two extension requests. An allegation of sexual abuse was confirmed. • 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 eight of the 14 DFPS investigations reviewed (57%) in sample #D.1 and #D.2, concerns or recommendations for corrective action were included. Four of those cases resulted in referrals back to the facility for further investigation. Concerns were appropriate based on evidence gathered during the investigation. <u>Facility Investigations</u> The following summarizes the results of the review of investigations completed by the facility from sample #D.3 : • Ten (100%) of the UIRs reviewed indicated that the investigation began within 24 hours. • Ten of 10 (100%) indicated that the investigator completed a report within 10 days of notification of the incident. All UIRs in the sample noted completion within 24 hours. Documentation of activities, however, did not support completion within 24 hours in all cases. For example, o UIR #41 indicated that the investigation was completed on 10/18/11, the same date that the incident was reported. An extension was filed on 12/2/11. The extension indicated that the facility had not completed interviews in order to not interfere with OIG investigative activities. Further investigation by the facility and a conclusion was not	

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		documented. The case was reviewed by the facility director on 2/20/11. o UIR #135, investigation of a sexual incident, indicated that the incident was reported on 3/15/12 and the investigation was completed on 3/15/12. Documentation of the activities of the investigation showed that an extension was filed on 3/22/12. A final interview was completed on 3/29/12. • Nine of 10 (90%) investigations included recommendations for corrective action. Recommendations were not always comprehensive. Investigation should include follow-up recommendations regarding medical care, changes in levels of supervision, environmental modifications, or behavioral interventions that might prevent a similar incident from occurring in the future. UIRs should clearly indicate when an investigation is completed and include adequate recommendations for follow-up to any incident.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including	DADS 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; 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	Substantial Compliance

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	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.	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 10 facility investigations included in sample #D.3 • 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 of 10 (100%), the names of all persons interviewed during the investigation; o In seven (70 %), 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. Exceptions included UIR #73, UIR #41, and #141 o In 10 (100%), all documents reviewed during the investigation; 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. o In 10 (100%), the investigator's findings; and o In nine (90%), the investigator's reasons for his/her conclusions. ▪ UIR #41 did not include a summary of the concluded case. The facility was in substantial compliance with this item. Facility investigators should include a summary of all witness statements taken during the investigation.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in	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 a sample of 15 DFPS investigations included in Sample #D.1: • In 10 (100%) investigative files reviewed from Sample #D.1, there was evidence	Noncompliance

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	the investigation and/or report shall be addressed promptly.	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. For UIRs completed for Samples #D.1, • Ten (100%) DFPS investigations were reviewed by both the facility director and IMC following completion. o Six of 10 (60%) were reviewed by the facility director and Incident Management Coordinator within five days of receipt of the completed investigation. Exceptions included: ▪ DFPS #40300419 – reviewed 18 days after completion, ▪ DFPS #41376093 – reviewed 13 days after completion, ▪ DFPS #40450217 – reviewed 9 days after completion, ▪ DFPS #40999856 – reviewed 8 days after completion, DFPS noted concerns or made recommendations in four (40%) of the cases in sample #D.1. The facility maintained a log of follow-up action taken to address concerns and recommendations. Documentation of follow-up to DFPS concerns was not found in two (50%) of the four investigation files making it difficult to ensure that follow-up was completed. For example, • In DFPS #41399464, the review approval form indicated that the facility did not agree with the DFPS's finding and would be requesting a methodological review. There was no documentation that a methodological review was completed. • In DFPS #41350592, DFPS noted concerns regarding the lack of documentation regarding the injury. Although the UIR noted the concerns, there was no evidence of follow-up to the concerns. Sample #D.2 included four investigations that were referred back to the facility for administrative review. • Three were clinical referrals. Reviews were completed by clinical staff, two at the facility level and one at the state level. The two investigated at the facility level did not find evidence of wrong doing and, as a result, there were no recommendations. The investigation conducted by state level PNM staff resulted in recommendations for corrective action. • The fourth investigation was referred back to the facility as a theft allegation that did not meet the DFPS's definition of exploitation. The incident was referred to OIG for further investigation. Criminal activity was confirmed. Two daily review meetings (IMRT) were observed during the monitoring team's visit to the facility. Completed investigations were reviewed at the daily IMRT meetings.	

#	Provision	Assessment of Status	Compliance
		Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility. <u>Facility Investigations</u> • In 10 of 10 (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. • Six of 10 (60%) reviews were completed within five days of the completion date. The exceptions were UIR #41, UIR #73, UIR #106, UIR #129, and UIR #135. • Nine of 10 UIRs included recommendation for follow-up. None of the investigation files included adequate documentation of follow-up to ensure that recommendations were completed. See examples in D3i. The facility needs to ensure that all investigations are reviewed in a timely manner to ensure swift completion of follow-up action when indicated. Documentation of follow-up to recommendations should be included in the investigation file. The sample reviewed during the previous monitoring visit showed that reviews of investigations by the IMC and facility director were occurring in a timely manner for most investigations. The sample reviewed for this visit did not show maintenance of the timely review of investigations. As a result, this item was no longer in substantial compliance.	
	(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 24 out of 24 (100%) unusual incidents in the sample. A brief statement regarding review, recommendations, and follow-up was included on the review form.	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.	Documentation was reviewed to show what follow-up had been completed to address the recommendations resulting from investigations in the sample. Four investigations in Sample D.1 included confirmed allegations of abuse or neglect. Documentation provided by the facility indicated that disciplinary action had been taken in all four cases. The facility had developed a log to track follow-up action taken in regards to recommendations included in investigations. As noted in the following summary, not all recommendations were included on the tracking log. Due to turnover in the Incident Management Department over the past six months and lack of clerical staff, the facility was still struggling with ensuring that disciplinary and	Noncompliance

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		programmatic action was documented in the investigation file. In four of 10 DFPS cases reviewed from Sample #D.1, DFPS documented additional concerns or recommendations. In two of those four cases (50%), the facility investigation file did not include documentation that concerns or recommendations were addressed. Examples found where documentation of programmatic action was not adequate included: • In DFPS #41399464, the review approval form included a statement indicating that the employee involved was terminated, the video surveillance policy was updated, and a methodological review request was filed by the facility. The investigation file did not include a copy of the employee termination letter, documentation of policy change, or results of the methodological review. Additional information was not included on the investigation follow-up tracking log. The UIR did not include a summary of the completed investigation or recommendations for follow-up. • In DFPS #41350592, DFPS noted concerns regarding the lack of documentation regarding the injury. The facility UIR included several recommendations to address this concern. Completed action regarding the concern was not documented in the investigation file or included on the facility follow-up tracking log. Recommendations for programmatic actions were made in nine of 10 cases reviewed for facility investigations in Sample #D.3. Adequate follow-up documentation was not included in any of the cases that had recommendations. • UIR #41 included a recommendation to replace a stolen game system. There was no documentation that the game system had been replaced. • UIR #59 included recommendations for preventative action after an individual fell sustaining a serious injury in the bathtub. The investigation file included emails indicating that environmental modifications were in process, but had not been completed. There was no further documentation to indicate that the work had ever been completed. • Documentation of follow-up to corrective action recommended was not included in the investigation packet or on the facility tracking log for UIR #73. There were 22 recommendations for corrective action included in the UIR. An ISPA was held following a serious incident for Individual #191 during the week of the onsite visit. He rolled his wheelchair off of the porch at his home resulting in significant injury. The IDT met the day after the incident occurred to discuss putting protections in place. The team agreed that rails on the porch were needed immediately and his level of supervision should be increased. According to team members, the issue regarding railing	

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		had been raised prior to the incident, but the work had not been completed. The facility needs to focus on preventative action prior to incidents occurring. The facility needs to ensure that appropriate follow-up action is completed and documented. The facility did not achieve 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 recently implemented the new statewide system to collect data on unusual incidents and investigations. Data were collected through the incident reporting system and trended by type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of the investigation. Information collected by the facility should be used to address systemic problems that are barriers to protecting individuals from harm at the facility. As the facility continues to develop a system of quality improvement, these reports will be critical in evaluating progress towards improvement. The facility needs to gather accurate data and 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 in substantial compliance with this provision item.	Substantial Compliance
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	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	Substantial Compliance

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	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.	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 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. 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 12, criminal background checks were submitted for 149 applicants. There were a total of applicants who failed the background check in the hiring process and therefore were not hired. 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 21 of 24 employees (86%). The facility remained in substantial compliance with this provision. The facility, however, needs to ensure that all employees review and sign an acknowledgement to self report criminal activity.	

Recommendations:

1. The facility needs to document all required notifications in the investigation file (D2a).

2. Appropriate personnel action should be taken in all instances where abuse, neglect, or exploitation are not reported to DFPS immediately (D2d).

3. Audit findings should be analyzed in terms of whether or not the current audit system is adequately identifying problems that need to be addressed by the facility in reporting injuries for investigation (D2i).

4. UIRs should clearly indicate when an investigation is completed and include adequate recommendations for follow-up to any incident (D3e).

5. Facility investigators should include a summary of all witness statements taken during the investigation (D3f).

6. Efforts should continue to complete investigations within 10 days unless extraordinary circumstances exist (D3e).

7. Investigation documentation should indicate that all investigations are reviewed promptly by the facility to ensure that the investigation is thorough and complete and that the report was accurate, complete and coherent (D3g).

8. The facility needs to ensure that appropriate follow-up action is completed and documented in investigation files (D3g, D3h, D3i).

9. 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 if data is accurate and how data can best be used to evaluate that progress (D4).

10. The facility, however, needs to ensure that all employees review and sign an acknowledgement to self report criminal activity (D5).

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 #003.1: Quality Enhancement, new policy revision, dated 1/26/12 o LSSLC facility-specific policy related to quality assurance: Quality Assurance-01-QA Policy, 4/27/12 with attachments, and training roster showing seven signatures, 4/27/12 o Email from DADS assistant commissioner describing the formation of the statewide SSLC leadership council, 3/5/12 o Draft Section E self-assessment tool from state office, 4/19/12 o H&W Solutions QA training handouts, January 2012 o LSSLC organizational chart, 4/10/12 o LSSLC policy lists, 2/23/12 o List of typical meetings that occurred at LSSLC, 3/28/12 o LSSLC Self-Assessment, 4/20/12 o LSSLC Action Plans, 4/20/12 o LSSLC Provision Actions Information, 4/19/12 o LSSLC Quality Assurance Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 4/30/12 o LSSLC DADS regulatory review reports, through 3/21/12 o LSSLC QA department meeting notes, 11/7/11 through 3/30/12 (13 meetings) o LSSLC data listing/inventory draft, undated, but likely April 2012 o LSSLC Quality Assurance Plan/matrix, undated, but most likely March 2012 o Set of blank tools used by QA department staff (7) o List of QA staff and each staff member's monitoring responsibilities o DADS SSLC family satisfaction survey, cumulative October 2011 through March 2012, 79 participants o Self-advocacy meeting minutes, November 2011 through March 2012 (4 meetings) o Notes from weekly home meetings for staff, February 2012 o Recent facility newsletters, Pine Bark, Spring 2011 and Winter 2012 o QA Reports, monthly, December 2011 through April 2012 (5) o QAQI Council agenda and meeting minutes since last onsite review, 12/5/11 through 5/1/12 (13 meetings) o QAQI Council agenda and handouts for 5/1/12 meeting o CAPs information on a variety of spreadsheets for 6 CAPs Interviews and Meetings Held: o Todd Miller, Interim Director of Quality Assurance o QA staff: Tabitha Anastasi, Elizabeth Carnley, Stephen Webb, Charlene Brown o Sherry Roark, Settlement Agreement Coordinator o Gale Wasson, Facility Director

	o Residential Director and Unit Directors: Keith Bailey, Rotley Tankersley, Kenneth Self, Todd Miller, Mary Stovall o David Daniel, DADS Settlement Agreement program compliance coordinator o George Zukotynski, DADS state office psychology coordinator, Sylvia Middleton, LSSLC psychology director o Royce Garrett, Consumer and Family Relations Director Observations Conducted: o QAQI Council meeting, 5/1/12 o Weekly home team meeting, 520A, 4/30/12
	Facility Self-Assessment: LSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. During the week of the onsite review, the monitoring team engaged in lots of discussion with facility staff regarding the new self-assessment. Facility staff appeared interested and eager to implement this new process correctly and in a way that would be beneficial to them. The most difficult aspect of this appeared to be understanding the somewhat subtle difference between assessing whether substantial compliance was met versus engaging in activities to meet substantial compliance. Determining how to assess the quality assurance provision items is a challenging task. Consider that much of what the QA department does is to help the departments self-assess their own performance (and to make changes, corrective actions, etc.). In reviewing the details of the QA, section E, self-assessment, the monitoring team noted that the QA director (a) looked only at trend reports for injuries and restraints, (b) noted that a QA report was completed, and (c) commented on some of the early CAP activity. This was insufficient for an adequate self-assessment. Instead, the self-assessment should look at whether important components of a QA program have been created and the quality of each of these components. The monitoring team provided more detail on this in section E1 in the last paragraph of the subsection Policies. In this paragraph, and in general, the monitoring team recommends that the QA director review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring

	team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead the QA director to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." The monitoring team and the QA director engaged in detailed discussion about this during the onsite review. In addition, he should also work with the DADS central office QA coordinator and other SSLC QA directors on this task. The facility self-rated itself as being in noncompliance with all five of the provision items of section E. The monitoring team agreed with these self-ratings, however, as noted in the narrative report below, progress was evident since the time of the last onsite review.
	Summary of Monitor's Assessment: There was some progress in the development of some aspects of a comprehensive QA program even though there was again change in the management of the QA department. One of the residential unit directors was serving as a bridge until the newly hired QA director could begin her duties on 6/1/12. The new QA director will need direction and assistance from both the facility director and the state office Quality Assurance coordinator. The monitoring team continued to be impressed with the QA staff's competence and desire to engage in meaningful QA activities. QA staff spent their time collecting data implementing their department's own QA tools (there were seven), completing statewide self-assessment tools, primarily to assess interobserver agreement, and participating on various committees and in meetings. LSSLC had updated its facility-specific policy. Oddly, the new facility-specific policy contained the <u>old</u> state QA policy. The new QA director will need to sort this out and make a facility-specific policy that is based on the new state policy and that is relevant to LSSLC. A draft of a proposed statewide self-monitoring tool to be used for section E was shared with the monitoring team. In the monitoring team's opinion, this tool will not likely be helpful to the facility in obtaining substantial compliance or in self-assessing its own QA program. A tool with more relevant content is needed. The QA department made progress towards creating a list/inventory of all data collected at LSSLC. It was 15 pages long and was sectioned into 34 different departments and disciplines. Additional efforts will be needed to ensure that the list is comprehensive and as complete as possible. The QA department should consider putting the list/inventory into an electronic spreadsheet format. A QA plan narrative did not yet exist at LSSLC. The QA matrix had not progressed much, if at all, since the previous reviews. Comments regarding the QA plan narrative and matrix are below. The facility was beginning to consider making changes to the statewide self-monitoring tools. A new tool was completed and being used for section F. Other new tools were in development. This was good to see.

	Family and LAR satisfaction information was collected. There were 79 respondents and, overall, they were satisfied with the services and supports at LSSLC. The Consumer and Family Relations Director did a nice job of gathering and summarizing the data. There were no measures of individual satisfaction. One way to obtain some of this information might via self-advocacy committee and/or weekly individual home meetings for individuals to address problems, make group decisions, etc. This might not be appropriate for all homes, but certainly for many of them. The data that come into the QA department (i.e., the items on the QA matrix) need to be reviewed by the QA department (probably primarily by the QA director) and they need to be summarized. This was not yet occurring. Summarizing of data is typically done in the form of a graph or a table. One of the areas of progress was the development of a monthly QA report. The report was begun in November 2011 and had evolved into a longer document with lots of data included. The QA staff were eager for feedback and commentary on their QA report. A bulleted list of comments and suggestions are provided below. Overall, it is very important to make the report easily consumable by those who will be required to read it. For example, consistency and simplicity in graphic presentations are crucial. The QAQI Council met regularly. The facility director reported that she now planned to get back onto a regular schedule of reviewing a portion of the provision items at each meeting. There was some progress in the development of corrective action plans. Six existed and addressed important activities. Overall, however, the CAPs system needed more definition (i.e., a plan or policy/procedure) to specifically address the requirements of this provision.

#	Provision	Assessment of Status	Compliance
E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	Since the last review, there was again change in the management of the QA department at LSSLC. The previously newly appointed QA director resigned from LSSLC a few months ago and one of the residential unit directors, Todd Miller, was appointed to serve as interim QA director. Fortunately, the facility hired a new QA director who was scheduled to begin on 6/1/12. Mr. Miller was serving as a bridge until the new director could begin her duties. During this interim period, his goals were to keep stability in the QA department and to be the lead person regarding any DADS ICFMR regulatory activities, including the development and oversight of ICFMR plans of correction. Even so, there was some progress towards substantial compliance with the items of provision E. This was due to the activities of the previous QA director, the interim QA director, the QA staff, and LSSLC management.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Policies The state's QA policy was finalized and disseminated. The new policy was titled #003.1: Quality Assurance, dated 1/26/12. The new policy provided detail and direction to QA directors and facility staff, much more so than did the previous policy. LSSLC had updated its facility-specific policy. Oddly, the new facility-specific policy contained the old state QA policy inserted into it (#003, 11/13/09). In addition, QA staff were trained (documented on 4/27/12) on this new facility-specific policy that contained the old state policy. The new QA director will need to sort this out and make a facility-specific policy that is based on the new state policy and that is relevant to LSSLC. Once a facility-specific policy is developed, training and orientation of both the state and facility policies and their requirements needs to occur and should: • Be provided to QA staff. • Be required for senior management, including but not limited to QAQI Council. • Involve more than just the reading of the new policy. The new state policy also called for a statewide QAQI Council, and for statewide discipline QAQI committees. The statewide QAQI Council requirement was being met by the recent (3/5/12) formation of the statewide leadership council. Statewide discipline QAQI committees were not yet in place. Also, given that the statewide policy was in development for more than a year, edits may already be needed. State office should consider this. The interim QA director presented a draft of a proposed statewide self-monitoring tool to be used for section E. In the monitoring team's opinion, this tool will not likely be helpful to the facility in obtaining substantial compliance or in self-assessing its own QA program. The proposed tool included the wording from section E, but it did not include the many important components of a comprehensive QA program, such as those that the monitoring team has written about in this, and previous, monitoring reports. Examples include a detailed list/inventory of all data collected at the facility; a narrative QA plan; a QA matrix that lists the data that come into the QA department for review and analysis; a QA report that includes standardized sections, such as the Settlement Agreement, DADS regulatory, and key indicators chosen by QAQI Council, the QA director, and/or the discipline department head; the facility's processes for reviewing data; and the facility's process for implementing corrective actions, including CAPs, PITs, and/or other actions. An adequate self-monitoring tool should look at both the presence and the quality of these components.	

#	Provision	Assessment of Status	Compliance
		General QA Planning Listed below are important component steps in the development of a QA program. The monitoring team had the opportunity to discuss these at length with the interim QA director. These component steps were listed in the previous monitoring report, however, the detail is not repeated here. Instead, the reader should refer to previous monitoring reports. • Create a listing/inventory of all data collected at the facility that includes the variety of categories of data detailed in previous monitoring reports. • 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). • 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. • Create and manage corrective actions based upon the data collected, and direction from the QAQI Council. QA Department LSSLC will have a new QA director. The facility will be looking to her for direction regarding quality assurance. The monitoring team is optimistic that she will move the facility forward towards substantial compliance with this provision. To increase the likelihood of success, the QA director will need direction and assistance from both the facility director and the state office Quality Assurance coordinator. Furthermore, she may benefit from a mentoring relationship with another facility's QA director. Also important will be her working collaboratively with the Settlement Agreement Coordinator (SAC). The LSSLC SAC, Sherry Roark, was competent, organized, and knowledgeable about the Settlement Agreement and the facility. She was already working collaboratively with the QA department staff and interim director. In addition to the change in QA director, the QA department continued to have two other vacant positions. One was for a QA nurse, and the other for a QA staff member. These positions will not be filled until the new QA director is established. The monitoring team continued to be impressed with the QA staff's competence and desire to engage in meaningful QA activities. This continued to bode well for the department as it develops the structure and components required of a QA program and for the success of the new QA director. The QA department continued to have department meetings more-or-less weekly, as recommended and noted in previous reports. The agendas and topics appeared to be relevant. The SAC attended these meetings. As recommended in the previous report,	

#	Provision	Assessment of Status	Compliance
		these meetings should also include topics about quality assurance rather than only being used to make announcements. In other words, the meetings should be used as a staff training-type of opportunity, so that staff can learn about the profession of quality assurance, participate in creating processes for the department and facility, and so forth. <u>Quality Assurance Data List/Inventory</u> The creation of a list of all of the data collected at the facility is an important first step in the development of a comprehensive quality assurance program. The QA department had made progress towards this by creating a list for the first time. It was 15 pages long and was sectioned into 34 different departments and disciplines. This was a very good first step. To move forward: • Ensure that the list is comprehensive and as complete as possible. The list will evolve over the first six months of its development and then will likely only need updating once per year or so. • Consider putting the list/inventory into a format on an electronic spreadsheet. The monitoring team recommends that the new QA director consider the format developed at San Angelo SSLC and Mexia SSLC. Their format was a single electronic spreadsheet that contained a worksheet for each department and discipline, and an additional worksheet that was the QA matrix. Remember, the list/inventory should be a simple list. It does not need to (but certainly can) include additional information such as auditing, data responsibilities, sample size, and so forth. Remember, the goal is to have a simple listing that can be easily read by QAQI Council members as well as any other interested parties. Further, clinical and operational staff may be more likely to contribute to the list if it is easy to do so. (The additional information, however, is needed for the QA plan matrix, see below.) <u>Quality Assurance Plan and Matrix</u> The QA Plan should consist of a number of components. The first component should be a narrative description that might include a two or three page overall description of how QA is conducted at LSSLC; a description of the comprehensive inventory listing of all data that are collected across the facility; a description of the QA matrix and how those data are managed, reviewed, trended, and analyzed by the QA department; the role of any QA databases; the way that the QAQIC meetings work; and the overall expectation and processes for data analysis, corrective action planning, and corrective action management. A QA plan narrative did not yet exist at LSSLC. There likely can be a lot of overlap between what becomes the facility-specific QA policy and the QA plan narrative, but that will be up to the QA director and facility to decide upon.	

#	Provision	Assessment of Status	Compliance
		The second component should be the QA matrix. It should be attached to the narrative, thereby, creating the QA plan. The QA matrix had not progressed much, if at all, since the previous reviews. Below are comments for the new QA director as she moves to develop the QA matrix. • All items in the QA matrix are data that are to be submitted to the QA department and analyzed by the QA department. Some of the summarizing and graphing of the data, however, can be done by the discipline/department prior to submission to the QA department (see E2 below). • The selection of what items are in the QA matrix should come from: o QAQI Council, o Clinical, service, and operational department heads, and o The QA director. • Typically, this will result in a number of "types" of items, such as: o A list of tools to monitor each of the provisions of the Settlement Agreement. Usually, these are the statewide self-monitoring tools, plus any other self-monitoring tools used by the department. o A list of data that the QAQI Council wants to see. In some facilities, these are called key indicators. o A list of data that the QA staff collect themselves. o Any other data that the QA department wishes to receive from the facility's many departments. o Any data that the discipline department heads determine are important to submit to the QA department. • All items on the QA matrix should also appear in the data list/inventory. QA Activities and Indicators QA staff spent their time collecting data implementing their department's own QA tools (there were seven), completing statewide self-assessment tools, primarily to assess interobserver agreement, and participating on various committees and in meetings. The department's own QA tools were for topics resulting from QAQI direction (i.e., at risk, environmental), current POCs from ICFMR reviews (i.e., orders, weights), and completed POCs from ICFMR reviews that the facility decided to continue (knowledge of ANE, ANE documentation, knowledge of lifts). To conduct IOA on department statewide self-monitoring tools, each QA staff member was assigned to a set of Settlement Agreement provisions. If a department, in the future, was to modify or change what tool it used, the QA staff planned to use the modified/new tool and continue to conduct IOA. Sometimes, departments did not conduct an implementation of their own self-assessment, even if the QA staff competed an IOA. If the	

#	Provision	Assessment of Status	Compliance
		QA staff member found anything of note, he or she reported it to the department head. Across the facility, a great deal of time was devoted to the implementation of the statewide Settlement Agreement provision self-monitoring tools. The DADS state office had recently given new direction to the facilities regarding these tools. The monitoring team's understanding was now that each facility could choose to use the current statewide tools, modify the current tools, or develop new tools. Thus, Settlement Agreement self-monitoring tools could become facility-specific. State office approval was not required, however, the facility department head was supposed to collaborate with his or her state office discipline coordinator. Further, state office did not require the facility to have any specific type of facility-level review and approval process, other than the involvement of QAQI Council. On the other hand, it seemed that the state office discipline coordinator could require the facilities to all use the same tool. At the time of this review, LSSLC had made its own section F tool to replace the state tool, was working on its own section S tool to replace the state tool, and was working on a section J tool because no state tool existed. The facility was reported to have begun working on tools for sections O, P, and R, but was directed by the state discipline coordinator to wait for new statewide tools instead. Similarly, a section T tool was being drafted by the statewide discipline coordinator. In addition, the statewide discipline coordinator for psychology met with the monitoring team and the LSSLC director of psychology during the week of the onsite review for discussion of the statewide section K tool and considerations as they move forward in developing a new tool or set of tools for section K. Self-monitoring tools can be very helpful if done correctly and if they direct managers to important areas and activities. That is, the content needs to be valid and needs to line up with what the monitoring team is assessing. Thus, the self-monitoring tools should become an important part of the self-assessment process for each provision. It may be that a well-designed and comprehensive self-monitoring tool <u>is</u> the self-assessment, or it may turn out that self-monitoring tool is but one of a number of sources of data and information that the department uses in self-assessing its substantial compliance with each provision item. The monitoring team has commented on the facility's self-assessment of each Settlement Agreement provision at the beginning of each section of this report. There are some important considerations as the statewide tools are revised: • Again, the content of the tools should be relevant and valid. • Some items in each tool may be more important than others. These should be indicated.	

#	Provision	Assessment of Status	Compliance
		• Consideration should be given to the frequency of completion of each tool. Some might only need to be completed periodically. o It is possible to do too much monitoring, especially if it competes with the completion of other duties and responsibilities and/or if the additional monitoring does not provide any additional information. • Attend to duplication of efforts, such as two observers collecting information when it might have been done by one observer. For example, at an ISP meeting during the week of the onsite review, both the post move monitor and a QA staff member completed similar observation tools during the same meeting. As discussed in previous reviews, a variety of satisfaction measures are important indicators to include in a comprehensive QA program. Family and LAR satisfaction information was collected since the last onsite review. There were 79 respondents and, overall, they were satisfied with the services and supports at LSSLC. The Consumer and Family Relations Director did a nice job of gathering and summarizing the data. He had graphed the results by each of the last six months and did a cumulative graph after q request from the monitoring team. Also, he presented the results periodically at QAQI Council and at the LSSLC Family Council. This was all good to see. Going forward, the data should be incorporated into the QA program (e.g., QA matrix), and he should document follow-up to any concerns identified in the data and/or in the two open-ended questions at the end of the survey. In addition, the monitoring team has three other suggestions. First, the six month cumulative data could also be sorted by cluster area. Second, a small sample of families could be called on the telephone to gather satisfaction data in another format. Third, there were many positive comments in these surveys. Perhaps some can be shared with staff in the seasonal facility staff newsletter. There were no measures of individual satisfaction. One way to obtain some of this information might via self-advocacy committee and/or the weekly individual home meetings. Each home held a weekly home meeting, but these were for staff. Important information was covered, and good notes were kept, but there were no other meetings or gatherings for individuals to address problems, make group decisions, etc. This might not be appropriate for all homes, but certainly for many of them. Satisfaction measures should also extend to staff, and others in the community with whom the facility interacted, such as restaurants, stores, community providers, medical centers, and so forth. The QA director should figure out a simple way to include satisfaction data in the QA data listing and QA matrix.	

#	Provision	Assessment of Status	Compliance
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	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. The activities that are relevant to this provision item are the facility's management and analysis of data, the QA report, the QAQI Council, the use of performance improvement activities, and the management of corrective actions and corrective action plans. Progress was seen at LSSLC. <u>QA Data Management and Analysis</u> The data that come into the QA department (i.e., the items on the QA matrix) need to be reviewed by the QA department (probably primarily by the QA director) <u>and</u> they need to be summarized. This was not yet occurring. Summarizing of data is typically done in the form of a graph or a table. Most typical, and most useful, will be a graph. The importance of QA department review of data plays a very important role in the QA process. For example, QA department review of medical data might have identified the increase in hospitalizations and the decreasing average age of death (section L) as well as rates of dental refusals (section Q). 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. A proper graph takes time to initially create, but after that, only requires an additional data point to be added each month, quarter, etc. Note that 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 data and graphic summaries each month. Many of these graphs can be inserted into the QA report and be presented to QAQI Council. But to reiterate, the QA department should be managing all of the data on the QA matrix of which some, but not necessarily all, will end up in the QA report. No data sets were presented to the monitoring team other than the QA report. <u>QA Report</u> One of the areas of progress in QA at LSSLC was the development of a monthly QA report. The report was begun in November 2011 and had evolved into a longer document with lots of data included. Tabitha Anastasi was the QA staff member who had taken on most of the responsibility for putting together this report. She had done a very good job in getting the report up and running and had committed a considerable amount of time into making graphs, formatting pages, and creating the document. Ms. Anastasi and the other QA staff were eager for feedback and commentary on their report and requested that the	Noncompliance

#	Provision	Assessment of Status	Compliance
		monitoring team do so in detail in this report. It is provided below. Comments are based upon the April 2012 report because it was a culmination of the efforts represented in the five reports that preceded it. • It is very important to make the report easily consumable by those who will be required to read it. Think about the reader at all times. For example, consistency and simplicity in graphic presentations are crucial. • Ms. Anastasi should include in the QA report what is most important for the readers of the report to know. This should be determined by the QA department/QA director, with input from the facility's department and discipline heads, and from the QAQI Council. It is not necessary for the report to include every piece of data that is in the QA matrix. • The report should be divided into sections (i.e., a table of contents). One possible way to organize the report is as follows: Settlement Agreement provisions (all 20 provisions, this will be the largest section of the QA report), QAQI Council key indicators, DADS regulatory ICFMR information, FSPI information, PIT update, and CAPs update. The data list/inventory and the QA matrix (described above in E1) may help Ms. Anastasi in making the table of contents. The April 2012 report was comprised solely of the 20 provisions of the Settlement Agreement. o The monitoring team believes that the facility would benefit from direction from the state office QA coordinator regarding minimum standards, outline/table of contents, graph formats, and so forth. • Within each Settlement Agreement provision subsection, there should be two graphs of data from the self-monitoring tools. One graph should show the detailed data for the current month and a second graph should have a single data point for the current month in a line graph showing trending from month to month. o In the April 2012 report, a monthly detailed data graph was presented for <u>each</u> of the past five months. This took up too much space and distracted the reader. Only the current month should be in the report. o In this report, there was a month-to-month trend line graph, however, it also included IOA data lines on the same graph. The lines ran over one another and made the graph cluttered. IOA data do not need to be graphed. Instead, they can be simply reported in a sentence or two, such as, "There were 12 IOAs conducted this month and the overall percentage of agreement was 92%. Areas of disagreement were XYZ and were resolved in the following manner…" o The "Overall Compliance" bar graph was a duplication of the line graph and, therefore, was not needed and could be deleted.	

#	Provision	Assessment of Status	Compliance
		• Within each Settlement Agreement provision subsection, the QA report needs to include other data from the QA matrix that are relevant to that provision (and that are of interest to the reader). For example, the section on restraints should not only include data on the self-monitoring tools, but data on the actual use of restraint. Similarly, the section on incident management should include data on number of incidents, ANE cases, and so forth. • Section F had a subsection called Analysis and Summary. This was good to see and should be in all subsections, that is, a paragraph (or two at the most) that helps to explain that month's data. • The vertical graph ordinates should not be more than 100%. • Corrective actions don't need to be in each subsection. In the April 2012 report, they took up space and did not provide any valuable information to the reader. The only CAPs that should be in the QA report are the more major CAPs, that is, the ones that are formed and managed by the QAQI Council. • For section F, there were 12 pages of graphs of engagement data. There were two graphs for every home, one for the 6-2 shift and one for the 2-10 shift. Further, all of the many variations of engagement were graphed separately. The monitoring team recommends that Ms. Anastasi instead make a simple line graph that summarizes all of the desired types of data into a monthly total for each home from month to month. This is more likely to be what QAQI Council and the reader would want to see. The more detailed data could be used by unit directors and house managers. • Section E included graphs of various measures for 27 pages. Ms. Anastasi should determine which of these data would be of interest to the reader. Some of the data might make more sense to be included within one of the other Settlement Agreement provision subsections. • Three provision subsections had some narrative, but this information was not presented in a clear manner, consistent with other subsections (subsections M, T, and U). • Five of the provision subsections varied in format. Some included data on specific individuals. Narrative descriptions in these subsections of aspects of data of specific individuals were not of much interest to the reader (subsections O, P, Q, R, and V). • For seven of the 20 provision subsections, there wasn't much data. This was the case for sections G, H, I, J, L, N, and S. Section I, however, included data that the QA staff collected regarding the at-risk knowledge of staff. • The interim QA director reported that April 2012 was the first month in which they were looking at all of the "no" findings for all statewide self-monitoring tools. This was good to see. The information, however, needs to be presented in a more understandable manner.	

#	Provision	Assessment of Status	Compliance
		QA-Related Meetings • QAQI Council: This meeting plays an important role in the QA program and is to be led by the facility director. Since the last onsite review, the QAQI Council met regularly. The facility director reported that she now planned to get back onto a regular schedule of reviewing a portion of the provision items at each meeting. The facility director should consider having the QA staff member who is assigned to specific Settlement Agreement provisions attend the QAQI Council meeting when his or her provisions are discussed. • The monitoring team reviewed the minutes from previous QAQI Council meetings and attended a meeting during the week of the onsite review. Overall, there appeared to be good attendance and participation. Important topics were raised. As is often the case, there was more discussion and participation when there were data that were presented. It was clear that the facility director and some of the participants had reviewed the QA report prior to the meeting because they had questions or comments about specific graphs or data sets. Corrective Actions and Performance Improvement Teams LSSLC had six Corrective Action Plans (CAP) and four Performance Improvement Teams (PIT). PITs were also known as work groups. CAPs were managed by the QAQI Council and PITs were directly managed by the facility director. It was good that the facility was working in a systematic way to address a variety of problems and needs and, as a result of these activities, improvements were made at the facility. Four of the six CAPs addressed the problems of four different specific individuals, one CAP addressed a staff training need, and the sixth CAP addressed improving engagement and activities. PITs addressed the submission of assessments, evaluations of individuals who were enterally fed, and language supports. Each CAP had a spreadsheet with numerous columns, but there was no report indicating status from month to month or how the requirements of E3, E4, and E5 were met. Status of PITs were included in the QAQI Council minutes. It seemed to the monitoring team that each of these 10 activities could have been classified as either a CAP or a PIT. The facility needs to clarify the difference between a PIT and a CAP. As the new QA director moves forward in improving the CAPs system to meet the requirements of this provision item, as well as E3, E4, and E5, she should also: • Clearly indicate, perhaps in the QA plan: o How a determination is made for there to be corrective action, o How the determination is made as to whether that corrective action will require a formal CAP,	

#	Provision	Assessment of Status	Compliance
		o The role of QAQI Council in the management of a CAP, and o The role of the QA department in the management of a CAP. • Ensure that the expected outcomes are written in a clear and measureable manner that is related to the reason for there to have been a CAP. For example, some of the expected outcomes only referred to an increase in scores on the statewide self-monitoring tool. • Have documentation describing the progress of CAP dissemination, implementation, and modification. • When a CAP is concluded, write a summary description of the status of the issue that led to need for the CAP.	
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. Make an appropriate facility-specific policy that correctly reflects the January 2012 state policy (E1).
2. Provide training to QA staff, and senior management and clinical staff on the new state policy and any QA-related facility-specific policies. Training should involve more than the reading of the policies (E1).
3. Implement the statewide discipline QAQI committees, as per the new state policy (E1).
4. Consider whether the state policy might need any updates or revisions (E1).
5. Develop an adequate self-monitoring tool for section E (E1).

6. Ensure that the new QA director gets support from the facility director and central office quality assurance coordinator; possibly mentoring from another experienced QA director (if deemed appropriate to do so by the central office quality assurance coordinator and the LSSLC facility director; and collaboration from the SAC (E1).

7. Include professional development activities for QA staff during the QA staff meetings (E1).

8. Complete the comprehensive listing/inventory of all data collected at LSSLC. Consider using the electronic format developed at San Angelo SSLC and Mexia SSLC (E1).

9. Make an appropriate QA plan, with a narrative as described in E1 (E1).

10. Make sure the QA matrix is complete, correct, and comprehensive. Ensure that it lists the data that will be coming in to the QA department (E1).

11. Determine how to best use the statewide self-monitoring tools and whether/how to update their content. Consider the monitoring team's many comments in E1 (E1).

12. Make additions and improvements to the family survey data as described in E1 (E1).

13. Include a range of other satisfaction measures in the QA program (i.e., individuals, staff, and related community businesses) (E1).

14. Consider having periodic peer home meetings for individuals during which the staff can address skills, such as group decision making and group problem solving, in those homes where this would be appropriate to do so (E1).

15. Review and summarize (e.g., graph) all data in the QA matrix (E2).

16. Consider the many bulleted comments and suggestions provided by the monitoring team in E2 regarding the QA report (E2).

17. Review a portion of the Settlement Agreement provisions during each QAQI Council meeting (E2).

18. Create a brief written description of how CAPs are chosen and managed, including the difference between a CAP and a PIT (E2).

19. Manage CAPs in the way required by E2 through 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 Supported Visions: Personal Support Planning Curriculum o DADS Policy #004: Personal Support Plan Process o DADS Procedure: Personal Focus Assessment dated 9/7/11 o LSSLC Self-Assessment o LSSLC Section F Presentation Book o A sample of completed Section F audits done by LSSLC o ISP, ISP Addendums, Assessments, PFAs, SAPs, Risk Rating Forms with Action Plans, Quarterly Reviews (for some individuals in the sample) for the following Individuals: • Individual #290, Individual #430, Individual #238, Individual #156, Individual #170, Individual #242, Individual #166, Individual #167, Individual #322, Individual #494, Individual #136, Individual #139, Individual #119, and Individual #567. <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, and in homes and day programs; o Sylvia Middlebrook, Director of Psychology o Luz Carver, QDDP Coordinator o Mike Ramsey, Incident Management Coordinator o Mary Bowers, CNE <u>Observations Conducted</u>: o Observations at residences and day programs o Castle Pine Morning Unit Meeting 5/2/12 o Incident Management Review Team Meeting 5/2/11 and 5/4/11 o Annual ISP meetings for Individual #252 o QDDP meeting 5/3/12 o Human Rights Committee Meeting 5/2/12 o Restraint Reduction Committee Meeting 5/2/12 o ISPA for Individual #191 following a serious injury

	Facility Self-Assessment: LSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from another document that listed all of the action plans for each provision of the Settlement Agreement. 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 and the facility was waiting for further guidance from the state office. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was a positive development in the facility self-assessment process. The "activities engaged in" section of the self-assessment noted use of the section F monitoring tool for most provisions in section F. The results of the self-assessment section gave a brief description of the sample size and a compliance percentage. The list of activities engaged in by the facility for many provisions was not as comprehensive as activities reviewed by the monitoring team to assess compliance. The QDDP Coordinator acknowledged that the section F monitoring tool alone would not be a sufficient measure of adequacy for each provision item. She was working in conjunction with the QA Department to develop additional tools and methods for assessing compliance in a number of areas. To take this process forward, the monitoring team recommends that the QDDP Coordinator continue to review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead the QDDP Coordinator to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." Then, the activities engaged in to conduct the self-assessment, the assessment results, and the action plan components are more likely to line up with each other. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the QDDP Coordinator. This was positive progress. The facility assigned a substantial compliance rating to F1e, F2a4, and F2a6. Although the monitoring team noted progress towards meeting substantial compliance with each of these provision items, processes to address these items were not yet consistently implemented in the ISPs. As noted in each of these sections, there were compliance concerns not yet addressed by the facility. For example, the facility found substantial compliance with F1e based on the fact that all teams were discussing community living options during the annual ISP meeting. The facility self-assessment did not address the quality of this discussion or note other requirements of this provision item. For example, teams were not adequately addressing provision of day habilitation services in the least restrictive environment. The monitoring team did agree with the facility's noncompliance rating for all other items in section F.

	Summary of Monitor's Assessment: DADS had recently initiated a thorough review of the ISP process and hired a set of consultants to help the SSLCs move forward in ISP development and the meeting of this provision's requirements. The facility reported that the ISPs for 146 individuals were done in the new format. LSSLC, however, had not yet received additional technical assistance from consultants. In meetings observed during the review week, the QDDPs were attempting to ensure that all necessary information was covered during the IDT meeting. The risk discussion had been moved to the annual ISP meeting, but was not an integrated part of the meeting. Teams were not adequately addressing guardianship and consent, community integration, or placement options. There was some progress being made on developing plans that would lead to a more meaningful day for individuals. IDTs were still building plans around programming that was available at the facility rather than looking at what each individual may need or want. There had been a focus on providing more meaningful active treatment in both the day habilitation and residential programs. Active Treatment Coordinators had been assigned to each program to assist staff in developing and implementing programming. During the onsite visit, it was evident that active treatment staff were out monitoring and providing technical assistance as needed. The monitoring team observed some great examples of individualized, functional active treatment, however, this was not occurring consistently throughout all day programs and residences. The facility needs to continue to focus on developing programming in response to preferences and individualized support needs. The QDDP Coordinator indicated that in recent months, a shortage of QDDPs due to vacant positions and staff on leave contributed to a delay in plan development and was a significant barrier to timely follow-up on issues identified by IDTs. QDDPs were understandably frustrated with the constantly changing ISP format. 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 ISPs were in the initial stages of development. The facility had begun to use state developed audit tools to review both meeting facilitation and the ISP 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 IDT.

	The ISPs that were reviewed were chosen from among the most recently developed ISPs. The sample included plans for individuals who lived in a variety of residences on campus. Therefore, a variety of QDDPs and IDTs had been responsible for the development of the plans. Many positive steps had been taken towards the development and implementation of person centered plans. It was evident that the facility had noted the many concerns expressed during the previous monitoring visit and attempts were being made to address those concerns. Additional training and guidance by the state office on the new ISP process will be crucial to the facility's ability to move forward.

#	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.	Progress had been made with regard to the facilitation of ISPs by one person from the team who ensured that members of the team participated in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports. Positive steps taken by the facility included: • The QDDP Coordinator continued to attend a sample of IDT meetings to evaluate the QDDP's facilitation skills using the Q Construction QMRP Facilitation Skills Performance Tool. • The QDDP Coordinator audited a small sample of quarterly reviews to determine if treatments, services, and supports were revised when appropriate. According to the facility self-assessment, this sample was too small to determine overall compliance. Assessing facilitation was still a new process for the QDDP coordinator, but should be an effective tool for evaluating the facilitation skills of each QDDP and focusing training efforts where most needed. The facilitation tool used to assess compliance rated: • The QDDP's knowledge, preparedness, and whether he/she could demonstrate inclusiveness and assertiveness, • The QDDP's ability to solicit information using the ISP prompts, and • The QDDP's ability to guide team members through the ISP process. During the week of the review, the monitoring team observed a number of team meetings. Progress definitely continued to occur with regard to the facilitation of meetings. One meeting observed was facilitated by a new QDDP. An experienced QDDP had been assigned to assist her with the meeting. A second meeting observed was	Noncompliance

#	Provision	Assessment of Status	Compliance
		facilitated by a QDDP not assigned to the individual. His QDDP was on leave. The QDDP assigned to facilitate the meeting did an excellent job of coordinating discussion among team members who knew the individual best. Based on these observations and a review of ISPs, some of the areas in which progress had begun included: ▪ Efforts were made to include the individual and focus the discussion on him/her. ▪ More efforts were made than in the past to elicit information from all team members. However, not all team members participated to the extent they should have. • Although not consistent, there was an increase in the use of specific clinical data to support risk ratings. • Efforts had been made to try to reduce the length of ISP annual meetings, while covering important content. Based on the meetings observed, QDDPs appeared to have come prepared, and the documents, such as a draft Integrated Risk Rating Form and a draft ISP format, appeared to provide team members with some relevant information and assist teams to remain focused. It was positive that the facility had focused on making better use of teams' time. A sample of IDT attendance sheets was reviewed for presence of the QDDP at the annual IDT meeting. The attendance sign-in sheet for Individual #494 did not include the QDDP's signature. It was not clear who facilitated the meeting in her absence. Based on review of ISPs as well as during observations of meetings held the week of the onsite review, facilitation of team meetings was improving, but it was not yet resulting in the adequate assessment of individuals, and the development, monitoring, and revision of adequate treatments, supports, and services. While progress had been made in towards meeting substantial compliance, it will be important for the QDDPs 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. The facility remained out of compliance with this provision item.	
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	DADS Policy #004 described the Individual Support Team as including the individual, the Legally Authorized Representative (LAR), if any, the QDDP, direct support professionals, and persons identified in the Personal Focus Meeting, as well as professionals dictated by the individual's strengths, needs, and preferences. According to the state office policy, the Personal Focus Assessment (PFA) was the document that should have identified the team composition based on the individual's preferences, strengths, and needs. The facility had begun to track data on attendance at IDT meetings. It was not clear that	Noncompliance

#	Provision	Assessment of Status	Compliance
	supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	consideration was given to who should be in attendance at the meeting in the data collected by the QDDPs. Overall, data showed an attendance rating of 34% Five ISPs in the sample included attendance sheets. The sample was reviewed with the following results in terms of appropriate team representation at annual IDT meetings. The sample was Individual #156, Individual #136, Individual #322, Individual #290, and Individual #494. Two (40%) of five indicated that the individual attended the meeting; • The exceptions were Individual #322, Individual #494, and Individual #290. Only one of the individuals in the sample had a guardian. The guardian was in attendance at the meeting. The primary correspondent participated in one other ISP meeting. Family members participated in Individual #136's ISP meeting by teleconference. 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 and brainstorm ways to encourage participation. A review of signature sheets for participation of relevant team members at the annual IDT meeting indicated that none (0%) of the meetings were held with <u>all</u> relevant staff in attendance. There had not been progress made in ensuring participation of key team members in the planning process. Without the presence of key team members in attendance at meetings, there cannot be adequate discussion regarding risk areas and planning for comprehensive, integrated treatment and supports. Some examples where team participation was not found to be adequate were: • A review of the attendance sheet for Individual #156 indicated that communication staff, her dietician, occupational therapist, physical therapist, home supervisor, and day habilitation staff were not present. She had complex mobility, communication, and nutritional needs. Professional staff should have been in attendance to contribute their expertise in developing appropriate supports to address her identified risks and ensure adequate programming and supports were in place. • Individual #290 was at risk for weight concern, diabetes, oral hygiene, and choking. He was on an ADA diet and had both a mealtime plan and an oral hygiene plan. His ISP indicated that he was unable to express his preferences.	

#	Provision	Assessment of Status	Compliance
		Key team members that did not attend his annual ISP meeting included the dietician, occupational therapist, communication specialist, dentist, residential DSPs, and day habilitation staff. • Individual #494's physician was not present at his annual IDT meeting. He had unresolved healthcare issues regarding his weight loss and a hiatal hernia. He had multiple infections over the last year, including two instances of MRSA. His lab work was abnormal and he had not received a colonoscopy recommended by a specialist. His nursing assessment indicated that he was at risk for activity intolerance related to chronic pain, fatigue, or weakness. His physician should have been in attendance to advise the team on providing needed medical care. Dental staff were not present, though he was noted to have chronic periodontal disease at this last dental assessment. His dietician was not present. He was on a low cholesterol diet, had an unplanned weight loss, and took multiple medications that could affect his nutritional status. The absence of key members was a significant barrier to integration in the development of ISPs. 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. The facility had recently moved all ISP meetings to the same time every day in the afternoon to help increase attendance. The self-assessment indicated that the facility was not yet in compliance with requirements for integrated team participation. The monitoring team agreed.	
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.	DADS Policy #004 defined "assessment" to include identification of the individual's strengths, weaknesses, preferences and needs, as well as recommendations to achieve his/her goals, and overcome obstacles to community integration. Steps the facility had taken to improve the assessment process used for planning included: • The facility was using a database to track submission of assessments prior to the annual ISP meeting. • Change of status for individuals was being identified in the daily unit meetings. According to the facility self-assessment, the QDDP Coordinator had begun to gather data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. Data collected for November 2011 through March 2012 showed an 85% compliance rate with the requirement that assessments be submitted at least 10 days	Noncompliance

#	Provision	Assessment of Status	Compliance
		prior to the annual IDT meeting. Details were not given regarding whether or not the other assessments were submitted late or not at all. The monitoring team found the quality and timeliness 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 ISP, 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 individual, such as goals, interests, likes/dislikes, achievements, and lifestyle preferences. In the ISPs reviewed, the PFA was used to develop a list of priorities and preferences for inclusion in the annual ISP. The PFA format had been revised 9/7/11. The facility had begun using the new PFA assessment. PFAs were to be completed at the third quarterly meeting prior to the annual IDT meeting. PFAs were only found for three of 10 individuals in the sample. Only one (Individual #290) of the three had been completed the quarter prior to the annual ISP meeting. PFAs were completed the month prior to the ISP meeting for Individual #156 and Individual #136. The PFA process was reviewed for the three individuals that had a PFA. Teams were not adequately completing the assessment in a way that would make it a useful guide for determining preferences and priorities or the need for further assessment. For example, the PFA for Individual #136 included the following statement under Work Activities "physically unable to work." The section titled Other Club/Group Activities noted "not physically able to join group or club." Similarly, those two sections were marked as N/A for Individual #290 and Individual #156. The summary and identification of needed assessments section was not completed in any of the PFAs. Ten ISPs developed after 1/1/12 were reviewed to determine if the list of preferences was adequate for planning. The following are comments regarding those ISPs. • Progress had been made towards developing a list of individualized preferences for each individual in the sample. None were as comprehensive as they needed to be to provide the team with enough information for individualized planning, but all offered a good starting point for discussion. • None described preferences for daily schedules. Given the high number of self-	

#	Provision	Assessment of Status	Compliance
		injurious behaviors and aggressions towards others at the facility, this type of information would be critical for support staff to know. Structuring an individual's day and environment to encourage participation often relies on information such as: o Does the individual like to wake up early or sleep in? o Does he/she like quiet time in the morning? Or need quiet time after work to wind down? o Does he/she need coffee in the morning before getting dressed? o Does the individual prefer to shower/bathe in the morning or evening? o Is he/she more productive at work in the morning or afternoon? o Does the individual prefer to spend time alone in the evenings or socialize with friends? o Does the individual prefer assistance from particular staff members? Information gathered from the PFA was discussed in the IDT meetings observed. Each QDDP reviewed the individual's list of preferences and members of the team engaged in discussion on how these might be supported. Teams should use this list of preferences to brainstorm ways individuals might gain greater exposure to new activities that might be of interest. Consideration of outcomes was limited based on activities available at the facility. Outcomes should be considered that might lead to greater exposure to the community. The facility was using the Functional Skills Assessment (FSA) to assess each individual's functional skills. The FSA will not be beneficial to teams if it becomes a rote checklist to be completed annually. Staff completing the assessment will need to put thought into information gathered from the assessment and make recommendations that will assist the team in planning. FSAs were reviewed for Individual #136, Individual #567, Individual #156, and Individual #290. None of the FSA assessments in this sample included specific recommendations for training. Staff were completing the checklist, but not using it to develop individualized recommendations from the results. The facility rated F1c as not in compliance based on the timely submission of assessments. The self-assessment did not look at the adequacy of assessments submitted. All team members will need to ensure assessments are completed, updated when necessary, and accessible to all team members prior to the IDT meeting to facilitate adequate planning. Assessments should result in recommendations for support needs when applicable. The facility was not in compliance with this item.	

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F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	Little progress had been made in ensuring that assessment results were used to develop, implement, and revise the ISP. QDDPs continued to "cut and paste" information from assessments into the ISP making it difficult for direct support staff to understand what supports should be implemented. PNMP and psychiatric assessment recommendations were not clearly specified in any of the plans in the sample. There was little evidence that assessment results were discussed by the team and integrated into a comprehensive plan with clear instructions for staff providing daily supports. For example, • Individual #170's ISP indicated that the IDT discussed and agreed to continue his HMP for seizures, oral hygiene and hyperlipidemia/hypotension. There was no additional information included in his ISP regarding what staff should monitor or what specific supports may be needed to address these health issues. His nursing assessment noted a number of medication and medical appointment refusals. His IDT did not address this issue in his ISP. • Individual #290's ISP stated that the IDT reviewed and approved his PNMP, but gave no details of any recommendations or supports included in the plan. His nutritional assessment indicated that his diet should change to a 1200 calorie ADA diabetic diet. The team agreed but specific recommendations or even the reason for the change was included in his plan. It was not evident in the sample reviewed that assessments were always used to revise protections and supports, as necessary. For example: • Individual #410's medical assessment recommended consideration of a medical desensitization plan prior to diagnostic procedures and consult. The ISP did not document discussion regarding a desensitization plan. A review of his injuries over the past year showed 32 injuries. Most of the injuries were attributed to self-injurious behaviors and aggression from peers. His ISP noted that he had a PBSP in place that was "somewhat effective." There was no discussion regarding modifying his supports in an attempt to reduce his injuries. • Individual #430's nursing assessment noted that he had 44 falls over the past year. An assessment by an orientation and mobility specialist was obtained. The ISP did not address his high number of falls or include recommendations from the mobility specialist or the PNMT. The ISPs in the sample dated after 2/1/12 included a better description of how the individuals were spending their day, but stopped short of describing what supports and interventions should be provided. For example, the ISP for Individual #290 described his typical schedule and how his preferences were incorporated into his week. His medical assessment noted that he had vision impairment, hearing impairment, sleep apnea, and several other current diagnoses that might need monitoring or require specific supports throughout the day. This information was not clearly stated in his ISP. For example, it	Noncompliance

#	Provision	Assessment of Status	Compliance
		was not clear what supports he might need to get from his home to his day program or what supports he might need at mealtime or during personal hygiene activities. The facility was not yet in compliance with this item. QDDPs will need to ensure that all relevant assessments are completed prior to the annual ISP meeting and information from assessments is used to develop plans that integrate all supports and services needed by the individual. Plans should be clear and easy to follow for all non-clinical staff responsible for providing daily supports.	
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).	DADS Policy #004: Personal Supported Plan Process dated 7/30/10 mandated that Living Options discussions would take place during each individual's initial and annual ISP meeting, at minimum. A sample of 10 ISPs was reviewed for indication that individuals and/or their LARs were offered information regarding community placement, as required. The 10 ISPs were for Individual #139, Individual #156, Individual #290, Individual #494, Individual #136, Individual #170, Individual #167, Individual #238, Individual #410, and Individual #166. • In 10 (100%) this discussion took place at the annual IDT meeting. As evidenced by the summary below, this discussion, however, was not always adequate (also see section T of this report). • The ISP for Individual #167 summarized the most integrated setting discussion by stating that the IDT agreed that with the right supports, he could be successful in a less restrictive environment, however, he was unable to indicate that he understood the living options process. The decision was made that he should remain at LSSLC. There were no outcomes developed to further educate or expose him to alternate living options. • The ISP for Individual #156 indicated that she had been on community placement visit and showed enjoyment and interest. Additionally, she enjoyed community outings and preferred a smaller quiet living environment. The team did not list any obstacles other than her sister's preference that she remain at LSSLC. This information was relayed by the sister to the LA after numerous unsuccessful attempts had been made to reach her sister. The ISP noted that she had lived at the facility for 46 years and had no previous visits or contact with her family. The team should attempt to provide further information about specific supports available in the community to the family and include them in the team's discussion regarding community living.	Noncompliance

#	Provision	Assessment of Status	Compliance
		There were some common themes among the discussion and determination of most integrated setting placement and programming in the ISPs reviewed: • Community integration and employment were still not adequately being addressed. • Measurable action plans with reasonable timelines for completion were not developed when IDTs agreed that placement in a least restrictive environment would be an appropriate consideration. • Measurable outcomes to address community awareness were not developed when teams identified a lack of awareness regarding placement options. IDTs need to give consideration to the following: • The primary focus of all IDTs 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. The facility's self-assessment indicated that a SAP peer review group had been established at the facility and was assisting teams to develop plans that focused on community integration. This process was very new and it was not yet evident that recommendations from the workgroup were helping teams to develop more meaningful plans. For example, in one of the more recent plans developed for Individual #156 (1/12/12), only one outcome specifically addressed training in the community and it was more of a general statement than a functional outcome to achieve a desired objective. The outcome stated "to be given opportunities to go on van rides and community outings at least one time monthly" (see section S3b). Plans included limited opportunities for community based training. No plans included opportunities to develop relationships and gain membership in the community. Although it was evident that teams were attempting to include outcomes to ensure more frequent exposure to the community, outcomes were rarely written to ensure consistent implementation. Plans will need to include community based teaching strategies to ensure that training is functional, consistent, and measurable (see section S3b). The facility self-assessment determined that this item was in substantial compliance based on compliance with the requirement for each team to discuss community living options. Though, there was evidence of this discussion, it was not always adequate. Not only will teams need to look at living options, they will need to determine the least	

#	Provision	Assessment of Status	Compliance
		restrictive setting to provide day habilitation and other services. 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.	
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;	DADS Policy #004 at II.D.4 indicated that the Action Plans should be based on prioritized preferences, strengths, and needs. The policy further indicated that the "PST will clearly document these priorities; document their rationale for the prioritization, and how the service will support the individual." The ISPs in the sample 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. While this list was a good starting point, limited exposure to new activities meant that this list was often limited. As noted in F1c, lists of preferences did not include detailed information about what things are most important in regards to routine, environment, communication, relationships and other key areas. In order to meet substantial compliance requirements with F2a1, IDTs will need to identify each individual's preferences and address supports needed to assure those preferences are integrated into each individual's day. Plans developed after 1/1/12 were more comprehensive in describing how preferences would be supported, but again, not all preferences and needed supports were identified. Action steps were not included for many of the supports needed, so staff did not have clear direction for providing those supports. • The ISP for Individual #322 was a good example of a plan that offered guidance to DSPs on preferences and needed supports. The plan described in detail his daily schedule and his preferred routine.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Observation did not support that individuals were spending a majority of their day engaged in activities based on their preferences or that all supports were addressed in ISPs. For example, Individual #506 had a Dynavox that he used for communication at school. His ISP did not reference his Dynavox or include training at home to expand his ability to communicate when not at school. The facility was just beginning to focus on training in the community and community employment. Vocational staff were in the initial stages of offering opportunities for job exploration in the community as part of the vocational assessment process. This was a positive development. Four individuals were successfully employed in the community with varying levels of support services (three in supported individual placements, one in an enclave). While most plans included opportunities to take trips to the community, as well as minimal training opportunities in the community, plans did not include action steps to ensure 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. Some examples are noted above in F1e. The facility was not in compliance with this item.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	Examples of where measurable outcomes were not developed to meet specific health, behavioral, and therapy needs can be found throughout this report. ISPs 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. Specific behavioral indicators should be identified to determine successful implementation for all outcomes. For example: • Individual #410's ISP included an action step that stated "encourage consumption of fluids with meals and between meals." There was no instruction to staff for measuring fluid consumption, what type of fluids should be offered, or determining progress or lack of progress towards addressing his risk. He had an outcome to add use of a Dynavox for communication to his PNMP. There were no instructions for when or how the Dynavox should be used or how staff could provide training opportunities to increase his use of the Dynavox for communication. Another action step stated "will continue to have routine dental evaluations." The ISP should state what routine would consist of (e.g., annually, semiannually or quarterly)	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The risk action plan for Individual #290 did not include measurable indicators for DSPs to monitor. For example, his action step for weight stated "encourage physical activities." It was not clear what activities or how often staff should encourage activity. His risk for cardiac disease included monitoring by the nurse of his blood pressure and heart rate. There were no clinical indicators for the appropriate range. His oral hygiene was addressed with an action step that simply stated "brush teeth." There were no directions for staff to provide support to ensure that his teeth were adequately brushed. Many plans indicated that individuals would be "encouraged" to engage in an activity or would be "provided the opportunity" to engage in an activity. Action steps that refer to what the staff will do rather than what the individual will do cannot be measured in terms of progress towards a specific goal. Action steps should include specific behavioral indicators that would have to occur in order for support staff to indicate a successful attempt. This continued to be an area in which substantial effort was needed in order to comply with the requirements of the Settlement Agreement. The action plan section of the ISP was where measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports were to be detailed to attain identified outcomes related to each preference, meet needs, and overcome identified barriers to living in the most integrated setting appropriate to the individual's needs. The facility had placed considerable focus on developing action plans to address identified risks. Action plans related to individuals' risks were being developed as a separate document and were not fully integrated into the ISP. In reviewing the action plans that had been developed to address individuals' risk areas, adequate measurable clinical indicators generally were not included. This is discussed in detail in section I of this report. The lack of these clinical indicators resulted in teams not having a mechanism to measure whether the individual was progressing, declining, or remaining stable. 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 T1b1 for additional comments related to this requirement.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other	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 ISPs in the document request. These plans should be attached to the ISP and considered an integral part of the plan.	Noncompliance

#	Provision	Assessment of Status	Compliance
	interventions provided for the individual;	The facility self-assessment process found that assessments were not always submitted 10 days prior to the annual IDT meeting and available for review by team members. When developing the ISP 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. Assessments and recommendations will need to be available for review by the IDT prior to annual meetings.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	For the goals and objectives identified, ISPs described the timeframes for completion and the staff responsible. Completion dates were based on the date of the annual team meeting rather than the expected learning rate of the individual. Methods for implementation were not always adequate, as is discussed in further detail in section S below. The team should develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. Completion dates should correspond with each individual's rate of learning.	Noncompliance
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	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. Minimal functional learning opportunities were included in the ISPs in the sample. 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. There were constraints on training opportunities because individuals were living at a facility rather than in the community. 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	DADS Policy #004 specified at II.D.4.d that the plan should include direction regarding the type of data and frequency of collection required for monitoring of the plan. Generally, ISPs identified the person responsible for implementing service and training objectives and the frequency of implementation. ISPs also included a column to note where information should be recorded. Skill acquisition plans were developed for some action steps in the ISP with further detail for implementation, data collection, and review. As discussed above in section F2a2, many goals and objectives were not specified in individuals' ISPs, or other treatment plans that should have been integrated into the ISP (e.g., health management plans, PNMPs, psychiatric treatment plans). As a result, appropriate data were not being collected to assist teams in decision-making. Even when plans included objectives, such as those related to PBSPs, individuals' ISPs did not consistently identify the specific data to be collected, the frequency, and/or the persons responsible for reviewing data collected. The more recent ISPs included many more measurable training objectives, but still lacked measurable outcomes to monitor health and therapy related supports. Overall, the plans defined very little objective data that would be collected, reviewed, and used to make decisions regarding the efficacy of plans. The person responsible for review of data was not specified in current ISPs. 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.	Noncompliance
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 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. IDTs will need to work together to develop ISPs that coordinate all services and supports. Recommendations from various assessments should be integrated throughout the ISP. The facility did not have a process to ensure coordination of all components of the ISP.	Noncompliance

#	Provision	Assessment of Status	Compliance
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. Current ISPs were in place in all but one individual notebook. This was a significant improvement from the last monitoring visit. The facility self-assessment indicated that Active Treatment Coordinators (ATCs) were now monitoring individual notebooks to ensure current ISPs were accessible. Of 210 records audited by ATCs, 93% of the records contained a current ISP. The self-assessment noted that the facility was currently working to develop a tool to assess the comprehensibility of ISPs. It will be important to ensure that not only are plans comprehensible, but that staff are trained on the implementation of ISPs and competency based measures are included in training. As noted in F1d, ISPs did not always include staff instructions for support that were clear enough for DSPs to follow. Staff interviewed by the monitoring team were not consistently familiar with PBSPs, PNMPs, healthcare plans, and risk action plans. Some staff interviewed could not describe risks and interventions needed by individuals whom they were assigned to support. There had been a focus on educating DSPs on the significance of risk factors identified by the IDT. This was still a fairly new process, but should have a positive impact. As noted in F1c, it was not clear in most ISPs as to 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 separate plans existed that were not integrated into the one comprehensive plan. As the state continues to provide technical assistance in ISP 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.	Noncompliance
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible	A review of records indicated that the IDT routinely met to discuss significant changes in an individual's status, particularly regarding healthcare and behavioral issues, however, 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. There was no indication that all supports were reviewed at least monthly. The facility had a quarterly review process in place. The review form had a method for graphing data for specific SAPs. Without narrative detail, it was not possible to determine what specific progress or lack of progress was being made. It was not evident that the team considered modifying outcomes based on data collected. For example, • A quarterly review of training for Individual #567 dated 11/28/11 indicated	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	that he had mastered five of his objectives. The QDDP commented that no revisions were needed to the plan. • The November 2011 quarterly review for Individual #136 noted a new diagnosis of hyperkalemia during the previous quarter. Her nursing summary dated 1/31/12 noted that a new healthcare management plan (HMP) would be started for her diagnosis of hyperkalemia. Her ISP included an action step to address her potassium levels with a start date of 2/14/12. There was no indication that a HMP was developed to address the new diagnosis prior to that date. Her quarterly review noted lack of progress or regression on training objectives. There was detail regarding attempts at implementation and no recommendations to revise strategies that were not effective. • The quarterly reviews for Individual #242 dated 11/30/11 and 2/17/12 did not include any narrative comments on his response to implementation of training objectives. It was not possible to determine what data were being gathered, what specific progress had been made, or if training strategies needed to be modified. Data were being collected on his weight, but the quarterly review did not note his ideal weight range, making it difficult to determine if supports were adequately addressing his weight concerns. It was not evident that team members were using data collected to drive revisions in teaching strategies or supports. Monthly and quarterly reviews should address the lack of implementation, lack of progress, or need for revised supports. Follow-up on issues occurring during the month should be consistently 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 ISPs 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	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 ISP document. • A review of training transcripts for 24 employees indicated that 24 (100%) had completed the new training on ISP process entitled Supporting Visions. The facility was still waiting for additional training to be provided by the state office on further implementation of the new ISP format. QDDPs were utilizing the new format, but	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	had not yet been trained on the ISP development and risk identification processes. As evidenced by findings throughout this report, training on the implementation of plans was not ensuring that plans were being implemented as written. The facility was aware of deficits in the implementation of the ISP and was providing additional monitoring and training to direct support staff, particularly in terms of addressing risks. The facility's self-assessment indicated that training on specific plan implementation was not competency based. The facility self-rated the provision as being out of compliance with this requirement. The monitoring team agreed with that assessment.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	Of the ISPs in the sample reviewed, all (100%) had been developed within the past 365 days. The facility self-assessment indicated that out of the last 146 ISPs developed, 26 (18%) were not developed within the required timeframe. This trend was attributed to the fact that the facility currently only had 70% of the QDDP positions filled or active. The QDDP Coordinator noted that this was a serious barrier to ensuring that plans were developed and distributed in a timely manner. As noted in F2c, a sample of plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. Current plans were available in all individual notebooks in the sample except for one. This was a significant improvement since the last onsite visit. 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.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that	The facility was using its own self-created modified statewide section F audit tool to monitor requirements of section F. Other tools had been developed to measure timeliness of assessments, participation in meetings, facilitation skills and engagement. Quality enhancement activities with regards to ISPs were still in the initial stages of development and implementation (also see section E above). The facility had made some progress in this area. They had just begun to analyze findings and develop corrective	Noncompliance

#	Provision	Assessment of Status	Compliance
	the ISPs are developed and implemented consistent with the provisions of this section.	action plans.	

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 QDDPs 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. All team members will need to ensure assessments are completed, updated when necessary, and accessible to all team members prior to the IDT 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).

5. A description of each person's day along with needed supports identified by assessment should be included in ISPs. All supports and services should be integrated into one comprehensive plan (F1d).

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

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

8. IDTs 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).

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

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

11. Teams should develop meaningful, measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs. Specific behavioral indicators should be identified to determine successful attempts at outcomes. (F2a2)

12. IDTs 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).

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

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

15. 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).

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

17. QDDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow up on issues (F2d).

18. Develop a process to revise ISPs when there is lack of progress towards ISP outcomes or when outcomes are completed or no longer appropriate outside of schedule quarterly review meetings. 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).

19. Develop an effective quality assurance system for monitoring ISPs (F2g).

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 LSSLC Operational Procedures Manual, Medical 02, Integrated Clinical Services, 3/16/12 o LSSLC Facility Operational Procedures Manual Committee and Councils -12, Clinical Services Morning Meeting, 1/24/12 o LSSLC Section G Self-Assessment o LSSLC Section G Action Plan o LSSLC Sections G Presentation Book o Presentation materials from opening remarks made to the monitoring team o Organizational Charts o Review of records listed in other sections of this report o Daily Clinical Services Meeting Notes Interviews and Meetings Held: o Gale Wasson, Facility Director o Brian Carlin, MD, Medical Director o Mary Bowers, RN, Chief Nurse Executive o Frances Mason, RN, Medical Compliance Nurse 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 Dental Clinic o Psychiatry clinics o Morning medical meeting/clinical rounds
	Facility Self-Assessment: The facility submitted its self-assessment, an action plan, and a list of completed actions. For the self-assessment, the facility described for each of the two provision items, a series of activities engaged in to conduct the self -assessment, the results of the self-assessment and a self-rating. During the week of the onsite review, the monitoring team met with the facility staff to discuss the self-assessment and this provision. In moving forward, the monitoring team recommends that facility director and medical director both review this report. Most items will likely be executed by the medical director

	with the support of the facility director. For each provision item in this report, the medical director should note the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. Such actions may allow for development of a plan in which the assessment activities provide results that drive the next set of action steps. A typical self-assessment might describe the types of audits, record reviews, documents reviews, data reviews, observations, and interviews that were completed in addition to reporting the outcomes or findings of each activity or review. Thus, the self-rating of substantial compliance or noncompliance would be determined by the overall findings of the activities. The facility found itself in noncompliance with both provision items. The monitoring team agrees with the facility's self rating.
	Summary of Monitor's Assessment: The facility continued to make progress in this area. Several steps occurred, locally, in an effort to integrate clinical services. State office developed a draft procedure Minimum and Integrated Clinical Services to address the requirements of Provision G and Provision H. The final version of that policy had not been issued. The facility developed and implemented a local policy as well. The monitoring team had the opportunity to meet with the facility director, medical director, chief nurse executive, and medical compliance nurse to discuss integration activities at the facility. It was clear that this provision was taken seriously and, since the last onsite review, additional work had been done. It was also apparent that much work remained. Throughout the week of the review, the monitoring team encountered several good examples of integrated clinical services. Areas where integration was needed, but failed to be evident, were also noted. Continued work in this area is needed.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they	The facility director, who served as the lead for this provision, worked closely with the medical director on many issues. Two policies were developed. One addressed the daily clinical services meeting and the other addressed the overall provision of integrated clinical services. The Integrated Clinical Services operational procedure provided some guidance on the delivery of services, but was based on the initial draft from state office and will, therefore, need some revision. The procedure described many activities that already occurred in the facility. It essentially listed a series of actions and named the responsible parties. For example, it noted that the pharmacist documented that QDRRs were completed or the clinicians reviewed external consults. It did not describe how the activities helped to achieve integration.	Noncompliance

#	Provision	Assessment of Status	Compliance
	need.	The monitoring team reviewed local and state procedures, conducted interviews, completed observations of activities, and reviewed records and data to determine compliance with this provision item. During the conduct of this review, many examples of integration of clinical services were observed. There were also several instances in which integration needed to occur, but did not. The following are examples of integration that were noted: • Daily Clinical Services Meeting – The facility continued the daily 8:00 am clinical services meetings. The medical director facilitated these meetings, which were attended by multiple disciplines, including the medical staff, medical compliance nurse, QDDP coordinator, CNE, clinical pharmacist, the hospital liaison nurse, and RN case managers. Information regarding the past 24 hours was discussed, including hospitalizations, emergency room visits, campus calls, PNMT referrals, infirmary reports, etc. Also at this meeting, the LSSLC physicians reviewed various individuals' consultation reports and diagnostic tests. During this meeting, a decision was made regarding the need to refer the recommendations of the consultants to the IDTs. The QDDP Coordinator took notes and sent an email to the QDDPs when necessary. In addition, RN case managers were afforded opportunities to voice their concerns regarding individuals with significant changes in health needs/risks. The monitoring observed several meetings and noted that this was a good opportunity for integration of clinical services. • Clinical Pharmacy and Medical – The clinical pharmacist met with the primary providers when the QDRRs were completed rather than place the evaluations in the providers' mailboxes. This encouraged review by the providers and improved collaboration. Those meetings were informally observed during the week of the review. Due to changes in policy, many documents lacked signatures and did not reflect the collaboration and review. • Medical and Dental Desensitization Workgroup – Collaborative efforts between medical, dental, psychology, residential, and other disciplines continued and resulted in development of plans to overcome barriers to dental treatment for several individuals. • Dental and Habilitation – The habilitation department collaborated with the dental department on positioning individuals for clinic. The monitoring team was able to observe how the gauges supplied to the clinic by habilitation services were used to ensure that wheelchairs were positioned at the correct angles, thus minimizing the risk of aspiration. • Integration of psychology and psychiatry was improved. Integration of psychology and medical (around medical and dental desensitization) was improved. • Psychiatry clinic staff, (e.g., the psychiatric nurse and psychiatric assistant)	

#	Provision	Assessment of Status	Compliance
		attended meetings in lieu of a lead psychiatrist and attempted to keep the part time staff informed. This was a stopgap measure and not sufficient with regard to integration for psychiatry. During this visit, it was noted that the part time psychiatrists did attend other meetings if there was time in their daily schedule. This was not routine. Several areas offered great opportunities for improvement: • IDTs did not appropriately make referrals for assessment by the PNMT. A list of referral criteria was recently developed for IDT use and the monitoring team looks forward to reviewing the outcomes of that step. The PNMT did not include IDT members throughout the process of review at this time. The PNMT did not actually complete comprehensive assessments for individuals, but rather limited consultations for most individuals reviewed. PNMT members did, however, attend IDT ISPAs post-hospitalization and other changes in status of individuals they were reviewing. The PNMT nurse also conducted post-hospitalization assessments for individuals. • More improvement was necessary in the integration of psychology and communication around communication SAPs, and between psychology and DCPs and their supervisors. • Record reviews indicated some element of a lack of cooperation and/or response to information for some individuals who refused dental treatment. While individuals who reached the point of having SAPs developed benefitted from collaborative efforts, the monitoring team identified individuals for whom there appeared to be a lack of cooperative efforts between the IDTs and the dental clinic resulting in potential treatment delays. • The discussion and assessment of individuals' health risks during their ISPs and ISPAs was also a good opportunity for integration of clinical services, but this process continued to need improvement in order for it to more effectively and consistently ensure that individuals received the clinical services they needed.	
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	The facility recently made changes in how the consultation process was managed. All consults were reviewed at the clinical services meeting and a decision could be made regarding the need to refer the recommendations to the IDT for further discussion. This appeared to be a reasonable approach. The facility assessed itself by reviewing consult forms to ensure inclusion of referral of the recommendations to the IDT for integration with existing supports and services. It also reviewed a sample of minutes, consult forms, and integrated progress notes. The facility found that meeting minutes documented review of recommendations from consults that occurred. The QDDP Coordinator took notes in the logbook sent emails to	Noncompliance

#	Provision	Assessment of Status	Compliance
	IDT for integration with existing supports and services.	the individual's QDDP to inform them of the recommendations. There was not timely follow-up and integration with existing supports and services. The documentation in the integrated progress notes was often omitted and there was a failure to ensure timely follow-up as recommended in the consult. The compliance score for Question #27 (addresses IPN documentation of the consults) for Round 5 of the medical quality audit was approximately 72%. The monitoring team reviewed a sample of consults and corresponding IPNs to determine compliance with this provision item. A total of 35 consults completed after October 2011 were reviewed: • 25 of 35 (71%) consultations were summarized by the medical providers in the IPN o 17 of 25 (68%) consultations were documented in the IPN within five working days The monitoring team could not determine the overall number of consults forwarded to the IDT for review due to recent changes in the process. Further assessment will be done at the next review.	

Recommendations:

1. The facility director should review the most recent version of the state draft policy Minimum and Integrated Services (G1).
2. Consideration should be given to including in any local policy a requirement that all clinical departments develop a statement of their integration philosophy, describing how the department approaches integration with other key clinical areas. (G1).
3. The facility needs to develop a system to assess if integration of clinical services is actually occurring. This will require creating measurable actions and outcomes (G1).
4. The facility needs a mechanism to track all consultations and appointments for diagnostics. Consideration should be given to using a format that will allow sorting by multiple fields including specialty, individual, appointment date, and PCP (G2).
5. State Office will need to address the use of the current external audit criteria (questions 27 and 28) as an assessment for compliance with Provision G2 (G2).
6. DADS should develop and implement policy for Provisions G1 and G2 (G1, G2).

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 LSSLC Operational Procedures Manual, Medical 02, Integrated Clinical Services, 3/16/12 o LSSLC Facility Operational Procedures Manual Committee and Councils -12, Clinical Services Morning Meeting, 1/24/12 o LSSLC Section H Self-Assessment o LSSLC Section H Action Plan o LSSLC Section H Presentation Book o Presentation materials from opening remarks made to the monitoring team o Organizational Charts o Review of records listed in other sections of this report o Daily Clinical Services Meeting Notes Interviews and Meetings Held: o Gale Wasson, Facility Director o Brian Carlin, MD, Medical Director o Mary Bowers, RN, Chief Nurse Executive o Frances Mason, RN, Medical Compliance Nurse 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 Psychiatry Clinics o Daily Clinical Services Meetings
	Facility Self-Assessment: The facility submitted its self-assessment, an action plan, and a list of completed actions. For the self-assessment, the facility described for each of the seven provision items, one or two actions completed to conduct the self -assessment, the results of the self-assessment, and a self-rating. The data presented in the self-assessment was generally vague and should be more precise to be of assistance. In order to be helpful the assessment should state percentages or provide more complete date, such as “11 of 20” and not 11.

	During the week of the onsite review, the monitoring team met with facility staff to discuss the self-assessment and the provision. In moving forward, the monitoring team recommends that the CNE follow guidance from state office provided in the form of policy issuance or otherwise. Moreover, the CNE should review, for each provision item in this report, the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. Such actions may allow for development of a plan in which the assessment activities provide results that drive the next set of action steps. A typical self-assessment might describe the types of audits, record reviews, documents reviews, data reviews, observations, and interviews that were completed in addition to reporting the outcomes or findings of each activity or review. Thus, the self-rating of substantial compliance or noncompliance would be determined by the overall findings of the activities. The facility found itself in noncompliance with all seven provision items. The monitoring team agrees with the facility's self rating.
	Summary of Monitor's Assessment: During the week of the onsite visit, the monitoring team had the opportunity to meet with the facility director, medical director, chief nurse executive, and the medical compliance nurse. The CNE acknowledged that nothing new had been done in this area, perhaps because there was a lack of clarity on how to proceed. The self-assessment, therefore, listed very few activities and the facility's action plan addressed only provision H1. The list of completed items focused heavily on the new policy Integrated Clinical Services and cited H1 for every provision item. If the facility had not addressed this provision due to a lack of clarity on how to proceed, it was unfortunate that no assistance was sought from state office. The monitoring team found for every provision item, that the CNE had accurately reflected the facility's position of having nothing new to present. In some cases, this represented a serious failure to comply with some basic requirements to complete assessments in a timely manner. Having made no progress following the fourth compliance visit, the facility will need to devote resources to understanding this provision and how to move forward.

#	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	The state office policy, which remained in draft, required each department have procedures for performing and documenting assessments and evaluations. Furthermore, assessments were to be completed on a scheduled basis, in response to changes in the individual's status, and in accordance with commonly accepted standards of practice. The facility had not developed any local policy to address the provision and did not have a mechanism to track all of the required assessments in any kind of centralized way. In	Noncompliance

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	individual's status to ensure the timely detection of individuals' needs.	other words, the CNE as lead for this provision item, did not have data on the compliance for nursing assessments, psychological assessments, or the other required assessments. Work on this provision item had not started. This report contains, in the various sections, information on the required assessments. This provision item essentially addresses the facility's overall management of all assessments. In order to determine compliance with this provision item, the monitoring team participated in interviews, completed record audits, reviewed assessments and facility data. The results of those activities is summarized here: • Annual Medical Assessments were found in all of the records in the record sample. Compliance with timely completion (365 days since previous assessment for the sample reported in Section L) was 60%. The quality of the assessments was problematic and is discussed further in Section L. • Quarterly Drug Regimen Reviews were not completed in a timely manner. • Annual Dental Assessments – Compliance with timely completion for the six month review period was 68%. • Regularly scheduled quarterly and annual nursing assessments were present in 20 of the 22 sample individuals' records. However, there was consistent failure of nurses to conduct complete assessments in response to changes in individuals' health status and inconsistent application of the nursing protocols and their associated requirements for assessment and evaluation to ensure the timely detection of individuals' needs. • Psychiatry clinic was providing quarterly medication reviews that were timely. They had completed a large percentage of Comprehensive Psychiatric Evaluations (96%). As discussed in section J, there were issues with the quality of these evaluations. Furthermore, with regard to health status, the psychiatrist was not participating in the IDT meetings and will need to attend to discuss risks relative to polypharmacy and the effect of specific psychotropic medications on other health conditions. This could be accomplished by expanding the IDT in psychiatry clinic to include the review of risks related to polypharmacy. • Annual assessments and updates were not completed consistently for those who received some level of support or service from OT, PT, or speech. The review of individuals post-hospitalization or for other changes in status was less consistent and documentation by these clinicians was limited in many of these cases. Speech assessments were not completed in conjunction with the ISP schedule though ISPAs were generally conducted. • Not everyone had an initial psychological assessment. • Functional assessments were completed for all individuals with PBSPs and annual psychological assessments were completed for all individuals.	

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		Many of the deficiencies noted throughout the review were related to required annual assessments. It was clear that the facility was not meeting several basic requirements and will need to take immediate action to correct these deficiencies. The monitoring team emphasizes that the facility must monitor all three elements that this provision item addresses: (1) the timelines for completion of scheduled assessments, (2) the appropriateness of interval assessments in response to changes in status, and (3) the quality of all assessments (compliance with accepted standards of practice).	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	The facility's self-assessment noted that listings of individuals with specific diagnoses were grossly inaccurate and required corrections. It also noted that there was some improvement in psychiatric diagnostic reviews. The monitoring team assessed compliance with this provision item by reviewing many documents including medical, psychiatric, and nursing assessments. • Generally, the medical diagnoses were consistent with ICD nomenclature. • As noted in section J, there were issues identified with the quality of the Comprehensive Psychiatric Evaluations. It was necessary that quality assurance and/or peer review occur as there was a need for improvement with regard to documentation specifically of the justification of diagnosis, collaborative case formulation, treatment planning with regard to psychotropic medication, and the identification of non-pharmacological interventions in addition to the PBSP. • Over the course of the visit, the monitoring team observed the psychiatrist relying upon the diagnostic criteria in an effort to appropriately diagnose individuals. Additionally, records reviewed revealed some examples of documentation of specific criteria exhibited by an individual indicating a particular diagnosis. As stated in section J, this was an area in need of improvement. • Across 20 of the 22 sample individuals' reviewed, the conclusions (i.e., nursing diagnoses) drawn from the assessments failed to capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks.	Noncompliance
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.	The facility implemented the state issued protocols for a number of conditions, including seizure management, bowel management, aspiration, urinary tract infections, osteoporosis, and diabetes. Quality audits for specific diseases were not completed at LSSLC. The facility therefore had no data on the appropriateness of treatments and interventions. In order for the monitoring team to assess compliance with this provision item, the usual activities of interview and document reviews were completed.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Based on the review of records listed in section L, the medical staff generally responded to the needs of the individuals by providing treatments and ordering diagnostics. The monitoring team found through record reviews that improvement was needed in several areas including post hospital follow-up, follow-up of lab results, screening for osteoporosis, follow-up for individuals with seizure disorders, and interventions for those with pneumonia • The absence of complete nursing diagnoses 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. Thus, the overwhelming majority of the individuals reviewed failed to have HMPs that referenced specific, individualized nursing interventions developed to address all of their care needs, including their needs associated with their health risks. • Psychiatry clinic services were performed in a timely manner. Individuals were seen in clinic quarterly, or more frequently according to clinical need. • Initial (full) psychological assessments were complete and annual assessments were improving. Functional assessments and PBSPs were improving Again, the facility must include all clinical disciplines when addressing this provision item.	
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 facility had not compiled a comprehensive set of clinical indicators across all clinical disciplines. Medical quality audits were completed, but the criteria used will need to be reviewed. Clinical indicators assess particular health processes and outcomes. Monitoring health care quality is impossible without the use of clinical indicators. They create the basis for quality improvement and prioritization of health care delivery. The facility will need to give considerable thought to this process to ensure that a solid combination of clinical indicators is selected. This must be established for individuals and for facility aggregate data. The monitoring team again emphasizes that clinical indicators must be developed for all clinical areas but recognizes, that this may be premature for some areas given the current deficits: • Problems related to the comprehensive psychiatric assessments would make determination of treatment efficacy difficult at this time. • With regards to nursing, goals and outcomes were not specific, measurable, and person-centered. For example, a number of individuals' goals that set the expectation for the individuals to suffer <u>one less negative health outcome</u> this year than last year. This problem appeared to be the result of setting goals for individuals based upon limited experience and expectations rather than upon evidence-based practice outcomes, individuals' desired health goals, and a vision	Noncompliance

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		for the results of quality care. • For habilitation services, documentation of interventions was limited and not thorough or consistent with generally accepted standards. The PNMPCs monitored the plans for staff compliance with implementation but this should also be a role for the therapists in addition to determining if the plan and its components are effective in addressing the identified needs and risks. This should include a review of findings from the monitoring conducted by the PNMPCs or other IDT members.	
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.	The facility did not have an overarching plan to address this provision item. Databases were established to track some elements of preventive care, and seizure management. There was no evidence that these data were reviewed on a routine basis. For example, there was no analysis of the 30% increase in hospitalization rate. It had not been determined if more individuals were hospitalized or certain individuals were having recurrent issues. The monitoring noted that it was unclear whether or not LSSLC continued to expect nurses to complete the H-Sheets to effectively monitor the health status of individuals vis a vis their review of the effectiveness of interventions referenced in the individuals' HMPs to meet their expected outcomes. Thus, most of the 22 individuals' records reviewed revealed either blank or missing information in the H-Sheets, or HMPs where the references to nurses' documentation of their reviews of the individuals' HMPs were crossed out. Overall, there was no systematic monitoring of health status of all individuals. Achieving such a system will require collaboration among many disciplines due to the overlap between risk management, quality and the various clinical services. The first step in the process is to define what is important to the individuals and what is important that the facility monitor. The facility needs to proceed with developing a comprehensive list of indicators based on these findings. It will then need to understand how the various disciplines will collaboratively monitor health status of the individuals.	Noncompliance
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	As mentioned in H5, the facility needs to establish a comprehensive set of clinical indicators. Many of those will be based on clinical guidelines developed. Many other indicators could and should be included. Examples would include the rate of hospitalizations, readmission rates, the incidence of pressure ulcers, the days of healing for pressure ulcers, the number of acute interventions required for bowel management, the prevalence of dehydration, and the prevalence of undesired weight loss.	Noncompliance

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		The monitoring team noted the following with regards to treatments and interventions: • There was little evidence that changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes resulted in revisions to their HMPs. For example, individuals with plans to address obesity were not modified in response to their failure to lose weight; individuals with plans to address constipation were not modified in response to their repeated episodes of constipation, obstipation, impaction, hospitalization, etc. • The psychiatry department was just completing annual evaluations, and the quality of this documentation was in need of review. The practitioners were making adjustments to an individual's treatment based upon clinical data, however, in many cases, the accuracy of these data was reported to be questionable. • Intellectual assessments were not timely (every five years) for most individuals. Functional assessments were not modified as needed or at least yearly. PBSPs have been modified as needed, and at least yearly. Once clinical indicators are established and treatment expectations outlined, the facility will be better positioned to complete audits of records and other documents and objectively determine if treatments and interventions were appropriate.	
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.	State office had developed a draft policy for Provisions G and H. The facility had not addressed this provision item and had no specific action plan to address it.	Noncompliance

Recommendations:

1. The facility must ensure the following with regards to assessments:
    a. All assessments must occur within the required timelines. This will require tracking of scheduled assessments in all clinical disciplines.
    b. Interval assessments must occur in a timely manner and in response to a change in status.
    c. All assessments must meet an acceptable standard of practice (H1).

2. In addition to tracking assessments, the CNE or designee will need to generate a report on a regular basis, perhaps quarterly, that shows compliance with timelines, appropriateness of assessments, the quality of assessments and other chosen indicators. If deficiencies are noted, a corrective action plan should be developed to address the problems. This should apply to all clinical disciplines (H1).

3. The medical director will need to ensure that the medical diagnoses are consistent with the signs and symptoms of the condition. Databases with inaccurate data will need correction (H2).

4. The facility must develop a comprehensive list of clinical indicators across all clinical disciplines. The timeliness and clinical appropriateness of treatment interventions will be difficult to measure without establishing clinical indicators that assess (1) processes or what the provider did for the individual and how well it was done and (2) outcomes or the state of health that follow care (and may be affected by health care) (H3, H4).

5. When clinical indicator data suggest unacceptable results, there should be evidence that the current treatment plan was altered by performing additional assessments and diagnostics or modifying therapeutic regimens (H6).

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 Client Management: At Risk Policy 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 At Risk Training Rosters o Preventing Aspiration Training Curriculum o List of serious injuries for the past six months o List of individuals with the greatest number of injuries o List of individuals seen in the ER since 10/1/11 o List of individuals hospitalized since 10/1/11 o List of individuals seen in the infirmary since 10/1/11 o List of individual receiving enteral feedings. o List of individuals with pneumonia incidents in the past 12 months o List of individual needing meal time assistance o List of individuals with chronic pain. o List of individuals diagnosed with pica o List of individuals with choking incident since the last review o List of individuals at risk for aspiration o List of individuals at risk for respiratory issues o List of individuals at risk for dental o List of individuals at risk for skin breakdown o Individuals with a diagnosis of dysphagia o List of individuals at risk for dehydration o List of individuals at risk for falls o List of individual at risk for metabolic syndrome o List of individuals at risk for seizures o List of individuals at risk for osteoporosis o List of individuals at risk for constipation o List of individuals at risk for weight concerns o List of individuals with a pica diagnosis 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 Injuries since 10/1/11 o ISPs, Risk Rating Forms, Risk Action Plans for: • Individual #166, Individual #167, Individual #494, Individual #430, Individual #139, Individual #410, Individual #322, Individual #156, Individual #242, Individual #136, Individual #567, Individual #238, Individual #290, Individual #170, and Individual #119 <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, and in homes and day programs; o Sylvia Middlebrook, Director of Psychology o Luz Carver, QDDP Coordinator o Mike Ramsey, Incident Management Coordinator o Mary Bowers, Chief Nurse Executive o Gail Husband, Assistant Director of Programs <u>Observations Conducted</u>: o Observations at residences and day programs o Castle Pine Morning Unit Meeting 5/2/12 o Incident Management Review Team Meeting 5/2/11 and 5/4/11 o Annual ISP meetings for Individual #252 o QDDP meeting 5/3/12 o Human Rights Committee Meeting 5/2/12 o Restraint Reduction Committee Meeting 5/2/12 o ISPA for Individual #191 following a serious injury
	Facility Self-Assessment: LSSLC submitted its self-assessment The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The facility had implemented an audit process that appeared to be an informal audit system The self-assessment indicated that the findings from the facility's audit process were used to self-assess compliance. For I1, the CNE reviewed the risk ratings for "a few" individuals that had changes in health status. She

	determined that the quality of risk ratings and integration of action plans were not adequate. A noncompliance self-rating was assigned to I1. For I2, the CNE reviewed ISPAs for individuals that had a change in status since 11/1/11 to determine if the IDT had started the assessment process within five working days. She found that IDTs were not consistently meeting in response to changes in at risk status. The findings from the section F audit for determining if assessments were submitted on time prior to annual ISP meetings was also used to determine compliance with I2. That audit found that not all disciplines were submitting assessments on time. I2 was assigned a noncompliance self-rating. For I3, a random review of Risk Action Plans developed since 11/1/11 was reviewed to determine if needs identified on the Risk Rating Form were addressed through preventative interventions integrated into the ISP. The plans were also reviewed for the presence of clinical indicators and guidance on the frequency of monitoring. This review found that Risk Action Plans were not adequate for providing ensuring consistent implementation. I3 was also assigned a noncompliance self-rating. The facility did not currently have an effective audit system in place. The CNE was aware of this and had begun working with the QA department to develop a system for auditing compliance with section I. It will be important to look at the self-assessment activities in more detail and determine if the audit process is an effective way to assess compliance.
	Summary of Monitor's Assessment: Some positive steps LSSLC had taken towards compliance with this provision included: • A medical resource manual was developed and distributed to each residence that included clinical indicators for assessing risk in a number of areas. • Staff were trained on the purpose of the Risk Rating Form and Risk Action Form. • Changes in risk status were being reviewed in the Morning Daily Clinical Meeting. • The CNE was providing technical assistance to IDTs regarding the at risk process. • Risk Rating Forms and Risk Action Plans were placed in the front of individual notebooks for easy access by DSPs. • Posters had been placed around the facility defining the risk process. While progress had been made on meeting compliance through an initial attempt to ensure all individuals were accurately assessed and action plans were in place to address risks, the facility was not yet in compliance with the three provisions in section I. Teams were still not accurately identifying risk factors. Risk plans were not being reviewed and updated as changes in health or behavioral status warranted. Risk plans did not include clinical indicators to be monitored or specify the frequency of monitoring and review.

	As noted in section F, assessments were not being consistently completed prior to ISP meetings. Teams could not adequately discuss risk factors without current, accurate assessments in place. Staff were not adequately trained on monitoring risk indicators and providing necessary supports. All staff needed to be aware of and trained on identifying crisis indicators. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual. The facility was still waiting on consultation and training on the new ISP and risk identification process from the state office. This training should move teams further towards integrating the risk process into the ISP development process.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The state policy, At Risk Individuals 006.1, required IDTs to meet to discuss risks for each individual at the facility. The at-risk process was to be incorporated into the IDT 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 when appropriate. A list of indicators for each of 21 risk areas had been identified by the 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 state office had hired a team of consultants to work with facilities on developing person centered support plans. This was to include a risk identification process that would result in one comprehensive plan to address all support needs identified by the IDT. The consultants had not yet provided training and technical assistance to LSSLC. Although, the risk discussion was now held during the annual ISP meeting, this was still not an integrated process. The facility had taken some positive steps to address the development of an adequate at risk process including: • A workgroup was established to address compliance with sections G, H, and I of the Settlement Agreement. Minutes from committee meetings indicated that action steps were being written to address deficiencies in the at risk process. • Training had been provided to all staff regarding the location and purpose of the Individual Risk Rating Form and Action Plans for Risk. • Home managers had been assigned responsibility for quizzing DSPs regarding risks for individuals whom they supported. • The facility was now holding a Clinical Services Morning Meeting to review changes in health status for individuals.	Noncompliance

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		• The CNE was providing technical assistance to IDTs to understand the full scope of the At Risk process. • A copy of the Risk Rating Form and Risk Action Plan were added to the front of Individual Notebooks. • A resource manual containing clinical indicators for each risk area, along with, risk guidance, and preventative care was placed in each residence. All staff were trained on using the resource guide. The monitoring team had the opportunity to observe the annual ISP meetings for Individual #326 and Individual #252 during the onsite visit. At both meetings, the risk discussion was held at the end of the meeting, separate from the discussion regarding preferences, community living options, and supports needed. This did not allow for an integrated discussion on how to best support the individual while ensuring that health and safety protections were in place throughout his day. There was little integrated discussion regarding each risk category during the meetings observed. For example, at the meeting for Individual #252, each risk category was read out loud and a brief response was given by the department deemed responsible for that item. For choking, the SLP stated "low" without further discussion, and for aspiration, the nurse stated "no history, low". This continued until all risk categories were assigned a rating. The QDDP and RN case manager moved from one risk area to the next and completed the assessment and risk action plan without most IDT members involved in the process. Teams were beginning to address health indicators, but there was still a strong reliance on guidelines developed by the state that did not take into consideration integrated and individualized risk factors. A sample of ISPs, assessments, and the facility risk rating list were reviewed to determine if risks were being consistently identified and addressed by IDTs. Overall, there had been significant improvement in the action plans written to address identified risks. The concern still remained that not all risks were identified by IDTs. As noted in section F, all disciplines were not routinely attending ISP meetings. This lack of attendance contributed to IDTs not having the necessary information to accurately identify risk factors. The following are some examples where risks were not appropriately identified in documents reviewed, or where ratings conflicted with assessment information. • Individual #238 was rated at high risk for falls and had an action plan in place dated 1/5/12 to address his risk for falls. In March 2012, he had a number of additional falls, one resulting in a serious head injury. The team met twice in March 2012 in regards to the increased number of falls. An ISPA indicated that	

#	Provision	Assessment of Status	Compliance
		he would be referred for assessment by the PNMT. His Risk Action Plan was not updated to reflect findings from the assessment and there was no indication that the team met to review recommendations following this assessment. • Individual #242's nutritional assessment indicated that he was at medium risk for weight concerns and hyperlipidemia. The team did not consider him at risk for cardiac disease. The justification on his risk assessment simply stated, "no cardiac disease." • Individual #430's ISP stated that he was considered low risk in all nursing areas. He was overweight and had a list of active diagnoses that included hypertension, hypothyroidism, osteopenia, anemia, glaucoma, chronic sinus disease, and chronic constipation. Additional examples are listed at the end of section M5 and in section O2. Some of the more recent plans in the sample, however, included a much more comprehensive list of clinical indicators used to determine risk ratings for each category of risk. • Two examples of plans that included clinical indicators for determining risk were the Risk Rating Forms for Individual #139 dated 1/24/12 and Individual #567 dated 2/16/12. For both short and long range planning, the teams will need to: • Frequently gather and analyze data regarding health indicators (e.g., changes in medication, results from lab work, engagement levels, mobility) . • Consider and discuss the interrelatedness of risk factors in an interdisciplinary fashion. • Focus on long term health issues and be more proactive in addressing risk through action plans to monitor for conditions before they become critical. • 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. • 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. The facility's self-assessment indicated that the facility was not yet in substantial compliance for this provision based on quality of the risk rating system. The monitoring team agrees with this assessment.	

#	Provision	Assessment of Status	Compliance
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The At Risk policy required that when an individual was identified at high risk, or if referred by the IDT, 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 IDT within 14 working days of the completion of the plan, or sooner if indicated by risk status. The facility self-assessment found that: • Assessments were not always completed prior to ISP meetings to allow for adequate risk discussion. • IDTs were not consistently meeting in response to changes in risk status. • Teams are often waiting for individuals who were hospitalized to return to the center before starting the assessment process. As noted throughout this report, it was still not evident that all risks were appropriately identified by the IDT. The facility will have to have a system in place to accurately identify risks before achieving substantial compliance with I2. Additionally, there continued to be problems with health risk ratings that were not consistently revised when significant changes in individuals' health status and needs occurred (see I1 immediately above). The monitoring team observed an ISPA for individual #191 following a significant injury after he rolled off of a porch in his wheelchair. The IDT met the following day to review his supports. The team discussed additional supports that were needed to ensure a similar incident would not occur. The team agreed to add railing to the porch and increase his level of supervision. There was no discussion regarding his specific injuries and what follow-up medical treatment or monitoring may be 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 through the provision of adequate and appropriate health care supports and surveillance. A way in which this is accomplished is through the timely detection of risk and proper assignment of level of risk. The facility was not yet in compliance with this provision item.	Noncompliance
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the IDT. It required that the IDT implement the plan within 14 working days of completion of the plan, or sooner if indicated by the risk status. A majority of the ISPs that were reviewed included general strategies to address identified risks, but again, not all risks were identified as a risk for each individual. The policy	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	required that the follow-up, monitoring frequency, clinical indicators, and responsible staff will be established by the IDT 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 as high risk or medium risk in any area. However, as noted in I1, accurate risk ratings were not necessarily being assigned, so adequate plans were not in place for all individuals. None of the plans in the sample included include the clinical indicators to be monitored and the frequency of monitoring. For example, • The Risk Action Plan for Individual #238 included three action steps to reduce his risk related to seizures including continue medication, receive serum level checks, and receive neurological examinations as scheduled-requested-necessary. There were no clinical indicators set to monitor his serum levels and no recommendations for the frequency of follow-up with the neurologist. He had several falls related to seizure activity with two serious injuries recorded. There was no indication that an assessment was completed by the neurologist or the PNMT. • The Risk Action Plan for Individual #170 included three action steps for weight concerns. Actions included exercise, diet, and following his HMP. Frequency of monitoring his weight and his ideal weight range were not included in the action plan. The plan indicated that the team would review progress in nine months. His plan should have included instruction for checking his weight frequently to assess if his diet and exercise were effectively addressing his weight concerns. Additionally, plans were not always updated following a change in health status or adequately integrated into ISPs. It will be necessary for the facility to have a system in place that accurately identifies risk prior to achieving substantial compliance with I3 requirements. 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. See additional comments throughout this report regarding the monitoring of healthcare risks. The facility self-assessment indicated that the facility was not in compliance with this provision. The monitoring team agrees with that assessment.	

Recommendations:

1. Ensure assessments are completed prior to annual IDT meetings and results are available for team members to review (I1).
2. Ensure that risk rating accurately reflect risks identified through the assessment process (I1).
3. All health issues should be addressed in ISPs 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 IDTs 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. 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 (I1 and I2).

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 IDT meeting associated with the incident. o Five 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 Five dental skills acquisition plans and one medical skills acquisition plan. 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 ISP 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 Training curriculum 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 ISP 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; /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 IDT, ISP, ISPA, 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 Spreadsheet of all individuals designated as meeting criteria for intra-class polypharmacy. This included: Name of Individual; Name of treating psychiatrist; Individuals home; partial list of prescribed medications. 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 ISP, ISPA, BSP, or IDT 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 individual 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 IDT meeting associated with the incident. o Presentation book for section J, including the facility self-assessment. <u>Documents requested onsite:</u> o Five examples of psychiatry input into pretreatment sedation. o Four examples of dental desensitization plans created via DERST. o Outline of DERST work group process. o List of individuals who have had genetic screening in the last six months. o Information regarding the number of hours the neurologist was onsite per month. o Hospital records regarding emergency room visit of Individual #99 on 3/23/12. o All information presented, doctor's notes and documentation regarding Dr. Middlebrook's clinic on 4/30/12 regarding Individual #587. o IDT documentation regarding meeting 4/30/12 regarding Individual #578. o Ten examples of polypharmacy justification reviews. o Six examples of completed informed consent regarding Individual #339, Individual #279, Individual #323, Individual #497, Individual #68, and Individual #169. o All information presented, doctor's notes and documentation regarding Dr. Buckingham's clinic on 5/1/12 regarding Individual #273, Individual #14, and Individual #375. o Total number of annual medication consents completed by psychiatry. o All investigation information regarding Individual #490. o Protocol for Reiss Screens including spreadsheet of completed screens. o All information presented, doctor's notes and documentation regarding Dr. Vyas' clinic 5/2/12 regarding Individual #492 and Individual #252. o Five examples of pharmacy medication review requests including recommendations and outcome

	reports. o Lab matrix o All information presented, doctor's notes and documentation regarding Dr. Buckingham's clinic 5/3/12 regarding Individual #320 and Individual #345. o These documents: • Identifying Data Sheet • Consents for psychoactive medication • Personal Support Plan with addendums and signature sheets • Psychological Evaluations • HRC review of PBSP/Psychoactive medications • Positive Behavior Support Plan, summary and addendums • Restraint section • Annual medical summary and physical examination • Hospital section • X-ray section for the previous six months • Lab section for the previous six months • Psychiatry section for the previous six months • Side effects screening for the previous six months. • Pharmacy section for the previous six months. • Consults regarding neurology, EEG's, vision, cardiology, EKG's, gastroenterology, urology, endocrinology, nephrology, genetic testing, rheumatology • Physician's orders for the previous six months. • Integrated progress notes for the previous six months. • Comprehensive Nursing Assessment o For the following individuals: • Individual #99, Individual #169, Individual #166, Individual #57, Individual #175, Individual #60, Individual #490, Individual #506, Individual #395, Individual #388, Individual #148, Individual #479, Individual #170, Individual #592, Individual #424, Individual #194, Individual #162, and Individual #578 <u>Individual Interviews and Meetings Held</u>: o JoAnne Lancaster, R.D.H., Fred Glazener, D.D.S. facility dentist, Evelyn Barnes, D.A., Nancy DeVore, and Marrill Gerth, R.D.H. o James Buckingham, M.D., facility psychiatrist o Judd Williamson, R.N., Psychiatric Nurse and Kacie Collins, Psychiatric Assistant o Luz Carver, Director of QDDP services o Shyam Vyas, M.D., facility psychiatrist o Bertha Inez Sanderson, Pharm D., clinical pharmacist o Brian Carlin, M.D., Medical Director o Sylvia Middlebrook, Ph.D., Director of Psychology o Tom Middlebrook, M.D., facility psychiatrist

	o Mary Bowers, R.N., Chief Nursing Executive o Gale Wasson, M.Ed., facility director <u>Observations Conducted</u>: o Dr. Middlebrook's clinic on 4/30/12 regarding Individual #587. o Dr. Buckingham's clinic 5/3/12 regarding Individual #320 and Individual #345. o Dr. Buckingham's clinic on 5/1/12 regarding Individual #273, Individual #14, and Individual #375. o Dr. Vyas' clinic 5/2/12 regarding Individual #492 and Individual #252. o Polypharmacy review o Dental Desensitization (DERST) workgroup meeting o ISPA regarding Individual #578 o Pharmacy and Therapeutics Committee o Clinical Services Meeting
	Facility Self-Assessment: LSSLC had made a revision to its self-assessment. The document described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an improvement in the facility self-assessment process. The action steps included in the self-assessment packet 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. 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 in their entirety. There were no tools provided for review during this monitoring visit. There were reportedly tools in the process of development, however the quality assurance nurse position was now vacant and there had been no further activity with regard to their development. Currently, the self-assessment focused on the presence or absence of a specific item in the individual's record (e.g., a comprehensive psychiatric assessment). What was necessary, and acknowledged by the facility both verbally and in documentation was a review of the quality of the documentation in order to ensure that it meets generally accepted practices and to ensure the use of documentation by the IDT in a collaborative manner. Overall, the self-assessment should look at the same types of activities, actions, documents, and so forth that the monitoring team looks at, and should be modified following a review of each subsequent monitoring report. For example, in J12, the self-assessment indicated an action step of "improve documentation of psychiatric review and clinical utilization of DISCUS and examination results." This would be evidenced by a review of "integrated notes." The requirement for this provision is actually more detailed. The review should include timeliness of the assessment tools, nursing training regarding

	administration of the assessment tools, physician review and completion of the assessment tool, and physician documentation of the use of the clinical information derived from the assessment tools. There should be a specified percentage of total cases reviewed with subsequent corrective action as necessary. The facility self-rated itself as being in substantial compliance with two provision items: J1 and J12. The monitoring team agreed with these. In addition, although a substantial compliance rating was not assigned, the monitoring team would like to acknowledge staff efforts with regard to informed consent and comprehensive psychiatric assessment.
	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 section J. The facility did have physicians and a physician's assistant providing care, however, there was limited availability of clinical resources with 1.1 total FTE available. In the intervening period since the previous report, the full time psychiatrist had resigned. The four physicians and the physician's assistant currently providing services on a part-time basis 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. 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. Previously, there was some integration between psychiatry and primary care. With the vacancy in the lead psychiatrist position, the maintenance of any integration beyond what could be accomplished in psychiatry clinic was delegated to the psychiatric nurse and psychiatric assistant. These two staff attended facility meetings in lieu of the psychiatrist and attempted to provide information to the part time physicians. For example, 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 the absence of the lead psychiatrist, the psychiatric nurse attended this meeting. 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 attend ISP 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. In an effort to promote integration, the psychiatric nurse and psychiatric assistant alternated attending the behavioral support committee meeting. Psychiatry made gains in the area of informed consent. Psychiatrists were responsible for 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. The psychiatrists were now obtaining informed consent for annual medication renewals.

	There were areas where psychology could be more integrated with psychiatry (e.g., identification of target symptoms, data collection, collaboration regarding case formulation, behavioral support planning, and identification of non-pharmacological interventions). It was apparent 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. The facility psychiatric staff did make great strides with regard to the completion of comprehensive psychiatric assessments for the majority of individuals on the caseload. As discussed in the ensuing paragraphs, there was variability with regard to the quality of the documentation, which should be addressed via quality assurance and/or peer review.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	<u>Qualifications</u> LSSLC had a total of 1.1 FTE (full-time equivalent) psychiatrists/physician's assistant. All four physicians who were responsible for providing psychiatric treatment were board certified in adult psychiatry. Two physicians were 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, and had experience in the treatment of individuals with developmental disabilities. As such, the staff were qualified. In the intervening period since the last monitoring report, the facility lead psychiatrist (and only full time psychiatric physician) resigned. This resulted in an overall reduction in FTE from 1.63 to 1.1, even given the addition of a fourth part time psychiatrist and some increased time commitments from other part-time clinicians. <u>Experience</u> Of the four part-time physicians, two had been providing care at the facility for an extended period of time, one since 2003. A third part-time physician had joined the psychiatry department approximately one year prior to this monitoring review. The fourth part-time psychiatrist had begun providing services at the facility approximately six weeks prior to the monitoring visit, but had years of experience treating individuals with developmental disabilities in the community. 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. Given the current lack of a lead psychiatrist and the number of part-time providers, it will be a challenge for the physicians to effect IDT integration. In addition, although there was child and adolescent psychiatric expertise available at this facility, these were part time practitioners.	Substantial Compliance

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		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. Improvements necessary in the quality of services provided will be reviewed over the course of subsequent monitoring visits. Ultimately, the facility will need to develop quality assurance monitoring inclusive of peer review to determine compliance with policy and procedure, documentation requirements, and to ensure the provision of services in accordance with generally accepted practices. <u>Monitoring Team's Compliance Rating</u> Based on the qualifications of the FTE psychiatrists and the physician's assistant at LSSLC, this item was rated as being in substantial compliance.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	<u>Number of Individuals Evaluated</u> The psychiatrists had continued to perform comprehensive psychiatric assessments per Appendix B. At the time of this visit, 179 out of 186 assessments had been completed (96%). <u>Evaluation and Diagnosis Procedures</u> Overall, evaluation and diagnosis procedures were satisfactory and within generally accepted professional standards of care (e.g., interview, staff meetings, record reviews). As noted below, however, the content of documents were variable in their completeness. <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 18 records of individuals at LSSLC revealed varying quality of the documentation in the quarterly medication reviews. There was marked variability in the quality of the justification for the use of specific psychopharmacological agents. Given this, 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 staff revealed an awareness of the variability in clinical documentation. There were currently no quality	Noncompliance

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		assurance monitoring tools in place to review this documentation. <u>Tracking Diagnoses and Updates</u> LSSLC was at the very beginning stages of keeping a database of diagnoses and tracking of dates of updates to ensure they were being done regularly. That is, there was discussion of doing so and some data were available, but not yet comprehensive or complete. <u>Challenges</u> The facility had made great strides with regard to the completion of the psychiatric assessments. Given the lack of a full time psychiatrist and a reliance on part time providers, this was particularly impressive. As they have now managed to complete a large number of assessments, it was necessary that quality assurance (e.g., peer review) occur because there was a need for improvement with regard to documentation, specifically of the justification of diagnosis, collaborative case formulation, treatment planning with regard to psychotropic medication, and the identification of non-pharmacological interventions in addition to the PBSP. <u>Monitoring Team's Compliance Rating</u> The monitoring team would like to acknowledge the hard work of the facility staff with regard to the completion of the vast majority of the outstanding comprehensive assessments. There was a need identified during this monitoring review for quality assurance due to the variability in documentation. Given this, this provision item will remain in noncompliance.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	<u>Treatment Program/Psychiatric Diagnosis</u> Per this provision item, individuals prescribed psychotropic medication must have a treatment program in order to avoid utilizing psychotropic medication in lieu of a program or in the absence of a diagnosis. Per the review of 18 records, all had diagnoses noted in the record. Individuals prescribed psychotropic medication must have an active positive behavior support plan (PBSP). In all records reviewed, with the exception of one new admission, individuals prescribed medication had a PBSP on file. It was notable, however, that the PBSP documents did not include a signature from the treating psychiatrist. PBSP documents reviewed were improved with regard to quality and clarity, and with regard to their compliance with generally accepted practices; please see the discussion in section K. Staff interviews performed during this visit revealed plans to add the psychiatrist as a signor on the PBSP and to review the document with the psychiatrist via psychiatry clinic	Noncompliance

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		on a periodic basis. This collaboration would also allow for discussion and subsequent documentation with regard to non-pharmacological interventions in addition to the PBSP. All individuals prescribed medication had diagnoses noted in the record. As noted above in J2, psychiatric practitioners were beginning to justify diagnoses and describe appropriate pharmacological interventions, however, as discussed in the ensuing provisions, there was need for improvement. See J8 and J13 for additional information. Given the new team approach to psychiatry clinic that was piloted and expanded throughout the facility, psychology representatives and other staff disciplines were present at clinic. Given the documentation reviewed and observations of psychiatry clinic during this review, there were some collaborative efforts with regard to the justification of diagnosis and pharmacological interventions. An expansion to include a review of non-pharmacological interventions, either occurring or proposed for a specific individual, would be a natural outgrowth of this process. It will be important for collaboration to occur between psychology and psychiatry in case formulation, and in the joint determination of target symptoms and descriptors or definitions of the target symptoms, as well as the use of objective rating scales normed for the developmentally disabled population. 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. In addition, it can serve as a forum to discuss strategies to reduce the use of emergency medications. It is also imperative that this information is documented in the individual's record in a timely manner. Also, as noted in J9 below, PBSP documents reviewed for this monitoring period did not adequately identify non-pharmacological interventions outside of specific PBSP behavior supports. For instance, individuals require active engagement during the day. Lack of engagement must be addressed because it can lead to increased behavioral challenges including, but not limited to, self-injurious behavior, self-stimulatory behavior, and exacerbations of mood disorders (see section S). There was, however, no indication that psychotropic medications were being used as punishment or for the convenience of staff. <u>Emergency use of Psychotropic Medications</u> The facility use of emergency psychotropic medication for individuals during periods of agitation/aggression had remained low. During the prior monitoring period, there were a total of two incidents. During this monitoring period, there was one incident. A review of the documentation associated with this incident revealed that medication	

#	Provision	Assessment of Status	Compliance
		was prescribed by primary care due to "agitation…possible pain." The individual was ultimately sent to the emergency room where additional psychotropic medication (Ativan and Geodon) was administered. A review of the emergency room documentation revealed a clinical impression of "agitation consistent with psychiatric origin." The individual subsequently returned to the facility and was assessed by psychiatry the same day. No medication adjustments were ordered. <u>Monitoring Team's Compliance Rating</u> As discussed above, there was a need for improvement in the justification of diagnoses and medication regimens. There was also a need for psychiatric participation in the development of the PBSP and an overall need for improvement with regard to the identification of non-pharmacological interventions. As such, this provision will remain in noncompliance.	
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 128 instances of pretreatment sedation between 10/3/11 and 3/22/12. Of these, 96 were reported as medical pretreatment sedation and 32 were dental pretreatment sedation. TIVA (general anesthesia) accounted for 18 of the 32 instances of dental pretreatment sedation. Interestingly, of the total of 128 instances of pretreatment sedation, 70 (or 54%) were for individuals participating in psychiatry clinic who were prescribed psychotropic medications. <u>Interdisciplinary Coordination</u> Prior to the resignation of the full time lead psychiatrist, the full time psychiatrist performed a medication review. Currently, this information was being provided to the individual psychiatrist providing treatment. Five examples of this consultation were provided for review. The challenge with this process was that currently, all psychiatrists providing treatment at the facility were part time. Should pretreatment sedation be required on an emergency or unscheduled basis, there may not be psychiatry staff available for consultation. 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. As medications utilized for pretreatment sedation could result in unwanted challenging behaviors, sedation that could be mistaken by psychiatrists as symptoms of exacerbations of mental illness, or mistaken 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,	Noncompliance

#	Provision	Assessment of Status	Compliance
		psychiatry, and clinical pharmacology prior to the use of pretreatment sedation. This process was being utilized successfully at other SSLCs. Monitoring After Pretreatment Sedation A review of documentation regarding the nursing follow-up and monitoring following administration of pretreatment sedation revealed that per protocols, nursing did document review of the vital signs and assessment following TIVA and other pretreatment sedation administration. Desensitization Protocols and Other Strategies The facility, via a multidisciplinary work group the "Dental Education Rehearsal Simulation Training" or DERST, had developed a pilot plan to systematically address medical and dental desensitization. As part of this pilot, they created a dental desensitization suite, which consisted of a room designed to simulate a dental clinic experience. It included dental equipment inclusive of a suction machine (this noise had been identified as distressing to many individuals) for individuals to visit in order to acclimate to the environs of a dental clinic. There was also a video presentation for individuals to view prior to presentation to dental clinic. Individuals could be referred to DERST group by their IDT. 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, so that a desirable reinforcer could be utilized during DERST. The DERST group had identified candidates for desensitization education, and in doing so, determined that the majority of the individuals were experiencing difficulty with oral hygiene. As such, skills acquisition plans (SAP) were developed for them. The DERST also realized that many direct care staff, despite training, were not knowledgeable with regard to toothbrushing. As such, facility hygienists had focused on training direct care staff with regard to toothbrushing and oral care. Two listings regarding desensitization plans included in the data provided regarding pretreatment sedation revealed conflicting information. One document noted a total of 32 plans. Of these, one was dated in 2008, three in 2009, and 21 dated in 2010. The remaining seven were dated in 2011 and 2012. These plans were created prior to the formation of DERST. A second listing of 16 individuals revealed dates of implementation of desensitization plans between 10/1/11 and 4/1/12. A review of current plans, formulated following the formation of DERST revealed five examples of dental desensitization plans and one example of a medical desensitization plan. Of the five dental desensitization examples, all were SAPs, however, they were individualized. Three training program documents were provided. These were also	

#	Provision	Assessment of Status	Compliance
		individualized, with two of them addressing medical desensitization and one addressing dental desensitization. While the programs were provided for review, the individual data sheets documenting actual interaction with the individual and their progress through the plan were not reviewed. Monitoring Team's Compliance Rating This item will remain in noncompliance because further effort must be made with respect to interdisciplinary coordination for those individuals requiring pretreatment sedation. As noted above, the facility made great efforts with regard to developing a process to review individuals who require pretreatment sedation. The have also progressed with regard to the assessment of individuals as with regard to the development of both SAPs and desensitization plans.	
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 Approximately 50% of the census (186 individuals) received psychopharmacologic intervention requiring psychiatric services at LSSLC as of 4/20/12. There were four part-time psychiatrists and one physician's assistant providing services totaling 1.1 FTE at the facility. Current scheduling allowed for psychiatry presence on campus Monday through Friday. It was reported that the psychiatrists and physician's assistant were available via telephone as necessary. All psychiatrists contracted at the facility were board certified. Administrative Support Psychiatry clinic staff included a psychiatric nurse, a psychiatry assistant and a psychiatric administrative assistant. This team was organized and enthusiastic, but was experiencing difficulties as a result of the vacancy in the lead psychiatry position. This team was noted to consist of self-motivated individuals who will require direction to focus their efforts toward goal accomplishment necessary to satisfy the requirements of the section J provisions. Determination of Required FTEs The current allotment of psychiatric clinical services will not be sufficient to provide clinical services at the facility. At the time of the review, there were a total of 47 available clinical hours weekly. The lack of a lead psychiatrist had reduced the number of FTE from the previous review. LSSLC should engage in an activity to determine the amount of psychiatry service FTEs required. This computation should consider hours for clinical responsibility, but also documentation of delivered care, such as quarterly reviews, Appendix B comprehensive evaluations, and required meeting time (e.g., physician's meetings, behavior support planning, emergency ISP attendance, discussions with nursing staff, call responsibility,	Noncompliance

#	Provision	Assessment of Status	Compliance
		participation in polypharmacy meetings). And then, add to this the need for improved coordination of psychiatric treatment with primary care, neurology, other medical consultants, pharmacy, and psychology. During this monitoring review, the use of additional psychiatric nurses and nurse practitioners was discussed. The addition of personnel from either of these disciplines to the psychiatry clinic would assist with workload. Also, avenues for recruitment of a facility lead psychiatrist were also discussed (e.g., the Texas Society of Psychiatric Physicians, American Psychiatric Association, psychiatric residency programs). The facility was attempting to recruit; ongoing efforts will be necessary. <u>Monitoring Team's Compliance Rating</u> Due primarily to the lack of sufficient psychiatric resources to provide the services required, this provision remained in noncompliance.	
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 3/31/12. Per this document, which was reportedly based on the overarching DADS psychiatric services policy, a psychiatric evaluation must follow the format of "SSLC form 007 A" which in the exhibit section is denoted as the "Psychiatric Evaluation Assessment," also referred to as Appendix B. <u>Evaluations Completed</u> A listing of all individuals evaluated per Appendix B was requested. This list contained the names of 179 individuals. As there were a total of 186 individuals receiving treatment via the psychiatry clinic, the facility psychiatric practitioners had completed 96% of the evaluations on the individuals currently assigned to clinic. This did not include evaluations on newly referred individuals (e.g., new admissions, evaluation requests following a positive Reiss Screen). This was a marked increase in the number of completed evaluations as in the previous report only 35% of evaluations had been completed. <u>Review of Completed Evaluations</u> A review of 10 completed comprehensive evaluations revealed that these evaluations were completed between 1/11/12 and 3/6/12. There were sample evaluations provided from all facility practitioners. Specific challenges noted with the reviewed evaluations included the lack of a comprehensive collaborative case formulation in 50% of the sample, the variability in the documentation with regard to the justification for both the psychiatric diagnoses and the particular psychotropic medication regimen, and the lack of a behavioral-pharmacological hypothesis, and the lack of identification of non-	Noncompliance

#	Provision	Assessment of Status	Compliance
		pharmacological interventions outside of the PBSP (for further discussion regarding these issues, please see the discussion under J8, J9, and J13). In general, the physicians followed the required format, however, there was marked variability in the quality of the evaluation, as the evaluations differed across physicians with regard to detail provided both in historical data and in the comprehensiveness of the case formulation and treatment plan (for additional information regarding this issue, please see J8). While all of the examples included a five-axis diagnosis, there was variability with regard to the documentation of a detailed discussion regarding the review of required symptoms or the justification/rule out of each diagnosis. The information must include a collaboratively derived rationale for the diagnosis. All Appendix B evaluations must include a collaborative case conceptualization that reviews information regarding the individual's diagnosis, including the specific symptom clusters that led the writer to make the diagnosis, factors that influenced symptom presentation, and important historical information pertinent to the individual's current level of functioning. In addition, treatment recommendations that review the current psychopharmacological interventions including the symptoms that the psychiatrist was targeting with the various medications, as well as the physicians long range plans for the regimen. Collaboration in the PBSP process was needed, as were specific recommendations for non-pharmacological interventions. The psychiatrist must guide the IDT in a detailed fashion about intention of each medication and what to monitor in order to determine medication efficacy in an evidence-based manner. There must be documentation with regard to non-pharmacological interventions that are proposed by the team. The above documentation requirements are areas that would be amenable to quality assurance or peer review monitoring. <u>Monitoring Team's Compliance Rating</u> Facility staff had made a team effort and thereby completed the large number of outstanding comprehensive psychiatric evaluations. Review of the documentation revealed marked variability with regard to quality. The facility gave a noncompliance rating in its plan of improvement, however, the monitoring team wishes to acknowledge the continued progress made by the psychiatrists in regard to completion of the assessments. It is now necessary that quality assurance monitoring and peer review are implemented. These processes can objectively determine both strengths and weaknesses in documentation and allow for education and training in an effort to improve quality.	

#	Provision	Assessment of Status	Compliance
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 upon Admission</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 11/15/11. Four of the five newly admitted individuals received a Reiss Screen upon admission. The fifth individual was referred to psychiatry upon admission. A review of the dates of admission versus the dates the Reiss Screen was completed revealed a delay with regard to performance of the Reiss Screen. Documents revealed that the screen was performed an average of 27 days after admission (range 9-38 days). This result was a change from the previous review where there was no delay in completion of the Reiss Screen. <u>Reiss Screen for Each Individual (excluding those with current psychiatric assessment)</u> This was a difficult item to assess due to the presentation of the data. The total facility census was 365, with 186 individuals enrolled in psychiatry clinic. Therefore, 179 individuals were eligible for baseline Reiss screening. Information received for this visit revealed that from January 2011 through March 2012 a total of 47 individuals were screened. This indicated that 132 individuals had yet to receive baseline screening. Given the data provided, it was difficult to determine which individuals were previously psychiatry clinic patients, which were referred and entered the clinic following a routine Reiss Screen, and which were screened due to a change in behavior or circumstance and then entered the clinic. <u>Reiss Screen for Change in Status</u> There was no specific process for determining when a change in status should result in a Reiss screen being implemented. <u>Referral for Psychiatric Evaluation Following Reiss Screen</u> Per an interview with psychiatry clinic staff and a review of facility based policy and procedure regarding psychiatric services, there was no policy or documented method for the referral of an individual for psychiatric evaluation following a positive Reiss Screen. Of those who were screened, it was documented that for individuals other than new admissions, two individuals ultimately received a comprehensive psychiatric evaluation.	Noncompliance

#	Provision	Assessment of Status	Compliance
		These evaluations occurred 51 days and 13 days following the Reiss Screen (an average of 32 days). Monitoring Team's Compliance Rating Given the challenges with the data review documented above, the number of individuals pending a baseline Reiss Screen, as well as the lack of a formal process for the referral of an individual for a psychiatric evaluation in response to a positive Reiss Screen and for the implementation of a Reiss screen if there is a change in status, 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 3/31/12, "each State Center will develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation." While this was stated by the policy, 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. Interdisciplinary Collaborative Efforts Per interviews with psychiatrists and psychology staff, as well as observation during psychiatry clinic, the collaboration between the disciplines was improved since the prior visit, but remained limited to the psychiatric clinical encounter and the rare psychiatry participation in the ISP process. Psychiatry staff had focused on the completion of comprehensive psychiatric evaluations. A review of these revealed case formulations/diagnostic assessments. There was generally not documentation that these were performed collaboratively, however, per observation and staff report, they were performed in the presence of the team members with the benefit of documentation and input from other disciplines. Documentation, however, did not support this, but could easily do so with minor additions to the document. Integration of Treatment Efforts There were, as noted above, signs of the beginnings of integration between psychiatry and psychology, evidenced by the changes 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 four clinic observations performed during this monitoring review. Please also see J13.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 there was an improvement in the graphs presented to the physician (e.g., notation of medication changes), 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. <u>Collaborative Diagnostic Formulations</u> A review of the comprehensive psychiatric evaluations of 10 individuals revealed that all contained a case formulation. In 50% of the examples, there was documentation of input by psychology staff with regard to the evaluation. 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. The quality of case formulations was variable, though improved from previous reviews. Examples chosen from those that indicated consultation with psychology: • Individual #279: "diagnosis of autistic disorder and mild mental retardation… adopted at the age of 2…history is unavailable about any genetic factors…medical factors… limited involvement of his family…other medical reasons for his behavioral changes include…medications, including an antiviral steroid and antibiotic…has…demonstrated self injurious behavior, physical aggression, preoccupation with spinning objects, avoiding loud noises, and avoiding certain textures…has had a long history of problems within the school setting, as well as in the home setting." This individual was prescribed Risperdal and Clonidine, "for aggression due to autism." Non-pharmacologic interventions, "recommended to the treatment staff…responds better to a male staff…see the…PSP." o This example did not sufficiently review the issues in the school or home setting requiring treatment with psychotropic medication. It indicated that the individual responded best to a male staff, but it was not clear as to what other behavioral or non-pharmacological interventions could be considered.	

#	Provision	Assessment of Status	Compliance
		• Individual #471: "target behaviors of physical aggression and inappropriate sexual behavior…after he has completed a physically aggressive act he is known to be apologetic and…tearful…acts occur without any known provocation and his aggressiveness seems to be out of proportion to…psychosocial stressors on his unit…fits more closely with the DSM-IV criteria for Intermittent Explosive disorder…we are going to change his primary diagnosis…continue his weekly phone calls to his sister…he seems to…enjoy…these phone calls… continue… Zyprexa…this has…benefitted…as far as reducing his aggressive tendencies… continue… BuSpar…to help him keep his agitated behavior in check…past attempts to adjust the dose lower…resulted in…exacerbations…recommend…continue…his Positive Behavioral Support Plan." o This example reviewed the diagnosis, and medication regimen, but it was not clear as to what other non-pharmacological interventions could be considered. In the majority of the examples reviewed, the psychiatrist or physician's assistant simply referred the reader to the PBSP for behavioral or non-pharmacological interventions. This would be acceptable, if the physician or physician's assistant participated in the development of these documents. For further information, please see J9. Given the marked variability in documentation, the development of a quality assurance process for document review is recommended. This should consist of a peer review process with staff training and corrective action as needed. <u>Monitoring Team's Compliance Rating</u> Due to the paucity of completed combined assessment and case formulation, this provision remained in noncompliance.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served	<u>Psychiatry Participation in PBSP</u> Per interviews of both psychiatrists and psychology staff, the psychiatrists did not attend meetings regarding behavioral support planning, and they were not 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, however, verbalized a willingness to become more involved, but indicated that a lack of clinical contact time had made this impossible. There was concern that even if the facility was able to recruit a full time psychiatrist that they would continue to have insufficient time available to participate as required by this provision item.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	It was warranted for the treating psychiatrist to participate in the formulation of the behavior support plan via providing input or collaborating with the author of the plan. This provision item focuses on the least intrusive and most positive interventions to address the individual's condition (i.e., behavioral or psychiatric) in order to decrease the reliance on psychotropic medication. Given the presence of the IDT in psychiatry clinic, the monitoring team suggests that the PBSP could be reviewed annually during regularly scheduled quarterly clinic, with additional reviews as clinically indicated. Documentation of psychiatric attendance at IDT, ISP, and BSP meetings was reviewed. There were no meetings reportedly attended by psychiatry, although during the visit, psychiatry was observed to attend one IDT meeting (regarding Individual #578). Per discussions with facility staff, the psychiatric nurse or psychiatry assistant attended meetings as they were able and shared the information that they received with the psychiatric staff. <u>Treatment via Behavioral, Pharmacology, or other Interventions</u> The following example highlighted difficulties with regard to the coordination of treatment among disciplines, and illustrated how psychiatry participation in the development of the BSP was necessary. • Individual #578 – was admitted to the facility 3/21/12 and was experiencing increased aggression. The treating psychiatrist was concerned about this individual, and went to his home to visit him. Upon arrival, the psychiatrist was informed that the individual was in the process of a team meeting. Unfortunately, the psychiatrist was unaware that this meeting was occurring. The psychiatrist presented to the meeting, and learned that the individual had required restraints earlier in the day. There was also a report that the individual had been refusing psychotropic medication, which may have contributed to his increased agitation and aggression. A review of the medication administration record revealed documentation that the individual had taken medication. There were additional challenges with regard to this meeting. Some staff were openly negative with regard to their perception of this individual that he, "won't do things…he won't do anything." The individual was verbal and pleasant and, per the psychiatrist, required a structured reward program in order to motivate him. A review of documentation did not reveal a PBSP. Per a review of the PBSP documentation provided in the records of 18 individuals, 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 <u>all</u> meetings regarding the PBSP, there must be	

#	Provision	Assessment of Status	Compliance
		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. Staff interviewed revealed plans to add an acknowledgement of review of the PBSP via the treating psychiatrist. ISP Specification of Non-Pharmacological Treatment, Interventions, or Supports Non-pharmacological interventions were discussed during some of the psychiatric clinic encounters observed during the monitoring visit. These included references to behavioral supports, work programs, and outings. Observation and review of documentation revealed that in each psychiatry clinic, specific target behaviors associated with medications were reviewed by psychiatry and the IDT present in psychiatry clinic. While the comprehensive psychiatric evaluation documents reviewed noted recommendations for non-pharmacological interventions, the majority of these indicated a need to "continue behavioral support plan" with no additional interventions suggested. Overall, both observation and document review revealed that the focus was primarily on medication management and diagnostic clarification. There was evidence in the records that psychiatry and psychology, via the IDT present in psychiatry clinic, had collaborated with regard to specific target behaviors that were tracked for data collection and presentation. Psychiatry and psychology could also collaborate to develop non-pharmacological interventions that could be utilized on a routine basis. Monitoring Team's Compliance Rating To meet the requirements of this provision item, there needs to be an indication that the psychiatrist was involved in the development of the PBSP as specified in the wording of this provision item J9. As stated in other sections of this report regarding provision J, psychiatry and psychology must learn how they can assist each other toward the common goal of appropriate treatment interventions, both pharmacological and non-pharmacological. Therefore, this provision item was rated as being in noncompliance.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful	Policy and Procedure A review of DADS policy and procedure entitled "Psychiatry Services," dated 8/30/11, noted that state center responsibilities included that 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 the 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
	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 3/31/12, stated, "the psychiatrist, in conjunction with the IDT and pharmacist will conduct quarterly reviews of the 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. The quarterly review is documented in the record. The pharmacist's input will include the written quarterly Drug Regimen Review, but may also include participation in the discussion." 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." <u>Quality of Risk-Benefit Analysis</u> Per discussions with facility staff, 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 18 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 #388: Per the annual psychiatric evaluation dated 3/8/12, "diagnosis of psychotic disorder, not otherwise specified based on past behavior…laughing hysterically…flailing her arms…responding to something…that no one else could see or hear…currently…on Seroquel at the lowest dose she has been on and still remains relatively stable…functional abilities are quite limited…Seroquel has helped…with her levels of agitation…not seen any psychotropic behaviors in quite a few years…goal…taper…off the Seroquel…important that staff recognize the agitation that they see is the patients way of trying to communicate." o This description did not address risk/benefit per se. In this case, the individual was prescribed minimal medication and there were documented plans to attempt to discontinue pharmacological interventions altogether. • Individual #395: Per the quarterly psychiatric review dated 3/6/12, this individual was treated with medications including Cogentin, Haldol, and Trazodone. He had a history of diagnoses including autistic disorder and intermittent explosive disorder. The document included, "history of extremely severe aggressive outbursts…history of multiple psychiatric hospitalizations…target symptoms are …within acceptable limits…tolerating his	

#	Provision	Assessment of Status	Compliance
		medication well including a discontinuation of Valproic acid…behavioral plan has been generally effective in terms of addressing triggers of his outbursts…" Additional documentation revealed that Valproic acid had been discontinued due to abnormal lab values (blood count abnormalities). o Additional information did not include a risk vs. benefit analysis per se. There was, however, documentation located in the consent for treatment with psychotropic medication documents. For example: • Individual #339: Benefits: no physical aggression past two quarters and no signs of psychosis…potential risk…potential to cause Tardive Dyskinesia…" Additional examples and issues with the consent documentation are reviewed below in J14. Regardless of the improvements noted with consent documentation, there remained deficits with regard to the requirements of this provision. 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 risk/benefit documentation for treatment with a psychotropic medication should be the primary responsibility of the prescribing physician. It will also require that appropriate data regarding the individual's target symptom monitoring are 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. • Given the comprehensive manner in which psychiatry clinic was conducted during the review, the elements necessary to this documentation appeared to be readily available. 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 IDT process during psychiatry clinic could be an avenue for ensuring the IDT process is followed with respect to the requirements of this provision. <u>Observation of Psychiatric Clinic</u> During the psychiatric clinics observed by the monitoring team, the psychiatrist discussed the medication regimen with the team members present in clinic. The	

#	Provision	Assessment of Status	Compliance
		development of the risk/benefit analysis should be undertaken during psychiatry clinic. The team should consider reviewing this type of information together via a projector/screen and typing the information during the clinic process. The QDDP, psychologist, psychiatrist, and nursing staff must all contribute to the development of this section. Recommendations include accomplishing this goal together with the IDT currently participating in psychiatry clinic, access to equipment, and typing information received in the clinic setting. Of course, for the initial entry in the documentation, some prep time will be necessary to set up the shell of the document. The monitoring team is available to facilitate further discussion in regards to this recommendation, if requested. The documentation should reflect a thorough process that considers the potential side effects of each psychotropic medication, weighs those side effects against the potential benefits, includes a rationale as to why those benefits could be expected, and a reasonable estimate of the probability of success, and also compares the former to likely outcomes and/or risks associated with reasonable alternative strategies. Human Rights Committee Activities A risk-benefit analysis authored by psychiatry, yet developed via collaboration with the IDT, would then provide pertinent information for the Human Rights Committee (i.e., likely outcomes and possible risks of psychotropic medication and reasonable alternative treatments). Monitoring Team's Compliance Rating As noted above, the facility needs to develop a process for the formulation, documentation, and review of the risk vs. benefit analysis for treatment with psychotropic medication as well as the identification of alternate non-pharmacological interventions. Given the above, this provision will remain in noncompliance.	
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	Facility-Level Polypharmacy Review There was no standard monthly polypharmacy review committee in existence. Psychiatrists met individually with the pharmacist to review the medication regimens for those individuals who met criteria for polypharmacy. One challenge with this process, observed during the visit, was that the clinical pharmacist was utilizing an outdated definition of polypharmacy. In addition, the clinical pharmacist was not aware of the current psychotropic medication classification system. The monitoring team observed one meeting of a psychiatrist with the clinical pharmacist where a medication regimen was reviewed. This review was detailed, and staff discussed long range plans for medication titrations in an effort to address side effects that Individual #273 was experiencing (specifically increased prolactin levels resulting from treatment with atypical antipsychotic medication). Per discussions with facility staff, there was no current facility level review occurring with respect to polypharmacy.	Noncompliance

#	Provision	Assessment of Status	Compliance
	the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	<u>Review of Polypharmacy Justifications</u> Previously, the psychiatric physicians and physician's assistant were required to include polypharmacy justification as part of the quarterly clinical documentation. Currently, they were completing a document entitled "polypharmacy psychotropic review and recommendations report. Ten examples of this documentation were provided for review. There was variability in the quality of the documentation. For example: • Individual #90 had diagnoses including Bipolar Mood Disorder, Type 1. She was prescribed medications including Lithium, Lorazepam, and Ziprasidone. The justification authored by the psychiatrist read, "[Psychiatrist] was managing…medications until February 2012. He had started lowering Geodon. On my last evaluation on 4/27/12, I had lowered the Geodon further. The goal is to gradually reduce polypharmacy if possible. Psychiatric symptoms reported are hyperactive behavior, reduced sleep, dysphoria, pacing, anger outbursts." The pharmacist noted, "polypharmacy currently justified. Individual has a reduction/taper plan on file…has begun taper down…reduction time line may exceed one year, dependent upon increased/decreased psychosis, outburst, etc." • Individual #93 had diagnoses including Schizoaffective Disorder and Pervasive Developmental Disorder, not otherwise specified. She was prescribed quetiapine, fluphenazine, and benztropine. The justification authored by the psychiatrist read, "has a past history of dramatic psychotic…and affective dysregulation leading to physical aggression and disruptive behavior. The current regimen has led to significant stabilization. An attempt last year to reduce Prolixin resulted in a major increase in psychosis and assaultive behaviors not adequately treated by other interventions of the Positive Behavior Support Plan. The Interdisciplinary Team unanimously agreed that continued polypharmacy is needed at this time." Per the clinical pharmacist, "attempted to reduce Prolixin. Reduction failed…severely increased psychotic behavior and aggression…is functional on combination. Lab remains within normal limits…Benztropine acquired due to Prolixin EPS…" The above examples were representative of those received. The examples either indicated that a taper was in progress or outlined a rationale to continue the current regimen. It was discussed at length during the visit that polypharmacy, per se, is not always negative, because there are some individuals that, by the nature of their diagnoses, will require treatment with a regimen of psychotropic medications that meet criteria for polypharmacy. In these cases, it will be necessary to justify continued treatment with polypharmacy. This regimen and the justification would then be subjected to a critical facility level review.	

#	Provision	Assessment of Status	Compliance
		Review of Polypharmacy Data A review of the current data available regarding polypharmacy revealed a listing of 71 individuals who met criteria for polypharmacy, but as stated above, the clinical pharmacist was not using the correct definition for polypharmacy, nor was she utilizing the correct medication classification listing. As such, these data were incorrect. Per interviews with the facility clinical pharmacist, 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. 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 first step would be to ensure the use of the correct polypharmacy definition and medication classifications. Then, all medication regimens must be reviewed to determine if an individual meets criteria for polypharmacy. If the individual meets criteria, 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. This information would then be reviewed at the facility level. Further, it should be included in the facility's QA program. Monitoring Team's Compliance Rating Given the ongoing challenges noted above with regard to the need for a review of the medication regimens for the individuals and the use of the correct standards within which to determine polypharmacy for an individual regimen as well as the need for a facility level review of polypharmacy justifications, this provision was rated in noncompliance.	
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.	Completion Rates of the Standard Assessment Tools (i.e., MOSES and DISCUS) In response to the document request for a spreadsheet of individuals who were evaluated with MOSES and DISCUS scores, the facility provided information regarding scores and dates of completion of evaluations dated October 2011 through March 2012. Review of this information revealed timely completion of both evaluations. MOSES scales were being performed in the months of January and July. DISCUS scales were being performed every three months according an individualized schedule. Per 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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Training A review of information regarding training for nursing staff revealed that a two hour block of time during preservice orientation was assigned to MOSES and DISCUS training. It included videos, instructions on completing the examination, instructions on completing the forms, and the authorship of care plans for individuals experiencing side effects from psychotropic medication. Documentation provided for previous reports included information regarding a 15-minute block of training regarding MOSES and DISCUS included in nursing annual inservice training. Although copious training curriculum information was provided, the information did not include sign in sheets for staff, or data with regard to the number of nursing staff who had attended preservice or inservice training. Quality of Completion of Side Effect Rating Scales In regard to the quality of the completion of the assessments, it appeared that for the set of scales provided (10 examples of each assessment tool), all were completed appropriately and included the signature of the psychiatrist. In some cases, clinical correlation was documented on the evaluation form. For example, in the case of Individual #562, documentation included on the completed MOSES dated 3/12/12 stated, "I have switched…from Geodon to Seroquel in an effort to possibly reduce akathisia." This level of compliance noted in the 18 records in the sample reviewed showed a decrease since the last review. MOSES and DISCUS examination forms were included in these documents, and while they were all signed by the prescriber, compliance rates for the completion of the form (i.e., the evaluation and conclusion sections) were blank approximately 25% of the time. In both the clinic observations performed during this visit as well as the review of clinic documentation, MOSES and DISCUS scores were reviewed during clinic and documented as such. Four individuals were noted to have the diagnosis of Tardive Dyskinesia (TD). All were being followed by psychiatry. Although medications, such as antipsychotics and metoclopramide may cause abnormal involuntary motor movements, the same medications may also mask the movements (e.g., lowering DISCUS scores). Medication reduction or the absence of the antipsychotic or metoclopramide that occurred during a taper or discontinuation may result in increased involuntary movements, restlessness, and agitation. This presentation of symptoms may be confused with an exacerbation of an Axis I diagnosis, such as bipolar disorder. Therefore, all diagnoses inclusive of TD must be routinely reviewed and documented. Monitoring Team's Compliance Rating Given the documentation of review of MOSES and DISCUS examinations during	

#	Provision	Assessment of Status	Compliance
		psychiatry clinic, this area will remain in substantial compliance. For the facility to maintain this rating, there must be increased attention to the completion of the clinical correlation/evaluation section of the individual forms by psychiatry.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	<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. The facility had implemented facility specific policy and procedure entitled "Psychiatry Services Procedure Manual." This manual had been updated as of 3/31/12. The manual outlined the requirements for psychiatric practice consistent with statewide policy and procedure, however, did not specifically outline a procedure in order to accomplish a specific task. For example, with regard to integrated care, the facility policy simply stated, "each state center will develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation." There were no other procedural requirements identified. With regard to the specifics of this provision item, the policy stated, "match psychotropic medications used to treat specific target behaviors with an appropriate psychiatric diagnosis or a specific behavioral/pharmacological hypothesis…ensure that all staff involved with the individual receiving psychotropic medications are aware of the side effects; psychiatrist participate in staff education…clinical staff regularly monitor individuals prescribed psychotropic medications for side effects as directed by the prescribing provider…the psychiatrist, in conjunction with the IDT and pharmacist, will conduct quarterly reviews of the assessment of the risk vs. benefit of continued psychotropic medication therapy as well as the appropriateness of drug selection, effectiveness, dosage, and presence or absence of side effects…the quarterly review is documented in the record. The pharmacist input will include the written quarterly Drug Regimen Review, but may also include participation in the discussion." <u>Treatment Plan for the Psychotropic Medication</u> Per record reviews for 18 individuals, some of the information required to meet the requirements of this provision item were included in the psychiatric evaluation and the quarterly psychiatric review. For example, in the record of Individual #169, the psychiatric evaluation was completed 3/7/12, and noted participation of the IDT including psychology and nursing in the evaluation process. Although diagnoses were documented, specific symptoms or criteria that were present were not outlined for each diagnosis. Other diagnoses for this individual included Pervasive Developmental Disorder/Autism. These diagnoses were not discussed in detail with regard to specific criteria required.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The documentation did include a discussion regarding the psychiatrist's plan for pharmacological intervention for this individual, including, "she is on three psychotropic medications…she has had a change in milieu…that have been quite disruptive for the whole unit…continues to have problems with physical aggression and property destruction…" The documentation goes on to discuss the current medications, side effects that the individual was experiencing and plans for an adjustment of the medication regimen in order to address the specific side effects as well as to allow for efficacy with regard to the target symptoms identified. Other required elements (the expected timeline for the therapeutic effects of the medication to occur, the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur) were not consistently located in the documentation. Given the need for inclusion of these items in order for the facility to reach substantial compliance, the inclusion of these items as prompts on forms the physicians routinely utilize may improve documentation. Overall, while documentation was improved over prior reviews, there was variability in the documentation between providers. This was an area where quality assurance or peer review may be helpful. <u>Psychiatric Participation in ISP Meetings</u> At the time of the onsite monitoring review, there was no psychiatry participation in the ISP process. The facility did not have a full time psychiatrist on staff, and relied on contracted, part time psychiatric providers (including one physicians assistant). The schedules of providers did not allow for their attendance or participation in the ISP process. In an effort to utilize staff resources most effectively, the facility could consider incorporating IDT meetings into the psychiatry clinic process. Given the interdisciplinary model utilized during psychiatry clinic, the integration of the IDT 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 IDT members during psychiatry clinic. During this monitoring review, four 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 always take advantage of these	

#	Provision	Assessment of Status	Compliance
		opportunities. The fluidity of the discussion between psychiatry and the other IDT members varied based on the staff in attendance. There was marked variability in the quality of the interaction. Staff must be encouraged to discuss issues with the psychiatrist during psychiatry clinic. As psychiatry does not have the opportunity to attend ISP meetings, the clinical encounter was where the psychiatrist had most interaction with the various team members. During all four psychiatry clinics, the team, including the psychiatrist, met with the individual in the clinical encounter. This was an improvement over prior visits, where the individual was seen in his or her home and did not participate in the treatment team meeting. All treatment team disciplines were represented during the clinical encounter (there was one observation where staff were not initially in attendance, but arrived later). The team did not rush clinic, spending an appropriate amount of time (often 35-45 minutes) discussing the individual's treatment. During clinic, the psychiatrists reviewed behavioral data. In general, the data were graphed, and up to date. There were improvements in the data graphs as some included timelines for medication dosage changes or stressful life events. It was noted that psychology staff needed to review data presentation to ensure that it was clear. For example, data reviewed were generally graphed by the month via taking an average of incidents over that period and using the average as the data point. For individuals who were experiencing a spike in behavioral incidents over a period, it would be better to graph that data daily with the inclusion of timelines for specific occurrences over the course of the month. This would provide much better information for the psychiatrist to use when making pharmacological decisions. 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. Per a review of documentation regarding individual's participation in psychiatry clinic, it was not possible to determine the timeliness with regard to psychiatric follow-up. <u>Medication Management and Changes</u> Medication dosage adjustments should be done thoughtfully, one medication at a time, so that based on the individual's response via a clinical encounter with the individual and a review of appropriate target data (both pre and post the medication adjustment), the physician can determine the benefit, or lack thereof, of a medication adjustment. This was observed routinely at LSSLC.	

#	Provision	Assessment of Status	Compliance
		Monitoring Team's Compliance Rating As evidenced by the above, the facility psychiatry staff were making strides with regard to documentation, however, the specific items required by this provision were not routinely included. For example, there needs to be evidence of 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. In order to improve the rating, data presented to the psychiatrist must always be in a form that is useful for them to make data based decisions (e.g., graphed with indications of medication changes or significant events).	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	Policy and Procedure 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 3/31/12, "LSSLC will provide education about medications when appropriate to individuals, their families, and LAR according to accepted guidelines…the education will discuss characteristics of the medication, including expected benefits, potential adverse or side effects, dosage, standard alternative treatments, legal rights, and any question the individual and LAR may have…education is also provided to address significant changes in the individuals medication regimen…LSSLC will obtain informed consent…prior to administering psychotropic medications or other restrictive procedures…prescription of psychotropic medications will comply with all relevant ICF conditions of participation." 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		There were, 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 via mail. Additionally, the consent form should include space to document the conversation or conversation attempts with the individual and the LAR. <u>Current Practices</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. In addition to informed consent activities for newly prescribed medications, facility psychiatrists had engaged in obtaining informed consent for annual medication renewals. There were reportedly 77 completed annual consents (41% of the total of 187 individuals prescribed psychotropic medications at the facility). This number had increased from 41 reported during the previous monitoring visit. A review of 10 examples of informed consent documentation regarding new medication prescriptions and six examples of annual consent documentation also revealed improvements with regard to physician documentation. The 10 examples regarding new medication prescriptions included an attached signed IDT document regarding review of the proposed medication, including documentation of psychiatric attendance at the IDT. 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 10 examples, there was a lack of documentation regarding non-pharmacological interventions considered or utilized. Discussions with psychiatric clinic staff during the monitoring visit revealed plans to revise the current consent form completed by the psychiatrist to read, "document any non-pharmacological alternatives that exist and rationale for not implementing them at this time" as opposed to the current prompt "document any alternatives that exist…". Improved informed consent documentation was noted in the following examples: • Individual #542 – Consent documentation regarding the medication Clonidine to address "Impulse Control Disorder, Attention Deficit/Hyperactivity Disorder…motoric hyperactivity; fidgetiness; impulsivity with physical aggression towards others and sexually inappropriate behavior…decreased risk of hyperactivity and impulsive behavior. Research has documented for…years benefit of Clonidine (and other central alpha agonists) in treating a wide range of ADHD symptoms. FDA has approved long acting Clonidine in treatment of	

#	Provision	Assessment of Status	Compliance
		childhood ADD…major side effect is sedation but this is usually mild and transitory. Lowered blood pressure can be seen; dramatic hypotension and syncope is rare. See patient information…stimulant medications and Strattera…are major alternatives. Will attempt non-stimulant approach prior to trying a stimulant." • Individual #339 – Consent documentation regarding the medication Haldol to address "Autistic Disorder; Pica; History of Psychosis…physical aggression of head butting; choking and hitting others; and eating his own feces…[with this medication] no physical aggression past two quarters and no signs of psychosis…potential to cause Tardive Dyskinesia, tremors, restlessness, muscle stiffness, headache and drowsiness…patient has been on Haldol for over 30 years. Five previous attempts to lower dose or to cross titrate to Risperdal has resulted in destabilization." 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. Per discussions with staff, there had been two instances where the facility director had declined to consent to consent for medications. Upon further investigation, in both instances, the facility director had requested additional information regarding the individual's treatment. This was appropriate, as acting as the individual's LAR, the facility director was responsible for ensuring that all questions were answered to her satisfaction prior to providing consent, as any reasonable guardian would. <u>Monitoring Team's Compliance Rating</u> The efforts of the psychiatry staff with regard to completion of consent documentation were laudable and indicative of a transition toward appropriate practice. As they now had policy and procedures 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 need to perform informed consent for approximately 60% of the current caseload, and the need to begin quality assurance reviews of the physicians current consent practices, a noncompliance rating as proposed by the facility self-assessment was appropriate.	

#	Provision	Assessment of Status	Compliance
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.	Policy and Procedure Per DADS policy "Psychiatry Services" number 007.2 dated 8/30/11, "the neurologist and psychiatrist must coordinate the use of medications, through the IDT process, when medications are prescribed to treat both seizures and a mental health disorder." The facility-specific policy "Psychiatric Services Procedure Manual," updated 3/31/12, stated "the neurologist and psychiatrist will coordinate the use of medications, through the IDT process, when medications are prescribed to treat both seizures and a mental health disorder." Neither of these policies, however, described the process by which this would be accomplished. Individuals with Seizure Disorder Enrolled in Psychiatry Clinic There were 34 individuals participating in the psychiatry clinic who had a diagnosis of seizure disorder. At the time of the previous review, there were 66 individuals listed that required neuropsychiatric intervention to coordinate the use of medications prescribed to treat both seizures and a mental health disorder. This approximately 50% decrease in the number of individuals requiring medication coordination was curious. Perhaps there might have been an error in the reporting of data. Of the 18 records available for review, three had a diagnosis of seizure disorder. A review of these three records revealed: • Individual #388 – This individual was last seen by neurology in 2001. While Depakote levels were followed by psychiatry, there was need for collaboration with neurology in regard to the need for ongoing treatment with Depakote. Depakote has been associated with various side effects including osteopenia and osteoporosis. Individual #388 was diagnosed with these conditions and had a history of fractures. The information outlined regarding this case example revealed the need for consultation with neurology to determine if alternate seizure medications could be considered in order to decrease possible negative side effects. • Individual #57 – This individual was last seen by neurology in May 2011. Additional documentation located in the record was confusing, as per the ISP dated 11/16/11, "was taken off Keppra and had a seizure on 5/11/11 and restarted on Keppra." Given the review of the neurology documentation, this information was incorrect. Further documents revealed that more recently, Depakote was started to address impulsive behavior. The information outlined in this case example showed the need for improved coordination of care. Review of the documentation was confusing and the history varied dependent upon the document reviewed. • Individual #99 – This individual was last seen by neurology May 2011. Per neurology documentation, "neurologically he has had no seizure recorded…past	Noncompliance

#	Provision	Assessment of Status	Compliance
		history of have [sic] multiple seizures, but is currently on no seizure medicines specifically for that…he is on Valproic acid…Clonazepam and I am pretty sure all of these are for management of his behavior and mood…will just have the psychiatrist manage his behavioral issues." This clinical consultation highlighted the lack of coordination between neurology and psychiatry. The two medications discussed above would have efficacy with regard to reducing seizure activity. In this case, ongoing collaborative consultation between psychiatry and neurology would be necessary to address medication side effects and to ensure adequate dosing and medication levels to address both neurological and psychiatric conditions. It would be inadvisable for psychiatry to taper or discontinue one of these medications in the absence of consultation with neurology due to the potential exacerbation of seizure activity. <u>Adequacy of Current Neurology Resources</u> Per staff interviews and documentation reviewed, neurology consultation was available at the facility once a month. Neurology clinic reportedly lasted approximately three hours. It was reported that individuals could also travel to the consulting neurologists office "if need be." Staff interviewed reported attempts to increase neurology resources at the facility were not successful. Per the facility self-assessment, "neurology time has not been increased and since the loss of the full time psychiatrist in December 2011 [psychiatry] participation in neurology clinic has stopped." Other information provided via the listing of individuals treated in psychiatry clinic with a concomitant seizure disorder included the date that the individual was most recently seen by neurology. The information revealed that of the 34 individuals, there was "none found" for two individuals (indicating no recent neurology clinic evaluations). Four individuals had not been seen in neurology clinic in the past year. Of these, one individual was last seen in 2001, one individual was last seen in 2002, one individual was last seen in 2004, and one individual was last seen in 2010. Thus far in 2012, eight individuals were seen in neurology clinic. Given these data, the need for increased neurological clinical consultation was apparent because 17% 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	

#	Provision	Assessment of Status	Compliance
		currently contracted in other DADS facilities. <u>Monitoring Team's Compliance Rating</u> 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 lack of psychiatry resources, inadequacy of clinical consultation, and lack of integration of the present neurology resources via psychiatric participation in clinic and IDT process resulted in a noncompliance rating for this provision.	

Recommendations:

1. Complete Appendix B comprehensive psychiatric evaluations for all individuals participating in psychiatry clinic and review them with regard to quality (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 the development of collaborative case formulations between the disciplines, and the identification of non-pharmacological treatment interventions in addition to the positive behavioral support plan (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 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. Review those individuals requiring pretreatment sedation for medical and dental clinic and prepare individualized desensitization plans for them (J4).

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

7. Begin cross discipline consultation regarding pre treatment sedation options (J4).

8. Continue to recruit for a facility lead psychiatrist. (J5).

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. Begin quality assurance/peer review with regard to completed annual psychiatric evaluations. This review should include recommendations for additional training or corrective action as necessary (J6).

12. 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).

13. 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).

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

15. All individuals admitted to the facility and those residing at the facility who are not currently attending psychiatry clinic should have a baseline Reiss Screen. In addition, any individual who experiences a change in status (e.g., death of a family member, medical illness, change of residence) should have a Reiss Screen. (J7).

16. 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 non-pharmacological interventions (J8, J9).

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

18. Consider the development of a process by which psychiatrists are notified of IDT meetings regarding individuals on their caseload. This would allow them to attend, time permitting (J9).

19. 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 (i.e., non-pharmacological alternatives) to psychotropic medication. This should be developed in collaboration with the IDT during the clinic process. In an effort to improve documentation with regard to this requirement, consider the addition of a prompt to the current forms (J10).

20. Obtain the current definition of polypharmacy and the current medication classifications. Review all medication regimens in order to determine if they meet the criteria for polypharmacy per these standards (J11).

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

22. Ensure a multidisciplinary, facility level review of polypharmacy trends, prescribing practices, and justification of individual psychotropic medication regimens (J11).

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

24. 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).

25. Ensure that the indications for specific medications correspond to the diagnosis of record, 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, inclusive of the expected timeline for the expected therapeutic effects and the objective psychiatric symptoms that will be monitored to assess efficacy. Consider including the requirements of this provision as prompts on forms utilized by psychiatry (J13).

26. Consider incorporating ISP meetings into the psychiatry clinic (J10, 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. These 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 via quality improvement monitoring of a percentage of completed documentation (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. Ensure that individuals providing consent for psychotropic medication have the opportunity to ask questions regarding the medication as is required in the informed consent process. In the event that consent for a specific medication is declined, document the consenter's rationale.

34. Complete the informed consent process for all individuals prescribed psychotropic medication.

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

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

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

38. 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 (J1-J15).

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Functional Assessments for: • Individual #524 (3/19/12), Individual #97 (1/20/12), Individual #367 (3/20/12), Individual #469 (3/12/12), Individual #365 (12/01/11), Individual #587 (2/23/12), Individual #413 (2/20/12), Individual #131 (2/19/12), Individual #170 (2/9/12), Individual #308 (2/29/12), Individual #64 (3/27/12), Individual #133 (4/19/12) o Positive Behavior Support Plans (PBSPs) for: • Individual #524 (3/19/12), Individual #97 (1/20/12), Individual #367 (3/20/12), Individual #469 (3/12/12), Individual #365 (12/01/11), Individual #285 (12/5/11), Individual #413 (2/20/12), Individual #131 (2/19/12), Individual #170 (2/9/12), Individual #308 (2/29/12), Individual #64 (3/27/12), Individual #133 (4/19/12), Individual #410 (2/17/12) o Six months of notes on PBSPs progress for: • Individual #324 (3/19/12), Individual #97 (1/20/12), Individual #367 (3/20/12), Individual #469 (3/12/12), Individual #365 (12/01/11), Individual #587 (2/23/12), Individual #413 (2/20/12), Individual #131 (2/19/12), Individual #170 (2/9/12), Individual #308 (2/29/12), Individual #64 (3/27/12), Individual #133 (4/19/12) o Full Psychological Assessments for: • Individual #524 (3/19/12), Individual #97 (1/20/12), Individual #367 (3/20/12), Individual #469 (3/12/12), Individual #365 (12/01/11), Individual #587 (2/23/12), Individual #413 (2/20/12), Individual #131 (2/19/12), Individual #170 (2/9/12), Individual #308 (2/29/12 o Annual Psychological updates for: • Individual #199 (12/7/11), Individual #444 (3/19/12), Individual #265 (3/27/12), Individual #488 (12/27/11), Individual #142 (3/8/12), Individual #340 (1/18/12), Individual #300 (2/21/12), Individual #526 (2/20/12), Individual #51 (12/30/11), Individual #106 (2/8/12) o Policy for peer review/behavior support committee, dated 9/1/11 o Behavior Therapy Procedures, dated 4/1/06 o Request to post/training roster for: • Individual #68 o Minutes of Internal and External Peer Review meetings during the last six months o Minutes of psychology meetings during the last six months o Status of enrollment in BCBA coursework for all psychology staff, dated 3/31/12 o Section K Self-Assessment, dated 4/20/12 o Section K Presentation book, undated

	o Data reliability, IOA, and treatment integrity pilot o Dates of psychological assessments, undated o Spreadsheet of all psychology staff, and status of enrollment in BCBA coursework, undated o A list of all functional assessments completed from 10/11 to 4/12 o A list of all individuals with a PBSP o Data Collection Plan, undated o Positive Behavior Support/ IOA/Program integrity data form, undated o Replacement behavior pilot plan, undated o Behavior data sheet, dated 4/29/12 o Copies of treatment integrity and IOA data collected in the last six months o Section K Action plans, dated 4/20/12 <u>Interviews and Meetings Held</u>: o Sylvia Middlebrook, Ph.D., Director of Psychology o Robin McKnight, M.A., BCBA; Behavior Analyst I o Sylvia Middlebrook, Ph.D., Director of Psychology; Martha Thomas, M.S., Associate Psychologist V; Robin McKnight, M.A., BCBA; Behavior Analyst I; Mike Fowler, M.A., Associate Psychologist V; Kari Staley, M.A., Associate Psychologist V; Edward Hutchison, M.A., BCBA consultant o Donna Kimbrough, M.A., Associate Psychologist; Keri Leggett-Bush, M.Ed., Associate Psychologist; Kenneth Elerson, M.A., Associate Psychologist; Adam Williams, M.Ed., Associate Psychologist; Kari Staley, M.A., Associate Psychologist V o Schuyler Ivey, M.Ed.; Associate Psychologist; Julie Bradford, M.S., Associate Psychologist; Jill Harris, M.A., Associate Psychologist; Jackie Price, M.A., Associate Psychologist; Martha Thomas, M.S., Associate Psychologist V; Mike Fowler, M.A., Associate Psychologist V <u>Observations Conducted</u>: o Psychiatric Quarterly Review (5/1/12) • Individuals Presented: Individual #375, Individual #14 o Psychiatric Quarterly Review (5/3/12) • Individuals Presented: Individual #320, Individual #345, Individual 294 o ISPA meeting (4/30/12) • Individual presented: Individual #578 • Staff present: Kevin Snook, Psychologist; Robin McKnight, BCBA; Mike Fowler, Psychologist; Myra Washington, Active Treatment Coordinator, Maria Burt, RN; Keyna Ayers, SW; Jacob Diaz, DSP; Sydney Brennon, DCP; Shelia Gibson, QDDP; Luz Carter, QDDP Coordinator; Tom Middlebrook, Psychiatry o Restraint Reduction meeting (5/2/12) o PBSP training (5/3/12) • Instructor: Adam Williams, M.Ed., Associate Psychologist • Staff trained: Krystal Roberts, DCP; Shemika Almin, DCP; Brent Graham, DCP; Cary Duke, DCP; Alvaro Moreno, DCP

	• PBSP trained: Individual #68 o Psychology Peer Review meeting (5/2/12) • Staff presenting: Adam Williams, M.Ed., Associate Psychologist • Individual presented: Individual #298 o Behavior Support Committee meeting (5/2/12) • Individuals presented: Individual #64, Individual #133 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.
	Facility Self-Assessment: LSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document, separate from two other documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. Overall, the self-assessment included relevant activities in the "activities engaged in" sections. Further, the self-assessment appeared based directly on the monitoring team's report. LSSLC's self-assessment consistently included a review, for each provision item, of the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This allowed the psychology department and the monitoring team to ensure that they were both focusing on the same issues in each provision item, and that they were using comparable tools to measure progress toward achieving compliance with those issues. The monitoring team wants to acknowledge the efforts of the psychology department in completing the self-assessment, and believes that the facility was proceeding in the right direction. LSSLC's self-assessment 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 below in this report, was congruent with the facility's self-assessment. Finally, the self-assessment 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 recommends 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 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, there were several improvements since the last onsite review. These included: • Increase in the percentage of staff who wrote Positive Behavior Support Plan (PBSPs) that were enrolled in (or completed) coursework toward attainment of board certification in applied behavior analysis (K1) • One psychologist became a certified applied behavior analyst (K1) • The use of more informative and simple graphs (K4, K10) • Initiation of the collection and graphing of replacement behaviors (K4) • Initiation of the collection of data reliability (K4) • The expansion of the collection of inter-observer agreement (IOA) data (K4) • The expansion of the collection of treatment integrity data (K11) • Improvements in the quality of functional assessments (K5) • Improvements in the comprehensiveness of annual psychological assessments (K7) • Improvements in the quality of PBSPs (K9) The areas that the monitoring team suggests that LSSLC work on for the next onsite review are: • Revise the method of data collection reliability, establish goals, and pilot a method to ensure that those IOA levels are achieved (K4) • Track IOA scores, establish IOA goals, and ensure that those IOA levels are achieved (K4) • Track treatment integrity scores, establish treatment integrity goals, and ensure that those IOA levels are achieved (K11) • Expand the collection of replacement behaviors to all homes (K4) • Ensure that all functional assessments include direct observations of target behaviors (K5) • Ensure that all Positive Behavior Support Plans (PBSPs) are based on the hypothesized function of the target behavior (K9) • Ensure that all training of PBSP implementation includes a competency-based component (K12)

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs	This provision item was rated as being in noncompliance because, at the time of the onsite review, the majority of psychologists at LSSLC who wrote Positive Behavior Support Plans (PBSPs) were not certified as applied behavior analysts (BCBAs). The facility, however, continued to make improvements in this area. At the time of the onsite review, 13 of 15 psychologists who wrote PBSPs (87%) were either enrolled, or completed coursework, toward attaining a BCBA. This represented an improvement	Noncompliance

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	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.	from the last review when 77% of the psychologists were either enrolled in or completed BCBA coursework. Additionally, since the last review, one psychologist received her BCBA. The facility provided supervision of psychologists enrolled in the BCBA program by contracting with a consulting BCBA, and by the on-staff BCBA. LSSLC and DADS are to be commended for their efforts to recruit and to train staff to meet the requirements of this provision item. The facility had developed a spreadsheet to track each psychologist's BCBA training and credentials. It is recommended that the facility develop a plan to ensure that the remaining psychologists attain BCBA certification or are reassigned to duties that do not include the writing of PBSPs. To achieve compliance with this item of the Settlement Agreement the department needs to ensure that all psychologists who write 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 continued to be in substantial compliance with this item. LSSLC continued its weekly internal, and monthly external, peer review meetings. The facility conducted Behavior Therapy Committee (BTC) meetings that contained many of the elements of internal peer review, however, these meetings continued to only review PBSPs that required annual approval. The internal peer review meetings provided an opportunity for psychologists to present cases that were not progressing as expected. The peer review meetings also allowed more time to discuss cases. The internal peer review meeting observed by the monitoring team reviewed Individual #298's PBSP. The peer review meeting included active participation from the majority of the department's psychologists, and appeared to result in the identification of several new interventions to address Individual #298's target behaviors.	Substantial Compliance

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		Review of minutes from internal peer review meetings indicated that the majority of psychologists in the department regularly attended peer review meetings. Additionally, meeting minutes indicated that internal peer review meetings consistently occurred weekly, and that once a month, these meetings included a participant from outside the facility, thereby achieving the requirement of monthly external peer review meetings. Operating procedures for both internal and external peer review committees were established. 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.	
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 continued improvements regarding this provision item. In order to achieve substantial compliance, however, the facility needs to ensure that data are reliable by expanding the collection of interobserver agreement (IOA) data to all individuals with a PBSP, establishing acceptable IOA levels, and ensuring that those levels are achieved. Additionally, the facility needs to revise the data collection reliability method, extend it to all individuals with a PBSP, establish acceptable data collection reliability levels, and ensure that those levels are attained. Finally, the facility needs to expand the collection and graphing of replacement/alternative behaviors to all individuals with a PBSP. At the time of the onsite review, LSSLC utilized two data systems. In one, the direct care professionals (DCPs) were required to record the occurrence of target behaviors in each interval, and record a zero in each recording interval if target or replacement behaviors did not occur. The second system required staff to circle a yes or no in each interval to indicate if the target behavior occurred. In both data systems, staff were instructed to record the behavior, or indicate it did not occur, by the end of the interval. 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 at any time of day and determine if DCPs were recording data at the intervals specified (i.e., data collection reliability). As in past onsite reviews, the monitoring team did its own data collection reliability by sampling individual data books across all four residential units, and noting if data were recorded up to the previous recording interval for target behaviors. The results were as follows: • The target behaviors sampled for five (representing homes 557A, 563B, 549D, and 520A) of 14 data sheets reviewed (37%) were completed up to the previous recording interval. This represented an improvement over the last review when only 15% of the data sheets were completed up to the previous interval.	Noncompliance

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		These improvements are likely the result of inservices to DCPs in October 2011, November 2011, and March of 2012 reminding staff of data collection procedures. This level of data collection reliability, nevertheless, continued to be very low and 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. As recommended in the last review, the facility had begun to collect data reliability in a few homes. The self-assessment indicated that reliability had increased from 92% to 98% intervals complete. When the monitoring team reviewed the procedure the facility was using, however, it was apparent that the facility was reviewing completed data sheets at the end of the day. This method cannot identify if data were recorded at the end of the interval, or only at the end of the shift. The majority of incomplete data sheets discussed above were filled out only up to the beginning of the shift, suggesting that staff were waiting until the end of the shift to record data. The usefulness of data collection reliability is limited to observations made in the treatment site (that is, simply reviewing completed data sheets would not indicate when they were filled out). Additionally, being in the treatment site and discussing with DCPs why data are not being recorded immediately after they occur would likely improve the timeliness of data recording. Although the monitoring team was pleased that the facility initiated data reliability, it is recommended that they revise their method of data reliability to that described above. Additionally, data collection reliability goals should be established, and DCPs should be provided performance feedback to ensure that those goals are achieved. As recommended in the last report, the facility had continued to expand its collection of data on replacement behaviors. The self-assessment indicated that, at the time of the onsite review, replacement behavior data were collected in three of the four residential units. The monitoring team review found results similar to those of the self-assessment. The monitoring team found replacement behavior data sheets in 11 of the 14 individual notebooks examined (79%). As recommended in the last report, the facility recently began to graph replacement/alternative behavior. Replacement/alternative behaviors were graphed in the three (i.e., Individual #524, Individual #365, and Individual #131) of the 13 PBSPs reviewed (23%). It is now recommended that the facility extend the collection and graphing of replacement behaviors to all individuals with a PBSP. The monitoring team was encouraged by the continued development of IOA at LSSLC. Six of the 13 PBSPs reviewed (46%) contained a description of IOA data. The addition of	

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		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. It is also recommended that the facility continue to expand the collection of IOA to all individuals with PBSPs. Another area of continued improvement was the flexibility in the graphing of data in increments based on individual needs (rather than all individuals' data graphed in increments of one month). For example: • Individual #410's restraint frequency was graphed by shift and by day of the week to better understand the variables that affected the target behaviors that prompted restraints. • Individual #285's episodes of vomiting were graphed in daily increments to better understand if this behavior was decreasing. Another area of clear improvement was the routine use of simpler graphs. In all of the graphs reviewed, the effects of medication changes (and other potentially important environmental events, such as a move to a different residence) were clearly displayed by the use of phase lines or arrows, thereby, allowing the reader to quickly evaluate the possible effects of these changes on each individual's behavior. The positive outcomes of these clearer and simpler graphs capturing current data were apparent in all of the psychiatric clinics observed by the monitoring team. For example, in Individual #345's psychiatric review, the psychologist presented graphs that were current (the graphs represented data that occurred up to three days prior to the clinic meeting) and simple to understand. They clearly showed the effects of her medication changes and the increased use of replacement behavior on her target behaviors. The clear and current graphs contributed to a very productive discussion by Individual #345's entire team, and to data based decisions concerning her use of medications and various treatment interventions. In reviewing six months of PBSP data for 12 individuals, five (42%) indicated improvement in severe target behavior, such as aggression or self-injurious behavior (i.e., Individual #64 and Individual #133), or stable and low levels of severe target behavior (i.e., Individual #469, Individual #365, and Individual #413). This represented a positive trend in the improvement of dangerous behaviors at LSSLC. In the April 2011 review, 20% of the data reviewed indicted decreases or low stable levels of severe target behaviors, while 23% was reported in the last review (October 2011).	

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		Additionally, there was some indication that when progress was not occurring, action to address the lack of progress was occurring. For example, Individual #285's PBSP was modified prior to the annual review due to the absence of progress. 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. The monitoring team recognizes the substantial efforts the facility made on this provision item. Clearly, there had been a meaningful improvement, and LSSLC appeared to be on a very productive course toward future improvement in this area.	
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> One hundred and ninety-five of the 365 individuals at LSSLC (53%) had an initial (i.e., full) psychological assessment. Ten of the 90 initial psychological assessments completed since the last review (11%) were reviewed to evaluate their comprehensiveness. 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 was the percentage found in the last review, and represented an improvement in the comprehensiveness of initial psychological assessments at LSSLC compared to the April 2011 review when 86% of the initial psychological assessments 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 213 of the 365 individuals at LSSLC had a functional assessment. The monitoring team sample, and reports from facility staff, indicated that all individuals with a PBSP had a functional assessment. A spreadsheet of revealed that 97 functional assessments were completed since the last review. Twelve of these functional assessments (12%) were reviewed to assess compliance with this item of the Settlement Agreement. As discussed in previous reports, the facility used a format combining psychological evaluations, PBSPs, and	Noncompliance

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		functional assessments that included all of the components commonly identified as necessary for an effective functional assessment. The quality of some of these components, however, was insufficient for the functional assessments to be as effective as they could be. Ideally, all functional assessments should include direct and indirect assessment procedures. A direct observation 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 procedures can contribute to understanding why a target behavior occurred by conducting/administering questionnaires, interviews, or rating scales. All 12 of the functional assessments reviewed included appropriate indirect assessment procedures. Five (i.e., Individual #524, Individual #97, Individual #365, Individual #131, and Individual #308) of the functional assessments reviewed (42%) utilized direct assessment procedures that were rated as complete. This represented a substantial improvement in the percentage of direct observations rated as complete in the last two reviews (i.e., 13% and 6%). An example of a complete direct assessment procedure is described below: • Individual #308's functional assessment described a direct observation of Individual #308 engaging in the target behavior (self-injurious behavior and property destruction) that clearly suggested salient antecedents (request to participate in active treatment) and consequences (escaping the activity) of Individual #308's target behaviors. This direct observation revealed that Individual #308's target behaviors were most likely maintained by negative reinforcement (i.e., the escape or avoidance of undesired activities). The remaining seven functional assessments reviewed (Individual #367, Individual #469, Individual #587, Individual #170, Individual #64, Individual #133, and Individual #413) included direct observations, but they did not include an example of the target behavior, and did not provide any additional information about relevant antecedent or consequent events affecting the target behavior. 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 observations 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	

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		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 included regular ABC data collection, which is likely to substantially improve the collection of direct observations. It is recommended that the facility include these ABC data (when practical) in future functional assessments to add specific data, and therefore further improve, the direct observation procedures. All of the functional assessments reviewed (100%) identified potential antecedents and consequences of the undesired behavior. This was consistent with the last report when all functional assessments included potential antecedents and consequences. 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. All 12 of the functional assessments reviewed (100%) included a clear summary statement. This represented another sharp improvement from the last two reviews when 50% (April 2011 review) and 81% (last review) of the functional assessments reviewed were judged to have a clear summary statement. 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). Five (Individual #524, Individual #365, Individual #131, Individual #97, and Individual #308) of the 12 functional assessments reviewed (42%) were evaluated to be comprehensive and clear. This represented another significant improvement over the previous reports when none (April 2011) and only 6% (last report) of the functional assessments reviewed were evaluated as acceptable. The monitoring team was very pleased with the progress LSSLC was making in the quality of functional assessments. It is recommended that the facility now focus on improving the direct assessments (and adding the recently developed ABC data), and ensuring that functional assessments are modified when necessary, but at least annually.	

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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. Six of the 10 intellectual assessments reviewed contained in the 10 initial psychological assessments reviewed (60%) were conducted in the last five years. This represented an improvement from the last review when only 6% of the psychological assessments reviewed contained intellectual assessments that were completed in the last five years. A spreadsheet of the dates of all psychological assessments indicated 58 of 195 (30%) were completed in the last five years. All 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) continued to be completed for all of the individuals at LSSLC. During the last review, none of the annual assessments reviewed contained all of components described in K5. The facility recently revised the annual psychological assessment format to include all of the necessary components. LSSLC's self-assessment indicated that 33% of the annual assessments reviewed contained all of the necessary components. The results of the monitoring team's review was consistent with the facility's self-assessment, and represented an improvement in the comprehensiveness in the annual psychological assessments compared to the last review when no annual assessments were judged to be complete: • Four (Individual #199, Individual #444, Individual #265, and Individual #142) of 10 annual psychological assessments reviewed (40%) were complete, containing a standardized assessment of intellectual and adaptive ability, a review of personal history and medical status, and a review of behavioral/psychiatric status. • Six (Individual #51, Individual #526, Individual #300, Individual #340, Individual #106, and Individual #488) did not contain a review of medical status. • One (Individual #300) did not contain a review of personal history In order to achieve substantial compliance with this item of the Settlement Agreement,	Noncompliance

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		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 (Individual #582) 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. This item was rated as being in noncompliance, because all individuals needing psychological services other than PBSPs should receive such services. In order to receive substantial compliance with this item the facility will need to ensure that the need for psychological services other than PBSPs is documented in each participating individual's ISP or PBSP. All psychological services other than PBSPs should contain the following: • A treatment plan that includes an initial analysis of problem or intervention target • Services that are goal directed with measurable objectives and treatment expectations • Services that reflect evidence-based practices • Services that include documentation and review of progress • A service plan that includes a "fail criteria"— that is, a criteria that will trigger review and revision of intervention • A service plan that includes procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings	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 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	This item was rated as being in noncompliance because several PBSPs reviewed were not complete in that they did not contain all of the required components, such as interventions that were not based on functional assessment results. A list of individuals with PBSPs indicated that 213 individuals at LSSLC had PBSPs, and 80 of these were completed since the last review. Thirteen (16%) of these 80 PBSPs were reviewed to evaluate compliance with this provision item. All 13 of the PBSPs reviewed had the necessary consent and approvals. All PBSPs reviewed included descriptions of target behaviors, and all of these were operational (100%). This represented an improvement in operational definitions from the last two reports when 80% and 95% of the target behaviors were operationally defined.	Noncompliance

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	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 13 of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors, but six (i.e., Individual #97, Individual #413, Individual #170, Individual #410, Individual #64, and Individual #308) of these (46%) identified antecedents and/or consequences that appeared to be inconsistent with the stated function of the behavior and, therefore, were not likely to be useful for weakening undesired behavior. This compared with the effectiveness of antecedent and consequent procedures reported in the last review when 47% were judged to be inconsistent with the stated function. An example of a consequent intervention potentially incompatible with the hypothesized function was: • Individual #410's PBSP did not include any antecedent interventions to address his physical aggression, which was hypothesized to be maintained by negative reinforcement (i.e., a way to escape or avoid unpleasant activities). The use of antecedent interventions is an important component of any effective treatment plan and, therefore, should always be included in every PBSP. The consequent interventions in Individual #410's PBSP included encouraging him to go to another area following physical aggression. If, however, avoiding undesired activities were reinforcing for Individual #410 (as hypothesized in the PBSP), then this intervention would likely increase the likelihood of his disruptive behavior. Encouraging (and allowing) him to indicate that he wanted to leave the area BEFORE he engaged in physical aggression would potentially be an effective antecedent intervention. After the targeted behavior occurred, however, Individual #410 should not be allowed to escape the undesired activity until he appropriately requests it. If the nature of his undesired behavior is such that it is dangerous to maintain him in the activity, 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 (i.e., replacement behavior) before he engages in physical aggression. The PBSP needs to clearly state that removal of the undesired activity should be avoided, whenever possible and practical, because it encourages future undesired behavior. 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 #365's PBSP hypothesized that her aggressive behavior functioned to gain others' attention. Antecedent interventions included providing her with staff attention when she exhibited appropriate behaviors, and encouraging/reinforcing her for engaging in her replacement behavior (i.e., asking for what she wants) before she was aggressive. Her intervention following aggression included interacting with her in a firm and emotionless voice while Individual #365 was agitated. The PBSP also included providing	

#	Provision	Assessment of Status	Compliance
		one-to-one attention once she was calm and complying with staff requests. 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. As in the last report, replacement behaviors were included in all of 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 100% of the replacement behaviors that could be functional were functional. This represented an improvement from the last report, when 84% of all replacement behaviors that could be functional were functional. Ten of the 11 functional replacement behaviors discussed above appeared to represent behaviors that staff needed to encourage and reinforce (i.e., skills that the individual already had in his or her repertoire), rather than new skills the individual needed to acquire. For example: • Individual #131's replacement behavior was voicing her desires/complaints. The PBSP included instructions for staff to encourage Individual #131 to express her desires calmly, and to accommodate her when possible. The one example of a functional replacement behavior that appeared to require the acquisition of a new skill was: • Individual #285's replacement behavior, which consisted of teaching him to sign "food" with physical prompts. The monitoring team was encouraged to find, as had been recommended in past reviews, that Individual #285's replacement behavior included a skill acquisition plan (SAP) for training this new behavior. Finally, in eight of 11 PBSPs reviewed, the reinforcement of functional replacement behaviors were included in the PBSP. For example: • Individual 285's PBSP included "If (Individual #285) appropriately communicates a want or need, respect the request." This represents an improvement over the last review when the reinforcement of only one functional replacement behavior was clearly found in the PBSP.	

#	Provision	Assessment of Status	Compliance
		Overall, seven (Individual #524, Individual #367, Individual #469, Individual #365, Individual #285, Individual #131, and Individual #133) of the 13 PBSPs reviewed (54%) represented examples of complete plans that contained operational definitions of target behaviors, functional replacement behaviors (when possible and practical), and clear, concise antecedent and consequent interventions based on the results of the functional assessment. This represented a substantial improvement over the last report when 21% of the PBSPs reviewed were judged to be acceptable.	
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 by the initiation of the collection of IOA data at LSSLC (see K4). In order to achieve substantial compliance with this provision item, a system to regularly assess, track, and maintain minimum levels of agreement of PBSP data (i.e., IOA) across the entire facility will need to be demonstrated. Target behaviors were consistently graphed, and replacement behaviors began to be graphed at LSSLC. As discussed in K4, the quality and usefulness of these graphs had improved. The graphs reviewed contained horizontal and vertical axes and labels, condition change lines, data points, and a data path. Replacement behaviors were not, however, consistently graphed. It is recommended that replacement behaviors be graphed across the facility.	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 data 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 tracked 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. The self-assessment indicated that treatment integrity measures were occurring in approximately 50% of the homes. At the time of the onsite review, treatment integrity checks occurred primarily after behavioral inservices (see K12). The monitoring team reviewed the treatment integrity tool the facility was using, and believes that it represented an adequate method for assessing treatment integrity. It is recommended that the facility now expand treatment integrity to each PBSP,	Noncompliance

#	Provision	Assessment of Status	Compliance
		schedule treatment integrity assessments at regular intervals (i.e., not just after behavioral inservices), track those data, establish minimal treatment integrity standards, and work with DCPs to ensure that those levels are achieved. The monitoring team looks 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. Psychologists and psychology assistants conducted the trainings prior to PBSP implementation and whenever plans changed. Additionally, the facility added a competency based staff-training component (see K11). At the time of the onsite review, however, the competency-based training component was not consistently occurring. Therefore, this item is rated as being in noncompliance. The director of psychology indicated that she believed a psychologist or psychology assistant had trained all staff implementing PBSPs on the use of that plan. The exception being staff "floated" from another home. Those staff, however, were reportedly trained in the implementation of the PBSP by the home supervisor. The monitoring team observed the training of DCPs on Individual #68's PBSP. The training included a review of the PBSP by the psychologist, role-playing, an opportunity for DCPs to ask questions, and written questions covering varying aspects of the PBSP. The training did not, however, include a competency based training component that allowed the psychologist to observe the staff implementing the plan, and an opportunity for the psychologist to provide performance feedback to the DCPs. As discussed in K11, at the time of the onsite review, the facility was conducting these direct observations following approximately 50% of the trainings. It is therefore recommended that the facility expand the competency-based component (i.e., treatment integrity) to all trainings. 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, there needs to be evidence that the training included a competency-based component. Finally, the facility should track DCPs that require remediation, and document that they have been retrained, and subsequently demonstrated competence in the implementation of each individual's PBSP.	Noncompliance

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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 365 individuals and employed 15 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. Revise the method of data collection reliability, establish goals, and pilot a method to ensure that those levels are achieved (K4).
3. It is recommended that the facility extend the collection and graphing of replacement behaviors to all individuals with a PBSP (K4, K10).
4. Establish IOA goals and ensure that those levels are achieved (K4, K10).
5. Expand the collection and tracking of IOA data to all individuals with a PBSP (K4, K10).
6. All individuals at LSSLC should have an initial psychological assessment (K5).
7. It is recommended that the facility incorporate ABC data in future functional assessments when practical (K5).
8. A revision of the functional assessment should be completed when new information is learned concerning the variables affecting an individual's target behaviors (with a maximum of one year between reviews) (K5).
9. All psychological assessments (including assessments of intellectual ability) should be conducted at least every five years (K6).
10. Ensure that all psychological updates contain all of the components described in K5 (K7).
11. All individuals needing psychological services other than PBSPs should receive such services (K8).
12. The need for psychological services other than PBSPs should be documented in each participating individuals ISP or PBSP (K8).

13. 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

14. 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).

15. It is recommended that the facility consistently implement treatment integrity measures throughout the facility, ensure that data are regularly tracked and maintained, establish minimal acceptable integrity scores, and ensure that those levels of treatment integrity are achieved (K11).

16. The facility needs to provide documentation that all staff assigned to work with an individual have 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).

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 Preventive Health Care Guidelines, 8/30/11 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 LSSLC Seizure Management, 2/15/12 o LSSLC Self-Assessment, Section L o LSSLC Presentation Book for Section L o LSSLC Organizational Charts o LSSLC Nursing Protocol: Seizure Management Guidelines, 2/11 o DADS Clinical Guidelines: • Aspiration Risk Reduction Interdisciplinary Protocol • Enteral Feedings Interdisciplinary Protocol • Constipation/Bowel Management • Constipation Interdisciplinary Protocol • Urinary Tract Infections • Assessment and Management of Urinary Tract Infections for DSPs • Assessment and Management of Urinary Tract Infections for Nurses • Seizure Management Interdisciplinary Protocol • Seizure Management Instruction for the PCP • Seizure Management Instruction for DSP • Seizure Management Instruction for Nurse • Diabetes Mellitus • Osteoporosis • Anticoagulation Therapy 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 and internal medical reviews conducted in 2011 and 2012

	o Listing of Medical Staff o Medical Caseload Data o Mortality Review Documents o Daily Clinical Services Meeting Notes o Consultation Tracking Logs o Onsite Clinic Schedule 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, MOSES/DISCUS forms, quarterly drug regimen reviews, consultation reports, physician orders, integrated progress notes, annual nursing summaries, MARs, annual nutritional assessments, dental records, and annual ISPs, for the following individuals: • Individual #458, Individual #547, Individual #258, Individual #521, Individual #157 Individual #492, Individual #213, Individual #271, Individual #490, Individual #569, Individual #172 o Neurology Notes for the following individuals: • Individual #189, Individual #389, Individual #469, Individual #404, Individual #258, Individual #521, Individual #515, Individual #97, Individual #34, Individual #326, Individual #42, Individual #128, Individual #213 o Annual Medical Assessments for the following individuals: • Individual #516, Individual #151, Individual #500, Individual #145, Individual #546, Individual #593, Individual #194, Individual #211, Individual #109, Individual #368, Individual #569, Individual #296, Individual #545, Individual #265, Individual #519, o Consultation Referrals and IPNs and for the following individuals: • Individual #339, Individual #286, Individual #105 Individual #218, Individual #401, Individual #9, Individual #488, Individual #371, Individual #459, Individual #182 <u>Interviews and Meetings Held</u>: 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 Cheryl Hyatt, RN, APRN o Candace Pellegrino, Physician Assistant o Frances Mason, RN, Medical Compliance Nurse o Mary Bowers, RN, Chief Nursing Executive o Kathleen Lockhart, Administrative Assistant o Gale Wasson, Facility Director <u>Observations Conducted</u>: o Daily Clinical Services Meeting o Infirmary Rounds

	Facility Self-Assessment: As part of the self-assessment process, the facility submitted three documents: (1) the self-assessment, (2) an action plan and (3) a list of completed actions. For the self-assessment, the facility described for each of the four provision items, mostly one or two activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating. This was a great improvement in the assessment process. For Provisions L1 and L2, the activities were limited to the medical audits. The results discussed the audit findings and action plans. During the week of the onsite review, the monitoring team made an effort to ensure that staff understood the self-assessment process and had an opportunity to ask questions. To take this process forward, the monitoring team recommends that the medical director review, for each provision item, the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. Such actions may allow for development of a plan in which the assessment activities provide results that drive the next set of action steps. A typical self-assessment might describe the types of audits, record reviews, documents reviews, data reviews, observations, and interviews that were completed in addition to reporting the outcomes or findings of each activity or review. Thus, the self-rating of substantial compliance or noncompliance would be determined by the overall findings of the activities. The facility rated itself in noncompliance with all four provisions. The monitoring team concurs with the facility's self-rating.
	Summary of Monitor's Assessment: The medical department continued to face staffing challenges. Locum tenens physicians were used to meet the needs of the facility. A new advanced practiced registered nurse and physician assistant started a few weeks prior to the review. The primary medical staff maintained a caseload and the rotating staff served as floaters. Individuals received basic medical services. When problems where brought to the attention of the medical staff, they addressed them. Instability in staffing and heavy caseloads likely contributed to some of the problems that were found in this review. There were instances when follow-up care was not provided. At other times, there were failures to provide preventive services or adequate neurological care. Documentation of care in the Annual Medical Assessments presented a great opportunity for improvement. In addition to providing information to consultants and others, this document now served as the lead for the new ISP, making the content and accuracy even more important. Quarterly Medical Summaries were no longer being done. The Active Problem Lists were found in the records, but were often incomplete. Consultation documentation in the IPN was improved.

	Throughout this review, as with previous reviews, the monitoring team noted very specific patterns related to documentation, and to the provision of certain services. Those patterns have been consistently noted in external medical audits as well and may be influenced by many factors, including fluctuating caseloads. Nonetheless, it is worth noting that compliance rates in the various areas ranged from very high to very low reflecting practitioners who consistently scored high to practitioners who consistently scored low. Those patterns should be addressed. Medical quality audits were completed and indicated some improvement. The medical management audits were not done. Mortality reviews were completed, but additional work is needed to improve that process. There had been no additional work in the development of a quality improvement program. The medical department will need to approach this with some sense of urgency. The foundation for development was created with implementation of the clinical guidelines.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	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 subsections based on the various requirements of the Settlement Agreement and as specified in the Health Care Guidelines. **Staffing** The medical staff was comprised of two primary care physicians, a medical director, two advanced practice registered nurses, and one physician assistant. One of the APRNs and the PA were contract employees. The medical director maintained a caseload of 79. The primary care physicians maintained caseloads of 154 and 59. The medical director reported that the provider with the caseload of 59 also acted as the physician for the employee clinic and this responsibility required approximately 20 hours a week. The APRN's caseload was 76. The contract employees were used as floaters. The medical program compliance nurse, who was hired in March 2012, reported directly to the facility director. An adequate agreement was in place between the physician assistant, APRNs, and the medical director. Although not included in the staffing roster, it was reported that the respiratory therapist was under the supervision of the medical department. The medical director acknowledged that this was a recent change. **Physician Participation In Team Process** The facility continued the daily 8:00 am clinical services meetings. The medical director facilitated these meetings, which were attended by multiple disciplines including the medical staff, medical compliance nurse, QDDP coordinator, CNE, clinical pharmacist, and the hospital liaison nurse. The monitoring team attended several of these meetings	Noncompliance

#	Provision	Assessment of Status	Compliance
		and observed that the process provided a collaborative means of reviewing events that occurred over the previous 24 hours. The meeting was brief, lasting approximately 30 minutes. Infirmary rounds were conducted immediately after this meeting. The primary providers were able to conduct the remainder of sick call following completion of infirmary rounds. **Overview of the Provision of Medical Services** The medical staff completed sick call in the morning following the daily clinical services meeting. The individuals received a variety of medical services. They were provided with preventive, routine, specialty, and acute care services. The facility continued to conduct onsite neurology, dental, and ENT clinics. Other services were provided by local facilities and community providers. Individuals were transferred to local hospitals in Lufkin for evaluation and/or admission. Informal agreements remained in place with local providers who continued to provide hospital services. To further increase continuity, the hospital liaison nurse conducted hospital rounds daily to obtain status updates of hospitalized individuals. Verbal reports were given in the daily clinical services meetings. 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. Through interactions and observations during various meetings clinics and rounds, the monitoring team sensed that the medical staff genuinely cared about the individuals who lived at the facility. It appeared that most providers did the best they could under difficult circumstances. The physician staff maintained unreasonably high caseloads given the medical complexity of the individuals, and they had other assigned duties as previously described. This workload may have contributed to the deterioration in clinical outcomes. While the facility had not assembled a good dashboard of clinical indicators of medical outcomes, it was clear that hospitalizations increased 30% over the past year. The number of deaths was increasing and the average age at death decreased from 63 years (median of 64) in 2009 to 49 (median of 53) in 2011. Record reviews demonstrated documentation of care that was good in some cases. Unfortunately, there was also documentation of lapses in care, some failures to provide necessary services, and a lack of appropriate follow-up care. Several individuals had multiple hospitalizations without clear evidence of a plan of care that would prevent recurrent episodes of illness from occurring. Moreover, there were individuals with seizure disorder who did not appear to benefit from aggressive management of intractable disease. The various sections of	

#	Provision	Assessment of Status	Compliance
		this report will provide examples of both the high and low points noted during this review. **Documentation of Care** The Settlement Agreement sets forth specific requirements for documentation of care. The monitoring team reviewed numerous routine and scheduled assessments as well as record documentation. The findings are discussed below. Examples are provided in the various subsections and in the end of this section under case examples. <u>Annual Medical Assessments</u> Annual Medical Assessments included in the record sample as well as those submitted by the facility were reviewed for timeliness of completion as well as quality of the content. For the Annual Medical Assessments included in the record sample: • 10 of 10 (100%) AMAs were current • 8 of 10 (80%) AMAs included comments on family history • 8 of 10 (80%) AMAs included information about smoking and/or substance abuse history • 8 of 10 (80%) AMAs included information regarding the potential to transition The facility submitted a sample of 15 of the most recent Annual Medical Assessments along with a copy of the previous years assessment. For the sample of Annual Medical Assessments submitted by the facility: • 9 of 15 (60%) AMAs were completed in a timely manner. • 13 of 15 (87%) AMAs included comments on family history • 13 of 15 (87%) AMAs included information about smoking and/or substance abuse history • 12 of 15 (80%) AMAs included information regarding the potential to transition It could not be determined if the AMAs in the record sample were completed within 365 days of the previous assessment because the previous assessment date was not known. For Individual #569, the assessment did not meet the time requirement. The monitoring team requested the AMA tracking log, which the medical director indicated was used to track the AMAs. A document entitled Annual Personal Support Planning Meetings was provided. This document did not provide any data related to the completion of the annual Medical Assessments. The facility required that Annual Medical Assessments be completed two weeks prior to the ISP date. For the purpose of this review, the AMA was considered timely if it was	

#	Provision	Assessment of Status	Compliance
		completed within 365 days of the previous summary. The AMAs reviewed were not standardized. The format varied among providers, as did the quality of information. Generally, most provided information on past medical history, interval events, and diagnostic studies. Many providers were documenting some key immunizations while some continued to state "up to date." Key preventive services were not consistently documented and were frequently not updated in the Preventive Care Flow Sheet. In many instances, the documents simply did not accurately reflect the status of the individuals or use the most recent information. For example, an individual with multiple hospitalizations often had phrases, such as " hospitalized March 2011 with pneumonia" with no further explanation regarding the hospitalization, the episode of pneumonia, or what interventions occurred following hospitalization. Another AMA indicated the individual had osteoporosis based on an x-ray done in 2007. It should have cited the BMD done in 2012 in support of the diagnosis. Overall, most providers did not adequately assimilate information and use this information to construct a cogent plan of care that appropriately aligned with the active medical problems. In fact, there was only one provider that consistently included a list of active medical problems and provided a plan of care that aligned with each medical problem. The medical director will need to work with the medical staff, develop a template, and ensure that the template is used in order to ensure that the quality of the annual assessments improves. In developing that template, consideration should be given to the following recommendations: • Ensure that illnesses and other events, diagnostic tests, surgeries, interventions, consultations, medication trials, etc. are 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. • Document core immunizations • Document preventive care requirements and screenings, including vision and hearing inclusive of the dates • Finalize the document by listing the active problems with a plan of care that addresses each problem. The reader should be provided adequate information on overall management. <u>Quarterly Medical Summaries</u> Quarterly Medical Summaries were not being completed as required by the Health Care Guidelines and the medical director was aware of this. While these were not consistently done in the past, they had been done by some providers. It appeared that this was stopped due to staffing issues.	

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		Active Problem List Significant improvement was noted in the updating of the Active Problem Lists. For the records contained in the record sample: • 10 of 10 (100%) records included APLs • 3 of 10 (30%) APLs were either not signed or dated • 4 of 10 (40%) APLs omitted significant diagnoses The APLs were being updated, but many excluded important diagnoses, such as pneumonia. The updates were handwritten and it did not appear that the documents were re-typed on a quarterly or even an annual basis resulting in documents that were at times difficult to read. At a minimum, the documents should be re-typed on an annual basis. If resources were available, re-typing them at the time that the Quarterly Medical Summaries were completed would be ideal, but not required. Integrated Progress Notes Physicians documented in the IPN in SOAP format. The notes were usually signed, dated, and timed. The notes of some providers were not clearly legible. Many notes failed to adequately document vital signs, pertinent positive, and negative findings. Pre-hospital notes were often not found and post hospital documentation was inconsistent. Physician Orders Physician orders were usually signed and dated. Several prescribers failed to time their orders. Incomplete orders or orders that required clarification or correction of dosages, routes, and stop dates were encountered, but again this was very practitioner-specific. Per the medical services policy, upon return from the hospital, all medication orders were to be rewritten. Record reviews indicated that the usual practice was for physicians to write "resume previous medications." The process used for medication reconciliation following hospitalization was not clear. Consultation Referrals The monitoring team was unable to determine if adequate information was provided to the consultants because the consultation forms now stated " follow-up" or " well woman exam" and included the statement "appropriate diagnostics and information attached." The consults and IPNs for 10 individuals were requested. A total of 35 consults completed after October 2011 (including those from the record sample) were reviewed: • 25 of 35 (71%) consultations were summarized by the medical providers in the IPN	

#	Provision	Assessment of Status	Compliance
		o 17 of 25 (68%) consultations were documented in the IPN within five working days **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. Documentation indicated that the yearly influenza, pneumococcal, and hepatitis B vaccinations were usually administered to individuals. Documentation of Zoster status was found in most records. This was an improvement from the previous review. Screening for prostate cancer was completed for nearly all eligible males. Screening for colorectal and breast cancer was also completed with high rates of compliance. Cervical cancer screening and pelvic exams will need to be addressed. The Preventive Care Flowsheets were found in all of the records reviewed. Some guidelines cited in the flowsheets were not consistent with state issued guidelines. This is discussed further is section L4. Moreover, record reviews revealed that multiple version of the flowsheets were being used. It was difficult to identify the most recent iteration because the documents did not include a date or a revision number. One version included a section for hearing screening that indicated this was required every three years. During the conduct of this review, many documents were reviewed, such as lab reports, consults, audiology tracking reports, and immunization records. Cross-referencing of all of these reports indicated that many flowsheets required updating with current data. Databases were developed to track preventive care services, such as cancer screenings and osteoporosis. The medical department also maintained a seizure database. Data from the 10 record reviews listed above and the facility's preventive care reports are summarized below: <u>Immunizations</u> • 10 of 10 (100%) individuals received the influenza, hepatitis B, and pneumococcal vaccinations <u>Screenings</u> • 10 of 10 (100%) individuals received appropriate vision screening • 8 of 10 (80%) individuals received appropriate hearing testing <u>Prostate Cancer Screening</u> • 2 of 4 males met criteria for PSA testing	

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		• 2 of 2 (100%) males had appropriate PSA testing A list of males greater than age 50, plus African American males greater than age 45, was provided. The total for both lists was 112 males: • 108 of 112 (96%) males had PSA results documented in 2011 or 2012 • 4 of 112 (4%) males had PSA results documented prior to 2010 <u>Breast Cancer Screening</u> • 3 of 6 females met criteria for breast cancer screening • 3 of 3 (100%) females had current breast cancer screenings A list of females age 40 and older was provided. The list contained the names of 118 females, the date of the last mammogram, and explanations for lack of testing: • 81 of 118 (69%) females completed breast cancer screening in 2011 or 2012 • 12 of 118 (10%) females completed breast cancer screening in 2010 • 6 of 118 (5%) females completed cervical breast screening in 2009 • 19 of 118 (16%) females had no documentation of breast cancer screening <u>Cervical Cancer Screening</u> • 5 of 6 females met criteria for cervical cancer screening • 1 of 5 (20%) females completed cervical cancer screening within 3 years • 1 of 5 (20%) females completed cervical cancer screening in 2008 A list of females age 18 and older was provided. The list contained the names of 149 females, the date of the last pap smear, and explanations for lack of testing: • 14 of 149 (9%) females completed cervical cancer between in 2008 and 2012 • 102 of 149 (68%) females had no documentation of cervical cancer screening • 26 of 149 (17%) females had undergone hysterectomies • 7 of 149 (5%) females refused screening <u>Colorectal Cancer Screening</u> • 4 of 10 (40%) individuals met criteria for colorectal cancer screening • 4 of 4 (100%) individuals completed colonoscopies for colorectal cancer screening A list of individuals age 50 and older was provided. The list contained 192 individuals: • 170 of 192 (89%) individuals had completed colonoscopies • 22 of 192 (11%) individuals did not have documentation of colonoscopy <u>Additional Discussion</u>	

#	Provision	Assessment of Status	Compliance
		The Physicians' POI Meeting minutes for November 2011 documented that cervical cancer screening guidelines were discussed and the decision was made to make no changes to the policy that was in effect. The monitoring team acknowledges the unique and special challenges that are faced in the provision of many of these services. With regards to the decision to perform cervical cancer screening and pelvic examination, the monitoring team highly suggests that a through risk assessment, inclusive of family history, be completed prior to making the determination that the examination is not indicated. This assessment should be clearly documented in the individual's record. The monitoring team noted that Round 5 of the external medical audits found 40% compliance with the requirement to document explanations when preventive services were not provided as required. Individual #213 had a routine GYN exam. The consult clearly documented a complete pelvic examination, including a rectal exam, of a female of advanced age. Both positive and negative findings were noted. The consult indicated that a pap smear was not indicated. This example simply illustrated proper documentation of the exam and assessment that led to the decision. Simply documenting "pap not indicated" with no examination or risk assessment is not appropriate. This individual probably had cervical cancer screening in the past (not verified), was of advanced age, and was not sexually active. The American Cancer Society considers discontinuation at age 65 a "reasonable option." **Disease Management** State office issued numerous multidisciplinary clinical guidelines. The monitoring team reviewed records and facility documents to assess overall care provided for osteoporosis, GERD, and pneumonia. Data derived from record audits and the facility reports are summarized below. <u>Osteoporosis</u> The following information was obtained from the review of the record sample: • 2 of 10 individuals were diagnosed with osteoporosis • 1 of 2 (50%) individuals received calcium and vitamin D supplementation • 2 of 2 (100%) individuals had vitamin D levels monitored • 1 of 2 (50%) individuals received treatment with Actonel • 1 of 2 (50%) individuals had appropriate monitoring of bone mineral density A list of individuals with the diagnosis of osteopenia or osteoporosis was provided. The list contained the names of 42 individuals:	

#	Provision	Assessment of Status	Compliance
		• 40 of 42 (95%) individuals received calcium and vitamin D supplementation • 41 of 42 (97%) individuals had vitamin D levels monitored • 42 of 42 (100%) individuals received treatment with bisphosphonates/other agents • 31 of 42 (74%) individuals had appropriate monitoring of bone mineral density Overall, it appeared that some individuals who needed screening for osteoporosis were not screened. This was particularly noted for individuals who received high risk AEDs. Examples are found in the case reviews. <u>GERD</u> The following information was obtained from the review of the record sample: • 2 of 10 individuals were diagnosed with GERD • 2 of 2 (100%) individuals received appropriate treatments with a PPIs • 2 of 2 (100%) individuals had additional non-pharmacologic supports in place <u>Pneumonia</u> The facility submitted a list of individuals with the diagnosis of pneumonia over the past 12 months. Individual #258 had multiple episodes of pneumonia and did not appear on the list. Individual #172 also had recurrent aspiration pneumonia and ultimately required a fundoplication. Data related to the number of episodes of pneumonia appeared to be incorrect. As discussed previously, it was noticed that several individuals who had issues with aspiration and/or pneumonia did not have the diagnosis captured in the AMA or the APL. The medical director should review the accuracy of the data and ensure that all episodes are captured. Moreover, this information should be used to ensure that all individuals have been appropriately assessed and have adequate interventions in place. Those individuals with recurrent events should be managed appropriately. The revised state guidelines provide guidance for the management of recurrent aspiration. **Case Examples** Individual #458	

#	Provision	Assessment of Status	Compliance
		• Osteopenia and lumbar compression fractures were noted on x-rays dating back to 1993. The records provided did not indicate that any bone mineral density testing was done until 2008. At that time, the diagnosis was severe osteoporosis with a T score of – 4.6. Documentation of repeat testing was not located in the active records. • This individual's AMA did not list a plan of care. • Following hospitalization for a serious medical condition, the individual was seen on 10/10/11. The next physician IPN entry was on 11/9/11. Individual #271 • This individual had chronic aspiration with respiratory failure requiring mechanical ventilation, yet recurrent aspiration was not listed as a diagnosis in the APL, or addressed as a problem in the AMA. • The pelvic exam was deemed not indicated although this individual had "marked weight loss of unclear etiology." • Lab and IPN data were incomplete, but nursing documentation indicated that the individual had an elevated CEA level that required follow-up • The individual was seen in neurology clinic in 2/11 and scheduled for follow-up in three months. No follow-up was documented. Individual #258 • This individual was hospitalized four times in three months due to seizures and aspiration pneumonia. The individual had a severe form of epilepsy that is difficult to control. The individual's annual assessment failed to provide an adequate assessment of the problems, did not provide important information, and provided no plan for the individual's problems. • The AMA documented the following information: 12/8/11 seizures and 1/16/12 ^Dilantin. The individual was hospitalized with a diagnosis of status epilepticus. For the second item, according to hospital and facility records, the individual was admitted with Dilantin toxicity and aspiration pneumonia. It is important for the IDT, consultants, and anyone who reads this document to understand the medical issues. The information in the AMA is now simply pasted into the first page of the ISP. • This individual had a VNS implanted, but continued to have seizures, and drop attacks. The neurologist recommended consideration of a new drug, but wanted to discuss this option with the family due to significant risks. Three months later the recommendation was made again and the PCP agreed. There was no documentation of this in the IPN. The AMA, which was completed several weeks after the initial recommendation, did not mention the potential use of the drug or the need to discuss with the family. Due to the significant risk	

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		in using this drug, the monitoring team expected to find documentation of a team discussion as well as discussion with the family. This individual should be referred to a qualified epileptologist for further evaluation and management. The follow-up neurology appointment was scheduled and further consideration of the additional medication appeared to be pending that evaluation. • The individual had a diagnosis of osteoporosis. The only medication that would appear to address this diagnosis was Vitamin D3. The annual assessment should make that clear, but it did not. In fact, the AMA stated osteoporosis x-ray -2007 and did not mention further evaluation and it should have. A DEXA scan was obtained in April 2012 and confirmed the diagnosis of osteoporosis made in 2007. **Seizure Management** A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 169 individuals with a diagnosis of seizure disorder. The seizure database maintained by the medical department provided information on the medications received by individuals for management of seizure disorders: • 82 of 169 (48%) individuals received 1 AED • 47 of 169 (28%) individuals received 2 AEDs • 28 of 169 (17%) individuals received 3 AEDs • 7 of 169 (4%) individuals received 4 AEDs • 2 of 169 (1%) individuals received 5 AEDs • 1 of 169 (.6%) individuals received 6 AEDs The polypharmacy data should be reviewed regularly by the medical director as a quality indicator. The medical director or medical compliance nurse should validate these data. The AED polypharmacy submitted by the facility appeared to be based on the 228 individuals who received AEDs for all diagnoses or as stated "All AED medications." This has been noted as the incorrect method of calculating seizure AED polypharmacy in every monitoring report, but continued to be reported in the same manner. The number of individuals seen in the on-campus clinic and community clinics is summarized in the table below.	

#	Provision	Assessment of Status	Compliance

Neurology Clinic Appointments 2011 - 2012		
	On-Campus	Community
Oct	16	4
Nov	--	3
Dec	13	2
Jan	11	4
Feb	14	2
March	15	3
Total	69	18

There were 87 visits during the six month period. Six of the community visits were for one individual. The onsite neurology clinics lasted approximately two hours and, on average, 14 individuals were seen during each clinic. This would result in each individual having less than five minutes per visit, which would obviously be inadequate. The facility had not been able to increase the number of neurology clinic hours available. Since the departure of the full time psychiatrist, there was no means to integrate neurology and psychiatry.

The monitoring team requested neurology consultation notes for 10 individuals. The facility submitted neurology consultation notes documenting seizure management for only five individuals. These individuals are listed in the documents reviewed section. The following provides a summary of the review of these records:

- 4 of 5 (80%) individuals were seen at least twice over the past 12 months
- 3 of 5 (60%) notes indicated a description of the seizures
- 4 of 5 (80%) notes included a review of current medications for seizures and dosages
- 5 of 5 (100%) notes included recent blood levels of antiepileptic medications
- 0 of 5 (0%) notes referenced the presence or absence of side effects, including side effects from relevant side effect monitoring forms
- 5 of 5 (100%) notes included recommendations for medications
- 1 of 5 (20%) notes included recommendations related to monitoring of bone health, etc.

In order to further assess the quality of the provision of neurological services, the clinic records of seven additional individuals with a diagnosis of seizure disorder were selected. Two individuals had no clinic notes for the past year. Nearly half of the individuals in this sample did not have the appropriate follow-up care as ordered by the consulting neurologist. The following are examples of the cases reviewed by the monitoring team:

- Individual #521 received three medications for control of seizure disorder and was seen in neurology clinic in 2009. During that visit, the neurologist

#	Provision	Assessment of Status	Compliance
		requested follow-up in two months. That follow-up never occurred. An order was written in March 2012 for neurology follow-up. In spite of long term treatment with phenobarbital, this individual never had bone mineral density testing. The individual also had an abnormal TSH with no documented follow-up. • Individual #97 was seen by the neurologist for follow-up after hospitalization for seizure activity. Follow-up was to occur in six months, but evidence of that was not found. • Individual #128 was seen in clinic in June 2011 following hospitalization for breakthrough seizures. Again, follow-up was to occur in three months, but did not occur. **Do Not Resuscitate** The monitoring team requested a list of individuals with current DNRs, reason/criteria for DNR, implementation dates, notes, and orders for DNRs. The facility submitted a list of three individuals with current DNR orders. • Individual #42 had a long term DNR order implemented on 1/16/94 due to anencephaly. It was renewed on 6/24/11. • Individual #437 had a DNR order implemented on 1/1/10 due to a diagnosis of seizures. It was renewed on 10/20/11. • Individual #61 had a recent DNR order implemented on 3/4/12 due to cancer. Notes and orders for DNRs and rescinding of DNRs were requested, but not provided. The monitoring team could not review the physician or team assessments of the individual's status and reason for the DNRs. It is suggested that the facility review all DNRs to ensure that the process for implementation and renewal comply with all state guidelines.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	<u>Medical Reviews</u> External medical reviewers, from sister SSLCs, conducted medical reviews in December 2011 and March 2012. 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. There were seven essential elements related to the active problem lists, annual medical assessments, documentation of allergies, and the appropriateness of medical testing and treatment. In order to obtain an acceptable rating, essential items were required to be in place, in addition to receiving a score of 80% on nonessential items. Data for individual provider performance were provided. Aggregate data are presented in the table below. Compliance scores represent the average scores for the four providers.	Noncompliance

#	Provision	Assessment of Status	Compliance

External Medical Reviews 2011 - 2012 % Compliance			
	Date of Review	Essential	Nonessential
Round 4	December	71	78
Round 5	March	76	88

The data represented improvement in those areas assessed by the audits. Areas with low compliance rates for Round 5 were related to signing and dating the APL, updating the APL, adequacy of the past history in the AMA, documenting drug and food allergies, and documentation for failure to provide preventive services. The medical director also completed internal audits in March 2012. Those data showed 90% compliance with essential elements and 95% compliance with nonessential elements. The inter-rater reliability of the audits should be evaluated. There was no information provided related to audits of specific disease conditions, such as seizure disorders, diabetes, and aspiration. Copies of the audit tools were included in the document request and presentation books.

The QA department developed corrective action plans and tracked compliance with the plans. Data for Round 4 are presented below.

Corrective Action Plans Round 4			
	Total Action Plans	Action Plans Completed	Action Plans Remaining
Provider 1	28	23 (82%)	5 (18%)
Provider 2	51	12 (24%)	39 (76%)
Provider 3	4	4 (100%)	0 (0%)
Provider 4	41	21 (51%)	20 (49%)

The timelines for the follow-up were not clearly identified, but the data indicated improvement in completion of corrective actions since the last review. The QA nurse position was vacant and correction action data for Round 5 were not available.

<u>Mortality Management at LSSLC</u>
At the time of the review, there were no outstanding death reviews. Since the last onsite review, there were three deaths. Information for the three deaths is summarized below:

- The average age of death was 41years with an age range of 21 to 55 years.
- The causes of death were: (1) aspiration pneumonia, seizure disorder, Down syndrome, (2) respiratory failure, hepatic encephalopathy, hepatorenal syndrome and cirrhosis and (3) intra-abdominal sepsis, perforated bowel, aortic occlusion.
- There were no autopsies performed.

#	Provision	Assessment of Status	Compliance
		• Two individuals died in hospice settings. • One individual died in a hospital. Administrative and clinical death reviews were completed in accordance with state guidelines. Clinical death reviews continued to generate few recommendations regarding care. For the most recent death, a member of the medical staff who was a locum tenens physician completed a case review. The state medical and nursing services coordinators also completed reviews of the death because the individual was young, had not been acutely ill, and expired within 24 hours of hospital admission. Both reviews were helpful and, while none of these reviews pointed to any lapses in care, the monitoring team was troubled by the absence of an autopsy. The monitoring team would like to emphasize the importance of having a post-mortem examination performed under such circumstances and not relying upon the hospital diagnosis. The primary purpose of an autopsy is to determine the cause of death, the state of health of the individual before death, and to determine if the medical diagnosis and treatment was appropriate. The monitoring team met with the medical director, chief nurse executive, and facility director to discuss mortality management at LSSLC. The mortality management interview is conducted with every onsite review with the intent of discussing death reviews and corrective actions related to any deaths and/or death reviews that occurred since the previous review. Neither the medical director nor chief nurse executive could provide comments or explanations for the findings of the Clinical Death Review Committee. They were also not prepared to provide follow-up on corrective actions related to clinical issues. Since this was the fourth meeting of this nature, these questions were not unexpected. Fortunately, the facility director did have information available and could address issues from an administrative perspective. The facility had not conducted an analysis of longitudinal mortality data. This was important because data indicated an increasing number of deaths over the past three years with a corresponding decreasing average age at time of death. The monitoring team did not have sufficient data to calculate overall mortality rates, but calculation of mortality rates and analysis of the data would be an important metric to be reviewed by the medical director and QA department. The monitoring team would expect that the facility conduct regular analysis of mortality data and respond appropriately if unfavorable trends are noted. Mortality reviews have a long tradition in medicine. They provide opportunity for frank and open discussion of causes and solutions for errors. The newest iteration of mortality reviews focuses on problems and systems, not on clinicians, which is a significant transition from the “old school find blame mentality.” Mortality reviews, in	

#	Provision	Assessment of Status	Compliance
		theory, are now considered a key component in the quality improvement process. A shift to a new paradigm will require a change in culture. The mortality review system will have little value if it is not fully supported and embraced by the clinical leaders of the facility.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	The facility did not have a structured medical quality program. A comprehensive set of measures had not been identified. State office developed a set of disease management audits to serve as one component of the medical quality program, but no data were provided for LSSLC. It appeared that this component of the review was not completed. The request for evidence of a medical quality program included the results of the external and internal audits. No other evidence was provided. Although the document request did not include any evidence other than the medical audits, there was one document that had the potential to reflect the type of activities that needed to occur in a medical quality program. The medical director collected data on osteoporosis. The data showed the number of individuals with the diagnosis, treatment with calcium and vitamin D, treatment with additional medications, and T-scores. These data should be expanded and used as part of a medical quality program. Deficiencies, if any, would be clearly identified and corrective actions implemented. Follow-up would determine if the corrective actions remediated the deficiencies. The medical director should take the principle used with the osteoporosis data and apply it to other areas of concern. In moving forward with this provision, the medical director should review provision L1. The content of provision L1 demonstrated that the monitoring team assessed structural (staffing and services available), process (documentation and provision of services), and clinical outcomes (osteoporosis, GERD, and seizure outcomes) to assess the quality of medical care. The facility will need to develop a comprehensive set of indicators that includes, at a minimum, a mix of process and outcome indicators in order to move towards substantial compliance with this provision item. Moreover, the facility will need to demonstrate that indicator data are collected, analyzed, and trended. When trends are not favorable, an appropriate performance improvement methodology should be utilized to ensure remediation is achieved.	Noncompliance
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish	State office issued a series of clinical guidelines and protocols on enteral feeding, aspiration risk reduction, constipation/bowel management, seizure management, urinary tract infections, osteoporosis, diabetes mellitus, and anticoagulation. The state-issued preventive care guidelines were also implemented to some extent.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	While there had been no development of a facility policy, the medical services policy, revised in April 2012, provided some additional guidance on aspiration pneumonia, GERD, diabetes, UTIs, and bowel management. The medical director needs to review this policy to ensure that it is consistent with state guidelines. The monitoring team also recommends that consideration be given to removing the disease management component from the medical services policy and developing a separate disease management policy. That policy could include a series of attachments for the various protocols. Each attachment or protocol should include the date it was developed and/or revised, as should all protocols and forms developed. During the October 2011 review, the medical director was informed that the Preventive Care Flowsheet was not consistent with the Health Care Guidelines. It was recommended that the flowsheet be updated, but no changes were made. Thus, the facility's current PCFS was not consistent with state-issued guidelines. Preventive care guidelines were added to the facility's lab matrix as well. The documents given to the monitoring team included multiple protocols, guidelines, policies, and procedures. Some were state issued and some were local. The content was not consistent. While many professional organizations issue practice standards, decisions must be made regarding which standards will guide professional practice. The Health Care Guidelines and the state generated guidelines clearly define the facility's adopted standards. This was discussed with the medical director who indicated that he was not clear on exactly how the various guidelines were to be used or if they were mandatory. He was not sure if he was to use the state-issued Preventive Care Flow Sheet or continue to use the current one. He indicated that he had not received any written guidelines. The monitoring team advised the medical director to work with the state medical services coordinator.	

Recommendations:

1. The facility should continue to pursue the services of a full time primary care trained physician (L1).

2. The caseloads of the medical staff should be evaluated. A practitioner with full time hours should not have a caseload exceeding of more than 100 individuals (L1).

3. The medical director should track physician attendance at ISPs, possibly using data that are already collected (L1).

4. The medial director should work with the PCPs in order to improve the quality and accuracy of required documents, such as the Annual Medical Summaries, Quarterly Medical Summaries, and Active Problem Lists as discussed in the body of the report (L1).

5. The Preventive Care Flow Sheet should be updated to reflect state issued guidelines. The revision date should be provided for tracking purposes (L1).

6. The medical director should ensure that a thorough risk benefit analysis is completed when determining the appropriateness of preventive screenings. Input should be solicited from the entire team including the individual/legally authorized representative when appropriate (L1).

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

8. 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).

9. The facility should increase the number of neurology clinic hours. (L1).

10. Individuals with refractory seizure disorder should be referred to a qualified epileptologist for evaluation (L1).

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

12. The template for the disease management component of the quality audits needs to be expanded to capture clinical outcomes in addition to processes (L2).

13. The facility must complete the disease management component of the quality audits (L2).

14. The medical compliance nurse should provide assistance in the follow-up of the corrective actions for Rounds 4 and 5 of the medical audits (L2).

15. The facility director must ensure that a longitudinal review of mortality data is completed as discussed in Section L2 (L2).

16. The facility should make every effort to obtain post-mortem examinations for individuals who expire unless the death was expected and the cause of death was known (L2).

17. The facility must develop a quality program based on a comprehensive set of process and outcome indicators in addition to the quality audits

that are occurring (L3).

18. The facility must demonstrate that indicator data is collected, analyzed, and trended. When trends are not favorable, an appropriate performance improvement methodology must be utilized to ensure remediation is achieved (L3).

19. The medical director should review the various policies, procedures, and guidelines and ensure that all are consistent with state issued guidelines (L4).

20. All forms, protocols, and guidelines should include an issue or revision date (L4).

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 Self-Assessment, Plan of Improvement, and Nursing Care Action Plan (updated 4/20/12) o Alphabetical list of individuals with current ISP, 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 3/1/12-4/30/12 o Locations of AEDs, suction machines, oxygen, and emergency medical equipment o All facility policies, procedures, and guidelines that directly describe the mission, vision, operations, etc. of the facility's infirmary o Infection control monitoring tools o Policies/procedures addressing infection control o Weekly Walk-Thru Monitoring reports by Infection Control Nurse 11/1/11-4/30/12 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 Wound Clinic 11/1/11-4/30/12 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 Last six months peer reviews for Nursing Department o Last six months mortality reviews and QI Death Reviews for Nursing for individuals who died o Nursing Departments plans of action to address 1/25/12 and 3/19/12 UIRs o Nursing Department reports to the TX BON 11/11 – 4/12 o Corrective Action Plans developed since the prior review o Sedative and Consent Policy o Clinical Services Policy o Provider Orders and Transcription Policy o QA/QI Council Meeting reports for Section M 12/11 – 4/12 o Modified barium swallow study (MBSS) for Individual #137 o List of nurses who participated in the state's physical assessment and training course o For the last six individuals who transitioned to the community, their completed nursing discharge summary o Records of: • Individual #240, Individual #110, Individual #144, Individual #167, Individual #284, Individual #213, Individual #542, Individual #340, Individual #137, Individual #223, Individual #367, Individual #24, Individual #419, Individual #468, Individual #61, Individual #430, Individual #354, Individual #16, Individual #545, Individual #357, Individual #252, Individual #490, Individual #170, and Individual #463 <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 Interim QA Director, Todd Miller o Hospital Liaison, Maria Jenkins o Nurse Educator, Zalinda Colston o Nurse Compliance Nurse, Gerald Davis o Nurse Recruiter, Elizabeth Moody o PNMT RN, Cheryl Fraser o Infirmary Nurse Manager, Paul Vann <u>Observations Conducted</u>: o Visited individuals residing on all units o Medication administration on selected units o Enteral feedings on selected units o 4/30/12 Medication Variance Committee Meeting o 5/1/12 Nurse Manager Meeting o 5/2/12 Infection Control Meeting o 5/3/12 Risk Process Meeting o 5/3/12 ISP for Individual #326

	Facility Self-Assessment: LSSLC submitted its self-assessment, which was updated on 4/20/12. Since the prior review, LSSLC made a number of revisions to its self-assessment process and separated the report into three separate sections. The self-assessment now stood alone as its own document and described, for each provision item the (1) lists of discrete activities, usually trainings, monitoring activities, and policy revisions, in accordance with state directives that had occurred over the past six months, (2) results of the activities as measured by attendance at training sessions and scores on monitoring tools, and (3) self-ratings that were based upon the results of the activities. This was a marked improvement in the facility's self-assessment process. During the conduct of the onsite review, the monitoring team reviewed the self-assessment with facility staff members and provided feedback on ways in which the various activities engaged in to conduct the self-assessment could be modified to promote compliance with the provision items. In addition, the following recommendations may be helpful to the facility when assessing, measuring, and rating compliance. • Do not rely solely on the results of the statewide self-monitoring tools as the measure of compliance. The tools may be one of several activities used to self-assess, but will not likely be sufficient to gauge substantial compliance. • Consider what the monitoring team evaluates and the activities they engage in to evaluate compliance. Their activities extend beyond completion of monitoring tools and almost always involve direct observations and assessment of outcomes for individuals served by the facility. • Reliability does not mean validity. These two distinct concepts are both important to measure and incorporate into evaluation and self-assessment activities. According to the Chief Nurse Executive and Center Lead for section M, at the time of the updated self-assessment, the facility's self-ratings indicated that it continued to need improvement in all six provisions of section M in order to meet a rating of substantial compliance. On the basis of all monitoring activities undertaken by the monitoring team, the monitoring team was in agreement with the facility's self-ratings. That being said, the current review continued to reveal evidence of substantial compliance in a number of the actions steps related to several of the components of assessment and reporting protocols, integration of clinical services, and medication administration. During the onsite review, the presentation books put together by various members of the nursing department were reviewed. Most, if not all, of the information in these books were already submitted vis a vis the monitoring team's document request and already reviewed by the monitoring team in preparation for the visit.

	Summary of Monitor's Assessment: Since the prior review, the Nursing Department took several steps toward substantial compliance with the provisions of Section M of the Settlement Agreement. They began using standardized protocols to guide and direct nursing care and its documentation, and they developed and implemented forms for documenting nursing assessments post-hospitalization and upon discharge from the facility. They also created and started using systems to track individuals' weight and their physicians' orders to help ensure that changes in their health would be detected and addressed in a timely manner. There were improvements to the storage and availability of emergency medical equipment, improvements in nurses' safe and sanitary administration of medications, and focused improvements in the assessment, planning, and delivery of nursing and health care services to specific individuals who were identified with high health risks during the prior monitoring review. Notwithstanding these positive findings, the review revealed that there were still a number of areas across all provisions of Section M that needed improvement in order to achieve substantial compliance. There continued to be problems ensuring that nurses' adequately identified of health care problems, performed complete assessments, implemented planned interventions, conducted appropriate follow-up, and kept appropriate records to sufficiently and readily identify and address the significant changes in individuals' health status and needs. 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. And, the overwhelming majority of the individuals reviewed failed to have specific, individualized nursing interventions developed to address all of the individuals' health care needs, including their needs associated with their health risks. LSSLC's nurses were working hard and were committed to meeting the provisions of the Settlement Agreement. However, with the continued vacancies, reportedly high turnover rates among the ranks of the nurses, and little to no evidence of an active and effective recruitment and retention program, nurses were often working at bare minimum staffing levels and covering for vacancies. These problems continued to make substantial compliance with the provision of Section M very difficult to achieve.

#	Provision	Assessment of Status	Compliance
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	Since the prior review, LSSLC had taken steps towards meeting this provision item. For example, according to the Section M Action Plan, LSSLC implemented the state's standardized protocol for SOAP documentation, gave all nurses the state standardized protocols developed to date, and required its nurses to "sign-in" on the 24-hour nursing logs on each unit, ostensibly to attest to nurses daily presence on the homes in the locale of the individuals and their direct care staff members. The facility also continued to utilize its previously established "Sick Call Log" and "24-	Noncompliance

#	Provision	Assessment of Status	Compliance
	appropriate records of the individuals' health care status sufficient to readily identify changes in status.	Hour Reports" and, in March 2012, developed and implemented order and weight monitoring spreadsheets to help 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 their health status. According to the facility's self-assessment, since the prior monitoring review, although the Nursing Department had made improvements in several areas, the results of their self-monitoring of nurses' documentation and care of individuals with acute illnesses and injuries and/or recently hospitalized or treated at emergency rooms/urgent care facilities revealed scores that fluctuated between 71% and 86% compliance. Thus, as of the review, they reported that they continued to "need improvement to meet a substantially compliant rating." The monitoring team agreed with the facility's finding of noncompliance, but based its rating on findings that failed to reveal substantial evidence of the presence and adequacy of assessment, reporting, documenting, planning, communicating, monitoring, and evaluating significant changes in individuals health status sufficient to help ensure that the changes were readily identified and addressed. During the conduct of the monitoring review, all presentation books and all documents submitted by the facility were closely examined, all residential areas were visited, daily observations of nursing care were made, 18 nurses were interviewed, and 22 individuals' records were reviewed. All told, and consistent with the findings and conclusions in the facility's self-assessment, the monitoring review revealed that there continued to be problems ensuring that nurses' adequately identified health care problems, performed complete assessments, implemented planned interventions, conducted appropriate follow-up, and kept appropriate records to sufficiently and readily identify and address the significant changes in individuals' health status and needs. Thus, a rating of noncompliance was made in this area. <u>Record-keeping and Documentation</u> As noted in the prior review, all individuals' records were organized in a unified form/format. Since the prior review, the format of nurses' notes was changed from DAP to SOAP. The review of the 22 sample individuals' records revealed that this transition was successfully implemented, and most nurses' notes were documented using the SOAP format, in accordance with the state's standardized protocol. Individual notebooks were present on their homes and available to direct caregivers. However, the notebooks were in varying states of completeness, and random checks of several individuals' notebooks revealed that they frequently failed to reference the most	

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		current, up-to-date assessments and plans. Thus, direct care staff members, who often appeared to rely upon the information filed in the notebooks, were not afforded current, complete, accurate information, data, assessments, and plans to guide and direct the implementation of the health care duties delegated to them by clinical professionals. There were also other recordkeeping and documentation problems found in the 22 records selected and submitted by the facility for review that impacted upon the findings, and noted in detail, in other provision items, including provisions M3, M4, and M5. For example: • Two of the 22 individuals failed to have current quarterly nursing assessments. • Of the two sample individuals recently admitted to LSSLC, neither had an admission assessment that was completed in a timely manner. Individual #240's and Individual #110's comprehensive nursing assessments were not completed until 17 and 23 days, respectively, after the individuals' admission to the facility. • One individual, who suffered multiple chronic health conditions failed to have a health management plan filed in his record. • One of the 22 individuals failed to have a current, annual ISP filed in his record. • Occasionally, entries were documented on the margins of the IPNs versus starting a new page. • Errors in entries were not consistently and properly identified as such. There continued to be obliterated and partially obliterated entries usually due to nurses' who attempted to write over incorrect entries of dates, times, and findings with corrected/revised information. • Incomplete documentation of nursing interventions and cryptic phrases, such as, "Tylenol given," "Edema continues," "His first blood pressure was low," etc. were found in nurses' notes. • As noted in prior reviews, a number of nurses' names and credentials continued to be illegible. <u>Hospitalization and Hospital Liaison Activities</u> According to the state's 5/11/11 Nursing Services Policy, "The State Center Nursing Department will ensure continuity of the planning, development, coordination, and evaluation of nursing/medical needs for all individuals admitted to or discharged from the hospital to the infirmary or moving between facilities. The hospital liaison will make periodic visits to a hospitalized individual to obtain as much up- to-date information as possible from the hospital nurse responsible for care of the individual. Information gained will include but not be limited to diagnosis, symptoms, medications being given, lab work, radiological studies, procedures done or scheduled with outcomes, and plans for discharge back to the State Center." Seven of the 22 individuals selected for in-depth review were hospitalized 18 times	

#	Provision	Assessment of Status	Compliance
		during the period of 11/1/11 – 5/3/12 for treatment of significant changes in their health. In accordance with the state's clear policy directives and the provisions of the Settlement Agreement, all of the individuals who were hospitalized had Hospital Liaison Reports filed in their records. These reports revealed evidence that the nurse Hospital Liaison, who kept in contact with the individuals' tertiary care providers throughout their hospitalizations, regularly visited the individuals. In addition, the nurse Hospital Liaison thoroughly reviewed individuals' hospital records, interviewed tertiary care providers, and reported to LSSLC interdisciplinary team members the hospitalized individuals' health status, response to treatment, and progress toward discharge. The monitoring team review revealed that all hospitalized individuals 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. A review of Individual #468's record revealed that he was hospitalized four times during the six-week period of 2/8/12-3/26/12. Across all of Individual #468's hospitalizations, the nurse Hospital Liaison ensured continuity of his health care and facilitated his discharges from the hospital. A review of Individual #463's record showed that during her hospitalization, the nurse Hospital Liaison identified a significant lapse in follow-up to one of Individual #463's medical specialist's recommendations and promptly brought the issue to the attention of the primary nurse and made certain that the issue was resolved. As noted during the prior review, due to vacancies in the nursing department, the nurse Hospital Liaison continued to participate in the conduct of Quality Assurance Death Reviews for Nursing and assisted the Infection Control Nurse with managing employees' adherence to the state's requirements for tuberculosis tests and immunizations. Notwithstanding these positive findings, as noted in the prior review, the nurse Hospital Liaison was not regularly involved in or invited to attend hospitalized individuals' IDT meetings prior to or upon their discharge from the hospital. This was a missed opportunity for the nurse Hospital Liaison to help teams learn about the individuals' new health risks, reconsider their prior levels of health risk, and help plan for their smooth transition from the hospital setting to their home unit. It was also a missed opportunity for the facility to take yet another step toward achievement of substantial compliance with provisions of the Settlement Agreement in section M, as well as other sections of the Settlement Agreement, such as sections F, G, H, and I, where collaboration between the nurse Hospital Liaison and other team members and clinical professionals would undoubtedly promote improvements in continuity of care, integration of clinical services, comprehensive assessment and planning to address individuals' health needs and risks, and outcomes.	

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		Wound/Skin Integrity According to the state's 5/11/11 Nursing Services Policy, "Individuals will be provided with nursing services in accordance with their identified needs...[and] nursing services includes participation in a Skin Integrity Committee that includes medical, dietary, nursing, specialized therapy, pharmacy, quality assurance, and residential services staff. The committee reviews data related to skin integrity issues, analyzes data for patterns and formulates recommendations for preventative measures and management." LSSLC did not have a Skin Integrity Committee. Rather, oversight of this important aspect of identifying, assessing, notifying physicians, monitoring, intervening, and keeping appropriate records of this important aspect of the delivery of nursing supports and services was assigned to the Infection Control Nurse. The Infection Control Nurse developed a spreadsheet and took photographs to track individuals with alteration in skin integrity and record their specific response to treatment interventions. She also attended the weekly Wound Clinic, participated in the wound care team's monitoring and evaluation of individuals with alteration in skin integrity, and included a standing item – "Skin Integrity" - on the monthly Infection Prevention and Control Committee meeting agenda. Despite the Infection Control Nurse's dutiful oversight of some individuals' altered skin integrity, a review of the documents submitted by the facility and information obtained during the onsite activities revealed problems, which were shared with the Infection Control Nurse during her interview with the monitoring team. For example: • A review of the weekly Wound Clinic schedules and appointments revealed a number of individuals who had alterations in skin integrity. Some endured slow healing wounds, some suffered pressure areas that progressed to open sores, and others sustained skin abrasions complicated by infections, boils, and abscesses. Yet, none of these data, which were captured by the Wound Clinic, were analyzed for patterns and trends, and no recommendations for preventative measures and management were formulated. • The Infection Control/Skin Integrity Nurse was not certified in wound care, and there was no evidence that she worked closely and/or collaborated with another clinical professional who had clinical expertise, certification, or credentials in ostomy/wound care management. • A review of the monthly Infection Prevention and Control Committee meeting minutes for December 2011 through May 2012 revealed no evidence of a review of skin integrity "topics," "discussions," "plans of action," and "outcomes," as called for by the meeting agenda. • There were inadequate policies/procedures developed by LSSLC to guide/direct the Infection Control/Skin Integrity Nurse's activities. The only	

#	Provision	Assessment of Status	Compliance
		policy/procedure that LSSLC submitted for review by the monitoring team was a January 2009 "Pressure Ulcers – Prevention, Treatment, and Management" policy that had not been reviewed/revised in over three years. Thus, it was unclear whether or not the Infection Control/Skin Integrity Nurse was adequately apprised of the expectations of her position or her job duties prior to assuming the position a little over one year ago. <u>Infection Control</u> During the prior review, the Infection Control/Skin Integrity Nurse was in the job less than one year. At that time, she was spending the majority of her days conducting environmental reviews, inspecting emergency medical equipment, reviewing records, investigating infection episodes, and participating in the wound care team's monitoring and evaluation of individuals with wounds. Since the prior review, it was noted that the Infection Control/Skin Integrity Nurse ensured that a number of policies and procedures were reviewed and revised to reflect and complement the state's 2011-2012 Infection Control Manual and nursing protocols pertaining to infections. In addition, there was evidence that she conducted "Weekly Walk Through Monitoring" of environmental conditions, individual and personal protective equipment and supplies, and use and disposal of sharps. She provided focused training materials on the prevention of infections and infectious illnesses to the Unit Directors and RN case managers to assist their efforts to train direct care staff members, and populated the infection control database with information regarding individual-specific occurrences of infections. Although all of the aforementioned activities of the Infection Control/Skin Integrity Nurse were consistent with the state's and LSSLC's policies that established guidelines for the systematic review and promotion of a sanitary environment and prevention and/or investigation of the spread of contagious, infectious, or communicable diseases, the ability of the Infection Control/Skin Integrity Nurse to carry out these duties to prevent infection and maintain sanitation were cut short when she was assigned the temporary tutelage of new RN case managers. Thus, the problems identified during the prior review had not been corrected, and some of the prior weaknesses in the program had worsened. For example: • During the prior review, most of the Infection Prevention and Control Committee's "plans of action" were verbatim month after month without evidence of a thoughtful review of the effectiveness and outcomes of the plans. As of the review, this problem had not been corrected. Thus, the same generic plans, such as "refresher inservices," "encourage good hand washing," "clean specimen receptacles," etc. persisted over the next six months regardless of their effectiveness or outcomes. • During the prior review of 22 individuals' records, there was no evidence that the Infection Control/Skin Integrity Nurse was informed of incidents that posed	

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		risks for possible transmission of contagious diseases. During the current review of 22 individuals' records, there continued to be no improvement in this area and evidence that this problem may have worsened. For example, there was no evidence that the Infection Control/Skin Integrity Nurse was notified that Individual #430 and Individual #542 suffered human bite wounds with "broken skin." There was no evidence of follow-up to Individual #463's physician's 12/8/11 order for the Infection Control/Skin Integrity Nurse to clarify and/or administer to the individual the remaining vaccinations of Hepatitis B immunization series. There was also no evidence of follow-up to Individual #542's physician's 3/27/12 order for the Infection Control/Skin Integrity Nurse to evaluate whether or not "deep cleaning" of the individual's environment was necessary as part of the treatment for skin abscesses. • A review of the findings of the Infection Control/Skin Integrity Nurse's "Weekly Walk Through Monitoring" reports revealed that, although she identified problems, such as water fountains with insect infestation, Plak Vac canisters unused, unclean, unlabeled, etc., malodorous conditions in bathing rooms and restrooms, and biohazard receptacles overfilled and overflowing, most, if not all, of findings of her environmental reviews were only very briefly, albeit repeatedly, shared with LSSLC Unit Directors via electronic mail. Absent effective plans to address the persistent pattern of problems, some of which were purportedly "ongoing problems" where "different actions have been tried with no success," there was no evidence of consistent follow-up to resolution. • A review of the LSSLC Employee Immunization database revealed a number of employees who were in "need [of] #2 & #3" of their hepatitis B vaccination series, but never received timely follow-up immunization. For example, according to these data, there were employees who had not received, or declined to receive, their second and/or third hepatitis vaccination in the past 2 to 15 years. A number of these employees were designated as "food service" workers. During the review, the monitoring team attended the Infection Prevention and Control Meeting chaired by the Infection Control/Skin Integrity Nurse. The agenda items referenced relevant areas of monitoring and surveillance of actual and potential risk of infection, but the presentation and discussion of topics included only a very cursory review of the patterns and trends, some of which were inaccurately portrayed to the Committee. For example, there was no discussion by the members of the Committee of the significant and increased trend of urinary tract infections until the monitoring team raised the issue. Also, there were no questions raised by the members of the Committee regarding the graphic depiction of decreased trends in certain infections, such as pneumonia, where the trend lines were obviously calculated incorrectly. More specifically, zeroes for the months of May 2012 through December 2012 were erroneously added to the calculation of these trend lines. The Committee's failure to	

#	Provision	Assessment of Status	Compliance
		raise and discuss concerning increased rates of infections and identify and correct misleading information and inaccurate depiction of data raised serious question and concern regarding the integrity of the infection prevention and control processes underway at LSSLC. <u>Emergency Response</u> Another 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 they and other staff members were adequately and appropriately trained and competent to respond to actual medical emergencies vis a vis mock medical emergency drills. During the monitoring review of the presence, availability, and functioning of medical emergency equipment, it was noted that since the prior review, improvements in the checks of equipment and presence and availability of AEDs and other emergency equipment in areas where the majority of the individuals reside were noted. A review of six randomly selected living areas revealed that suction machines, oxygen, emergency equipment, backboards, and AEDs were present and in working order. A review of Emergency Drill Checklists for 3/1/12-4/30/12 revealed that 69 drills were conducted during the two-month period. However, as noted during all prior reviews, although nurses continued to participate in the drills, in accordance with the state's and LSSLC's policies, other clinical professionals, who were in direct contact with the individuals served by the facility, failed to participate in over 85% of the drills conducted during the two-month period. A second problem identified during the monitoring team's review of the Emergency Drill Checklists and database was that although the database indicated that certain drills were "passed," the Emergency Drill Checklists clearly indicated that serious problems were identified during the conduct of the drill and these problems were not completely addressed by the Drill Instructors. The following examples were illustrative: • On 3/1/12, the Emergency Drill Checklist indicated that although staff members were unable to open the emergency medical supply bag and access the equipment and the suction machine was not working, the drill was "passed." • On 3/21/12, the entire section of the Emergency Drill Checklist that referenced the presence, availability, and functioning of equipment was blank. Nonetheless, the database indicated that the drill was "passed." • On 4/6/12, the Emergency Drill Checklist indicated that staff members failed to bring the emergency bag and the AED to the scene, however, based upon the Drill Instructor's note that he/she "...made sure staff know where [the equipment] is located," this too was a "passed" drill.	

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		A third problem identified during the conduct of the review was that LSSLC had not reviewed and revised its Medical Emergency Response and Drills policy, as promised in its 3/21/12 response to the regulatory survey statement of deficiencies. According to LSSLC's 3/21/12 plan of correction, the "Medical Emergency Response and Individual Supervision policies [were] revised to include specific instructions on supervision responsibilities during drills." More specifically, LSSLC's plan of correction stipulated that the facility would incorporate the directive for all staff members to always maintain their supervision assignments at all times in the facility's Medical Emergency Response and Drills policy. Notwithstanding this plan, on 5/2/12, LSSLC's Medical Emergency Response and Drills policy was reviewed, but it was not revised to clearly state the staff members' order of obligations during an actual emergency or planned drill. Rather, as of 5/2/12, the policy was still very confusing and left it to the reader to figure out what to do. For example, the policy stated, "...Available staff [must] respond immediately to the scene of the emergency," but "...Staff with individual supervision levels [were] not considered available staff." The policy also stated, "...Individuals with supervision levels must be maintained during drills," but "...Should there be an emergency situation in which staff must provide assistance, staff with individuals with increased levels of supervision will not be held accountable." It was strongly recommended that the facility again carefully review its policies/procedures to ensure that the expectations and requirements for staff members during actual medical emergencies and planned drills were clearly stated and helped to prohibit mistreatment, neglect, or abuse of the individuals, as required by regulation. <u>Infirmary</u> Another way 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 facility's 4/20/12 self-report, since the prior review, the Infirmary Nurse Manager provided training to all infirmary nursing staff and respiratory therapists regarding the privacy, dignity, respect, assessment, and treatment of individuals who reside in the infirmary. In addition, the Infirmary Nurse Manager began more formally collaborating and communicating with the QDDP Director/Active Treatment Coordinator and Unit Directors to help ensure that direct care staff members were knowledgeable of the individuals they supported in the infirmary and consistently implemented their active treatment programs, as tolerated. During the monitoring team's interview with	

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		the Infirmary Nurse Manager, he reported that since the prior review, communication and collaboration with the individuals' RN case managers significantly increased. Also, direct care staff members were more often attending the nurses' change of shift report and learning about the changes in individuals' health status and needs, which impacted the nature and level of the individuals' participation in their active treatment programs. The Infirmary Nurse Manager reported that since the prior review, on occasion, he was invited to attend selected individuals' interdisciplinary team meetings. However, as noted in the prior review, he was not regularly informed of or included in the meetings that were held to determine individuals' transfers to/from the infirmary. A major accomplishment since the prior review was the establishment of a true "treatment room" adjacent to the infirmary. The Infirmary Nurse Manager, who took a lead role in this accomplishment, proudly showed the monitoring team the new treatment room, which was clean, bright, well equipped, organized, and operational. A review of the admissions to the infirmary over the past several months revealed that, on average, there were greater than 30 admissions per month to the infirmary and lengths-of-stay that ranged from less than 24 hours to over 59 days. At the time of the review, the infirmary was half-full. There were six individuals residing in the infirmary who had an average length of stay of 21 days. According to the Infirmary Nurse Manager, the infirmary served individuals who needed 24-hour nursing care and/or close monitoring, as well as individuals who were discharged from the emergency room or hospital. The infirmary also served employees who suffered injuries any time while on-duty. In addition, at 9:00 pm, the infirmary was the "central hub" of activity, and as such all telephone calls were routed through the infirmary. The infirmary was also referenced in the facility's 2/10/12 plan of correction to address the regulatory survey finding of failure to provide documentation of efforts to address individuals who refused to eat, accept fluids, take medication, and suffered weight loss. According to LSSLC's plan of correction, "Individuals with orders for In's and Out's (i.e., intake and output monitoring) will be admitted to the infirmary for a more accurate measurement of their intake and output." Although the regulatory reviewers apparently accepted this plan, it was unclear how a facility with a census of 365 individuals and an infirmary with a capacity for 13 beds could or would carry out this plan. According to the Infirmary Nurse Manager, several of the direct care staff members who were trained and competent to carry out certain delegated health care duties were "cut" from the infirmary's staffing pattern. When the monitoring team asked the Infirmary Nurse Manager to explain the reason for the changes in the number and presence of trained, competent, and experienced direct care staff members in the infirmary, he was	

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		unable to do so. He was only able to presume that "down the road" or "in the future," the infirmary may only use "floating DSPs" and "no DSP charge." There were a number of demands placed on the infirmary to meet the needs of a diverse and ever-changing group of individuals with compromising health needs and risks while helping the facility meet its obligation to address individuals' significant changes in health. However, there were no policies, procedures, protocols, guidelines, etc. in place to guide and direct the leadership, management, design, staffing patterns, operations, and evaluation of the infirmary. Rather, in response to the monitoring team's request for any and all facility policies, procedures, and guidelines that directly address the operations of the facility's infirmary, only two policies - the June 2009 "Infirmary Nursing Admission Process" and "Infirmary Nursing Dismissal Process" – were submitted. Thus, it was not surprising that the Infirmary Nurse Manager was unable to explain the mission, vision, purpose, and scope of the facility's infirmary. <u>Other Significant Changes in Individuals' Health Status</u> According to the Health Care Guidelines, all health care issues must be identified and followed to resolution. In addition, documentation of the Integrated Progress Notes (IPNs) must include all information regarding the status of the problem, actions taken, and response(s) to treatment at least every day to ensure that treatment is appropriate and recovery underway until such time as the problem is resolved. In addition, the state's Nursing Services Policy stipulated that nursing staff members must document all health care issues and must have follow-up documentation reflecting status of the problem, actions taken, and the response to treatment at least once per day until the problem has resolved. Across the 22 individuals reviewed, there was evidence that their physicians usually responded to nurses' notifications of significant changes in their health status and needs and/or when the individuals needed to be seen in "sick call." However, as noted in the prior review, direct care staff members were usually the first responders and reporters of health care problems and concerns to the LVNs. Thus, there continued to be a heavy reliance upon the direct care staff members to readily identify problems and 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. A review of 22 sample individuals' records showed that the facility failed to ensure that its nurses consistently identified, implemented, and documented their interventions to address individuals' health care problems and changes in health status, and/or conducted at least daily follow-up until resolution of the significant changes in individuals' health status occurred.	

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		The following examples represented the seriousness of this problem at LSSLC. • On 2/8/12, at 9:00 pm, Individual #354's nurse documented that he/she was called to see Individual #354 due to his failure to respond to requests to take his medications. Upon the nurse's arrive to Individual #354's room, he was found "slumped in his wheelchair" and "unresponsive." Individual #354's direct care staff member reported to his nurse, "[Individual #354] was in his wheelchair all evening and 10 minutes ago he became unresponsive." At this time, Individual #354's nurse called his physician who ordered his transfer to the emergency room for treatment. • On 3/2/12, Individual #542 was "screaming" over the presence of white patches on his tongue and yellow discoloration of his throat. His nurse assessed him, concluded he suffered from "possible thrush and sore throat," placed him on sick call for the morning, and awaited physician orders. There was no evidence of follow-up to this significant change in health. Over the next several days, Individual #542 complained of pain in his mouth, lay on the floor, struck his head against the floor, and began to refuse portions of his meals. He was not seen or examined by his physician or dentist until 3/6/12 when it was noted that he had "...a full mouth of aphthous type ulcers." • Individual #419 was hospitalized from 4/5/12-4/6/12 for treatment of severe constipation with impaction that failed to resolve with multiple administrations of laxatives and enemas. Once Individual #419 was discharged from the hospital, her physician ordered her return to her home unit. Her nurse obtained her vital signs, listened to her lung and bowel sounds, and obtained a head to toe skin assessment. Despite the significant changes in health status, there was no evidence of complete assessments and monitoring of her health status until 4/9/12 when she was seen and evaluated by her physician during sick call. • On 3/3/12, at 9:00 am, Individual #213's direct care staff member reported to her nurse Individual #213 she lost her balance and fell hitting her head on the dining room table and dining chair. At this time, Individual #213's nurse noted that she had a "...3cm x 3cm knot with blue bruise area to middle (blank). 1.5 cm linear bruise to R cheek. Some swelling to R cheek as well." Despite the presence of a hematoma caused by a blow to Individual #213's head the nurse erroneously concluded that Individual #213 had suffered only a "mild" head injury and required only the lowest level of monitoring and assessment associated with the protocol for head injuries. In addition, although Individual #213's night nurse noted obvious worsening of her visible injuries, such as facial swelling, a blackened eye that was swollen shut, and bruises to her nose and jaw, he/she failed to notify Individual #213's physician and continued to consider Individual #213's injuries to be "minor." Several hours later when Individual #213's physician was finally notified of her injuries, he ordered her transfer to	

#	Provision	Assessment of Status	Compliance
		the emergency room to rule-out facial fractures.	
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.	In accordance with the provisions of the Settlement Agreement, 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. In addition, a review of the state's guidelines for completing the comprehensive nursing assessments revealed that they clearly required the comprehensive nursing assessments to be completed prior to and in anticipation of the individuals' annual and quarterly ISP meetings. Thus making it imperative that the Nursing and QDDPs/ISP Coordination Departments closely coordinate, communicate, and collaborate with each other. According to the facility's self-assessment, they continued to require improvement in this provision item. The self-assessment referenced the prior monitoring report and their recent regulatory review, which found problems related to their assessment and management of weight loss. A review of 22 sample individuals' records revealed that current annual and/or quarterly nursing assessments were present in all but two of the 22 records reviewed. Of the 20 sample individuals with current annual and quarterly nursing assessments records, two individuals' (Individual #16 and Individual #223) assessments referenced complete and accurate evaluations of the individuals' nursing care needs. The remaining 18 individuals' 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 failed to 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 was given to this provision item. At LSSLC, the annual and quarterly nursing assessments continued to play an important part in the delivery of nursing supports and services because they continued to be the	Noncompliance

#	Provision	Assessment of Status	Compliance
		only processes whereby individuals' nurses' collected, analyzed, and recorded their evaluations of individuals' health status and their responses to treatment interventions from "head to toe." As noted in all previous reports, at LSSLC, IPNs were episode-driven and almost always written in response to narrow, specific, and significant changes in individuals' health status. • The notable exception to this finding was that a few nurses, usually infirmary-based nurses, regularly documented weekly and/or monthly reviews of individuals' responses to the interventions in their health and medical care plans. This type of documentation provided evidence that these nurses conducted regular reviews of the outcomes of nursing care for individuals with multiple and interrelated health and behavioral needs and risks, which was consistent with the requirements of the state's Nursing Services policy. 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 discharged 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 11/1/11 – 5/3/12. Almost three-fourths of these individuals' assessments were complete. But, as noted in the prior review, there were a number of assessments that had one or more important sections that were incomplete or left blank. Other examples are given below: <u>Regarding specific individuals</u> • Individual #367 had several health needs and risks. He suffered a number of seizures during the most current quarterly review period, but his assessment inaccurately reported that he suffered only six seizures, failed to reference the findings and recommendations of his neurology consultation, failed to evaluate his response to and the effectiveness of his medications and treatments, and inconsistently referenced his current weight as both 123.6 and 128 pounds. The inaccurate and inconsistent information in Individual #367's current nursing assessment appeared to be the result of "cutting and pasting" old, outdated information and assessment data into the current assessment reports. • Over the past several months, Individual #468 was hospitalized four times for treatment of severe ileus, pneumonia, status epilepticus, and Dilantin toxicity. Notwithstanding his health needs and risks, his quarterly nursing assessments failed to reference his episodes of Dilantin toxicity and poor oral hygiene. In addition, his Braden score was significantly underscored and failed to accurately portray his risk of skin breakdown.	

#	Provision	Assessment of Status	Compliance
		• Despite Individual #284's fragile health and high health needs and risks, her nursing assessment concluded that only constipation, impaired gas exchange, imbalanced nutrition, and fracture were her current nursing problems. Notably, her nursing diagnoses failed to reference her risk of fractures due to bone loss, contractures, immobility, anemia, seizures and risk of injuries, vision and hearing loss, dysphagia, risk of aspiration, alteration in skin integrity, and degenerative osteoarthritis. Thus, there was no evidence that adequate and appropriate interventions were developed and implemented. • Over the past six months, Individual #430 suffered at least 20 falls, most of which resulted in head injuries, abrasions, contusions, and hematomas. Although Individual #403's nursing assessments reported the frequency of his falls, they failed to reference an in-depth analysis of the nature, cause, and extrinsic and intrinsic factors associated with his actual falls and heightened risk of falls and serious injuries. • Individual #545 was hospitalized five times in a three-month period. Four of the five hospitalizations occurred during and after his comprehensive nursing assessment was completed. Also, since the completion of that assessment, he suffered Dilantin toxicity, urinary tract infection, uncontrolled seizures, severe fecal impaction, abnormal liver enzymes, skin breakdown, weight loss, and escalation of his frequent refusals of medications, food, and fluids. Even with these significant changes in his health, a comprehensive nursing assessment was not done. <u>Regarding numerous individuals</u> • Since the prior review, LSSLC reported that they implemented "an integrated order tracking system" for all disciplines to track provider orders for inter-departmental and external consultations, labs, x-rays, and clinics. A review of these data for the two-week period of 4/15-4/30/12 revealed problems. o The single largest problem was missing data and blank entries for the "order tracking" of EKGs, x-rays, labs, and off-campus consultations, which made the system all but ineffective for its stated purpose of assuring that provider orders were accurately received and implemented as prescribed. o "ASAP" and "STAT" orders that were "pending" for at least two weeks without resolution, "completed" orders for procedures not scheduled to occur for two months, and almost no "special instructions" for staff members taking individuals for EKGs, x-rays, and other on off-campus appointments, were prevalent. o In addition, it was unclear whether or not obvious patterns and trends depicted by these data, such as the pattern of incomplete occult blood	

#	Provision	Assessment of Status	Compliance
		screenings, were identified and addressed. o Thus, it was not surprising that several of the sample individuals' records referenced physicians' orders requesting an answer to the question, "What happened to [my order]?" • Individuals' weekly Aspiration Trigger Assessment reports were not consistently completed on a weekly basis. • Many individuals with planned "weekly" and "monthly" reviews of their responses to various medications/treatments/etc. were inconsistently and sporadically documented in their records. • The "Post-Infirmary Nursing Assessments," which were referenced by nurses in the IPNs, were not filed in their records. Thus, critically important health status data and findings of assessments were not readily available and accessible to clinical professionals when making treatment recommendations and/or rendering health care decisions. • As noted in the prior review, the impact of many of the individuals' chronic conditions were either not adequately portrayed by the individuals' nursing assessments and/or not even referenced in the individuals' lists of nursing diagnoses. • Nursing assessments frequently failed to reference an assessment of individuals' pain. Although the Wong Baker pain rating scale was referenced as a tool that was used to evaluate pain, there was no further information provided in the nurses' assessment about the individuals' pain, such as the location, intensity, onset, duration, quality, etc. of the individuals' pain, and none explained how, where, when, and what verbalizations, behaviors, and/or gestures were associated with the individuals' communication of pain and what measures, in addition to medications, were effective in alleviating pain. • When significant weight changes were documented, there were no evaluations of the nature and impact of the changes on the individuals' health status. • Lists of nursing problems/diagnoses were incomplete and usually copied verbatim from prior assessments regardless of changes suffered by the individual during the quarterly review period.	
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	According to the Health Care Guidelines and DADS Nursing Services Policy and Procedures, based upon an assessment, a written nursing care plan should be completed, 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. The nursing interventions put forward in these plans should reference individual-specific, personalized activities and strategies designed to achieve individuals' desired goals, objectives, and outcomes within a specified timeline of implementation of interventions.	Noncompliance

#	Provision	Assessment of Status	Compliance
	conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	In addition, the state's 12/30/11 guidelines for the routine responsibilities of the RN case managers reaffirmed that, with regarding to planning, they must actively participate in ISPA meetings and IDT meetings to discuss and formulate plans of care to address the health risks, as well as other chronic and acute health needs or issues as they arise, for the individuals served by the facility. The guidelines also indicated that RN case mangers were not to provide RN coverage for the unit/campus on any shift, not to be scheduled to work or provide RN coverage for the unit/campus on weekends or holidays, not to work as a campus RN, RN supervisor or Office on Duty, and not to provide supervision to other nurses. Thus, while the guidelines confirmed expectations for RN case managers, they also sought to ensure that RN case managers would be afforded adequate time and attention to focus on their main task – the quality, clinically optimal, and cost-effective management of the health care status and health care needs of individuals on their assigned caseloads. According to the facility's self-report for section M3, since the prior review, the Medical Care Plans were revised, infirmary nurses were provided re-education on the implementation of Medical Care Plans, and additional care plan audits and monitoring tools were completed. However, mandatory training on care plan implementation and carrying out corrective action plans for areas of care plan compliance that scored below 80% were not scheduled to occur until after 6/1/12. Currently, the monitoring review of 22 individuals' records revealed that all 22 individuals had one or more HMPs, several individuals had one or more MCPs, and few individuals had one or more ACPs. Overall, since the prior review, there was progress made in improving the presence and quality of the individuals' health care plans. For example, during the prior review, the monitoring team raised concern to DADS and the facility regarding Individual #285, who had lost 27 pounds and suffered almost daily episodes of vomiting, meal refusals, and self-injurious behaviors, which usually involved repeatedly banging his head on walls, bed frame, etc. In the weeks following the onsite review, an action plan was put in place regarding this case. During the current review, an evaluation of the implementation of the facility's plan to address Individual #285's health needs and risks revealed improvements in his home environment, presence of familiar direct care staff members specifically trained to assist him with activities of daily living, and health status data indicative of positive health outcomes, such as improved intake, weight gain, and decreased episodes of self-induced vomiting and self-injurious behavior Notwithstanding these positive findings, the overwhelming majority of the individuals reviewed failed to have specific, individualized nursing interventions developed to address all of the individuals' health care needs, including their needs associated with their health risks. As a result, a rating of noncompliance was given to this provision item.	

#	Provision	Assessment of Status	Compliance
		Some general comments regarding the 22 sample individuals' care plans are below. Of note, most of the findings were consistent with the findings from the prior reviews. • As noted in the prior review, the purpose of the MCPs was unclear. They appeared to be developed in response to acute problems and 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, numerous pages of blank review forms were usually attached to the MCP, which referred the reader to "See IPN for detailed assessment data." • 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. o A number of the interventions put forward in the stock care plans were not consistent with the state's health and nursing care protocols. • Almost identical 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 constipation was used to address the needs of an individual who suffered occasional episodes of hard stool, as well as the needs of individual who was repeatedly hospitalized for abdominal distention, severe constipation, fecalith, and impactions. • ACPs were not consistently developed in response to emergent health problems and/or resolved in a timely manner. • 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. • Goals and outcomes were not specific, measurable, and individual-centered. For example, there were far too many goals that set the expectation for individuals to suffer <u>one less negative health outcome</u> this year than last year. This problem appeared to be the result of setting goals for individuals based upon limited experience and expectations rather than upon evidence-based practice outcomes, individuals' desired health goals, and a vision for the results of quality care. Examples of problems in the HMPs and ACPs of specific individuals are presented below: • Over the past several months, Individual #213 lost 17 pounds, broke her toe, fell and sustained trauma to her face, treated for a urinary tract infection, and suffered markedly elevated levels of phenylalanine (PHE). Despite the number and complexity of Individual #213's health problems and risks, she had only one HMP to address her hypothermia. Absent complete and comprehensive health care plans with interventions to meet Individual #213's health needs, there was	

#	Provision	Assessment of Status	Compliance
		evidence of lapses in the delivery of her health care supports and services, as recommended and ordered by her medical specialists and primary physician. • Although Individual #284's nursing assessments reiterated that she was "...non-ambulatory, nonverbal, and completely dependent on others to anticipate and meet her daily needs," at the time of the review, there were no HMPs filed in her record. • Despite Individual #252's many health needs, high health risks, and potential for significant complications, which were further challenged by his behavioral health needs and risks, at the time of the review, he had only one HMP – a 5/11/11 "Constipation" plan - filed in his record. • Over the past several months, Individual #463 was diagnosed with stage V renal failure and recurrence of submandibular cancer. In November 2011, a new neck nodule was identified, excised, and tested positive for adenoid cystic cancer. Although she initially began receiving radiation therapy to slow the progression of her cancer, as of 5/1/12, her radiation therapy was suspended pending her physician's consultation with her family. On 5/3/12, Individual #463's family and physician agreed to forego dialysis and changed her resuscitative status to "DNR." It was concerning to find that despite the significant changes in Individual #463's health status and obvious need for review/revision of many of her plans given the changes in her health, there were no ISPAs filed in Individual #463's record since her 1/3/12 ISP, when radiation and dialysis were still possible treatment options.	
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.	Of the six provisions of section M, M4 has the broadest scope. This provision item clearly ties assessment and reporting protocols to outcomes, and it requires rigorous implementation to achieve substantial compliance. More specifically, this provision item demands that each component of the nursing process is in place and put into practice such that the health needs of the individuals served by the facility are met. This means that, when properly implemented, the assessment and reporting protocols should produce results, that is, expected outcomes. Expected outcomes will depend on the individual and his/her situation, and they may include maintaining or attaining health or achieving end of life goals. The facility's self-assessment indicated that, since the prior monitoring review, all facility nursing policies and procedures were reviewed, all state standardized nursing policies and protocols were implemented, nursing policy and procedure manuals were placed in the infirmary and on all units, and nurses attended the second round of their physical assessment training course and a SOAP documentation training provided by the state's advanced practice RNs (APRNs). The CNE reported that the state APRNs found LSSLC's nurses' examples of SOAP documentation to be some of the best that they had seen	Noncompliance

#	Provision	Assessment of Status	Compliance
		across the state. The CNE also reported, however, that although some measures of their compliance showed progress toward the achievement of substantial compliance with this provision item, there were recent resignations, vacancies, and turnover in the Nursing and QA Departments, which were positions with functions and duties that were critical to attaining and maintaining compliance in M4. Thus, they concluded, "...the Nursing [Department] feels strongly that substantial compliance is extremely close, but based on the findings of the self-assessment, this provision will remain as noncompliance." The monitoring team was in agreement with the self-rating of noncompliance. The Nursing Operations Officer (NOO) continued to work closely with the CNE and shared her vision for an adequately staffed and stable Nursing Department. As noted in the prior review, the NOO continued to manage and supervise the nurse managers, RN case managers, shift nurse supervisors, and direct care RNs and LVNs. Since the prior review, the NOO started meeting with all nurse managers and the Program Compliance Nurse on a weekly basis. During these meetings, the nurses reviewed the findings from the monitoring tools and audits and developed strategies to correct problems. They also reviewed policies, procedures, staffing data, call-in logs, medication variance reports, and other issues that pertained to the operations and management of the Department. The NOO was also immersed in the department's endeavor to ensure that the state's and the facility's nursing policies, procedures, and protocols were properly implemented. This was no small task, especially given the past year's proliferation of standardized, statewide policies and protocols. During the review, nurses were observed to have the state's protocols on laminated cards on their person and/or in their workstations. Although they reported that they were implementing the protocols, at the time of the review, there was no evidence in either the IPNs, comprehensive assessments, or HMPs that the protocols were consistently and/or correctly used to guide and direct nursing interventions during episodes of acute changes in health, ensure that adequate and appropriate nursing assessments and monitoring of health status changes were completely carried out, and trigger the parameters and time frames for the reporting of signs and symptoms of significant changes in health to the individuals' physician and/or other clinical professionals, as indicated. Thus, supporting documentation failed to corroborate the facility's report that they had actually implemented the nursing protocols. For multiple individuals, their records revealed the following: • Individuals who suffered episodes of vomiting failed to have evidence of implementation of the protocol developed to address this problem. Thus, some developed respiratory distress and others required emergency medical	

#	Provision	Assessment of Status	Compliance
		treatment and/or hospitalization. • Several individuals who suffered head injuries were not assessed or monitored, in accordance with the head injury protocol. This was especially significant for individuals who suffered moderate to serious head injuries, but were mistakenly presumed to have only minor injuries. As a result, they were not closely and completely assessed and monitored, as indicated by the protocol. • Individuals with episodes of hypothermia failed to have their core body temperatures confirmed and monitored by obtaining rectal temperatures, in accordance with the hypothermia protocol. • The enteral feedings of individuals who suffered episodes of wheezing, gurgling, and change in breath sounds were not stopped immediately and their physicians were not notified, in accordance with the enteral feeding protocol. • Individuals who suffered episodes constipation were not assessed or monitored, in accordance with the constipation protocol. • Individuals who suffered acute illness/injuries were not assessed, monitored, and evaluated for their response(s) to treatment until their illness/injuries resolved, in accordance with the protocol. It was clear to the monitoring team that this continued to be a work in progress and that LSSLC was cognizant of the need for additional steps to be taken to ensure that their nurses would consistently implement the nursing protocols. "Re-education and training" continued to be the focus of recurring themes present in LSSLC's self-assessment, self-reports, and CAPs. The Nurse Educator reported that, since the prior review, she conducted the facility's annual competency and refresher training and provided re-education and training on nursing protocols, respect and dignity, individual supervision levels, response to actual emergencies and emergency drills, and SOAP documentation to all nurses. In addition, the Nurse Educator updated the facility's Preceptor Program to ensure that it was consistent with the state and facility policies and procedures and conducted a preceptor class once a month until all nurses who were interested and qualified were trained and ready to mentor new nurses. Since the prior review, the Nurse Educator and her assistant began conducting one-on-one training sessions with new RN case managers, performed remedial training with nurses who were referred to them for additional training and support in specific nursing duties, such as medication administration, and "fine tuned" a small group of RNs' physical assessment skills. Notwithstanding these positive findings, a review of the competency/skill and on-the-job training records for five of the most recently hired nurses' and five agency nurses'	

#	Provision	Assessment of Status	Compliance
		continued to reveal problems documenting and maintaining accurate and complete evidence that nurses actually received the orientation and training that was reported to the monitoring team, and that the nurses were truly evaluated and deemed competent to carry out their duties prior to their assignments to individuals, units and/or the infirmary. For example, a review of the five newly hired nurses' and five agency nurses' records revealed that some nurses had blank entries for the assessment and verification of their competence/skills in performing procedures, such as sterile dressing changes, neurological assessment, seizure management, etc. Some nurses' records had no documentation of the methods used to assess their competence and/or the dates when their competence was verified. Finally, the majority of the records reviewed failed to reveal the name of the Nurse Preceptor responsible for assessing and verifying the nurses' competence/skills. These problems were significant because they were indicative of gaps and lapses in three of the most important areas of nursing education – performing training, evaluating competence, and verifying skills. LSSLC's Nurse Recruiter continued to spend most of her time preparing the nurses' schedule, processing their requests for scheduled time off-duty, and helping the Infection Control Nurse. Since the prior review, there was little to no improvement made in recruiting and retaining nurses. As noted during the prior review, there continued to be a number of vacancies in the Nursing Department, and in order to ensure adequate nursing staff at the facility, contract/agency nurses continued to be used. As of the review, the Nursing Department continued to report 17 vacant FTEs. According to the Nurse Recruiter, one of the biggest reasons for this was because there were little recruitment activities. Another reason was that there was very little flexibility in most nurses' schedules, and many were afforded only one weekend off a month. Although the Nurse Recruiter continued to maintain 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, this was not enough to help LSSLC recruit and retain a stable, trained, competent nurse workforce. As recommended in the prior review, the monitoring team continued to encourage the Nurse Recruiter to calculate turnover rates, analyzed the data stored in the call-in log, and present more evidence-based information to the facility administration. The Nurse Recruiter was also urged to consider other creative, inexpensive recruitment strategies to propose to the CNE and facility administration. Since the prior review, the Quality Assurance Nurse resigned, and, at the time of the review, the position was vacant. Prior to the departure of the QA Nurse, she prepared "Corrective Actions" for section M that referenced several attempts to collaborate with the Nursing Department's Program Compliance Nurse to review and discuss monitoring tools and compliance scores, which were low and varied considerably depending upon	

#	Provision	Assessment of Status	Compliance
		the reviewer. There was no evidence that this occurred. Thus, on 4/25/12, the interim QA Director prepared "Corrective Actions" for section M that reference the plan "to meet with the Director and Department Head to determine how data will be disseminated and trended until the QA Nurse position is filled." As of the review, this meeting was still being scheduled. Many of the QA Nurse's responsibilities, which included tracking and monitoring unusual incidents involving abuse allegations and high profile incidents, as well as completing Quality Improvement Death Reviews of Nursing care, were assigned to other nurses, most of whom worked in the Nursing Department. As noted in the prior review, the monitoring team was concerned that nurses who worked in the Nursing Department may be less likely to critically review their colleagues' care of individuals who died and/or were involved in untoward incidents. Since the prior review, several corrective action plans were developed to address the findings and recommendations of regulatory reviewers and the QA Death Reviews of Nursing. A review of these plans revealed that a number of steps were taken to address some of the specific health and safety problems that were identified in these reports. However, the effectiveness and outcomes of these actions and plans were yet to be realized. For example, in response to the findings and recommendations of regulatory reviewers, the Nursing Department led the review of all individuals who suffered unplanned weight loss and developed a Weight Master Tracking system. As of the review, the tracking system was up and running, but its usefulness as a tool to help ensure that individuals with unplanned weight loss would be identified in a timely manner had not yet been evaluated and affirmed. In the absence of a QA Nurse, the evaluations and reviews conducted by the Program Compliance Nurse provided evidence of a comprehensive monitoring process that appeared to be the strongest component of the Nursing Department's self-assessment program. The Program Compliance Nurse was exceedingly knowledgeable of the provisions of the Settlement Agreement, the Health Care Guidelines, and the state and facility nursing policies, procedures, and protocols. The Program Compliance Nurse consistently applied excellent sampling strategy, systematically reviewed nursing care in accordance with the 12 monitoring tools, identified problems, and helped the Nursing Department break down barriers to compliance. In addition, the Program Compliance Nurse made certain that each and every day he was well informed of what was going on "acutely" at the facility to help him keep his findings in context. The scores on the monitoring tools, which were calculated by the Program Compliance Nurse, were not artificially inflated by scoring an item that was "not applicable" as a "yes" or a "positive finding." Rather, the scores were straightforward measures of what was	

#	Provision	Assessment of Status	Compliance
		actually documented and done at the time of the review. Each month, the Program Compliance Nurse reported the findings from the monitoring tools to the CNE and NOO. Areas of noncompliance were respectfully revealed, and explanations for what "could possibly be attributed" to the findings were put forward. In recent weeks, the Program Compliance Nurse began sharing the results of the monitoring tools at the weekly Nurse Manager Meeting. During the review, the monitoring team attended the weekly Nurse Manager Meeting and observed first hand the Nursing Department's efforts to thoughtfully and critically examine the findings of the compliance reviews and make plans to improve nursing care at LSSLC.	
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 had completed the first year of its implementation of the state approved health risk assessment rating tool and assessment of risk as part of the ISP process. According to the facility's self-assessment, since the prior monitoring review, the integrated risk rating forms and the risk action plans were added to the Individual Notebooks. Unit Directors and Home Managers were reportedly working with staff members to make sure that they understood how to use the information. In addition, the Nursing Department reported that they continued to monitor their compliance with infection control procedures, addressing alteration in skin integrity, and meeting the nursing care needs of individuals with seizures and chronic respiratory conditions. According to the self-assessment, "...the IDTs are not consistently meeting in response to changes in and at-risk individuals' conditions. Plans do not sufficiently address clinical indicators to be monitored to be able to determine the adequacy of the plan. Intervention plans often do not provide enough information for DSPs to consistently implement support." Also, the self-assessment revealed a decline in compliance scores that was "possibly attributed to the addition of three new auditors." One of the most obvious ways that the Nursing Department would improve its performance and compliance with the risk assessment and planning processes would be through nurses' assessment and documentation of individuals' indicators of risk and their attendance and participation in the IDT and ISP processes. During the conduct of the review, the monitoring team attended one annual ISP meeting, which was held on behalf of Individual #326. The QDDP who chaired the meeting was in training and paired another more experienced QDDP. Both QDDPs were courteous, respectful, organized, and able to keep the meeting discussion focused and on track. Although the QDDPs were knowledgeable of the individual, his preferences, strengths, abilities, etc., they were not adequately	Noncompliance

#	Provision	Assessment of Status	Compliance
		prepared or trained to answer the Individual #326's guardian's questions pertaining to topics, such as "most integrated setting," "restrictive environment," "community living options," etc. Thus, on several occasions, misinformation and misimpressions were not clarified. For the most part, the QDDPs attempted to keep the discussion of Individual #326's health and his health risks at the end of the meeting and separate from the discussion of other aspects of the his life. This had the unfortunate consequence of making the discussion of his health and health risks sound contrived and more like an "addendum" to his ISP rather than an integral and important part of all aspects of his life. The conduct of the RN case manager who participated in the ISP needed improvement. For example, although the RN case manager was prepared and knowledgeable of Individual #326's health needs, the RN case manager, together with the QDDP, quickly went through the list of risk areas, read the information from the prior review, indicated whether or not there was "anything else," and assigned a level of risk without ensuring that IDT members participated or contributed to the assessment. As long as there were no interruptions with a "disagreement" of the assigned risk level, the QDDP and RN case manager moved from one risk area to the next and completed the assessment and risk action plan without most IDT members involved in the process. All 22 of the sample individuals reviewed had multiple risks related to their health and/or behavior, and over half of the 22 individuals reviewed were referred to as having one or more "high" health risks. All of the 22 sample individuals whose records were reviewed were also reviewed by their IDTs and assigned levels of risk that ranged from low to high across several health and behavior indicators. As noted in the prior report and consistent with the facility's self-assessment, 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: • During the period of 2/8/12-5/26/12, Individual #468 suffered Dilantin toxicity twice, urinary tract infections, severe colonic ileus, severe constipation, impaction, and possible aspiration pneumonia, and was hospitalized four times. Nonetheless, Individual #468's 10/7/11 risk assessment and risk action plan were not reviewed and/or revised. In addition, it was concerning to note that a review of Individual #468's record revealed no evidence that his IDT met to review the significant changes in his health. • On 2/13/12, Individual #61 underwent a biopsy of an esophageal mass and was diagnosed with stage III esophageal cancer. On 3/17/12, Individual #61 was	

#	Provision	Assessment of Status	Compliance
		hospitalized after days of nausea and vomiting and treated for severe anemia, constipation, dehydration, and fluid/electrolyte imbalance. On 4/4/12, her physician changed her resuscitative status to "DNR." On 4/12/12, Individual #61's risk assessment and risk actions plans were updated. However, a review of her assessment and plan revealed dire need for additional training and support for her IDT members. For example, many, if not all, risk areas were assigned a risk level based upon whether or not Individual #61 had already suffered an untoward health outcome and not upon her IDT's evaluation of the likelihood that she may suffer untoward health outcomes given the significant changes in her health status. • Individual #213's 1/11/12 risk assessment indicated that she was at high risk of weight loss, complications of osteoporosis, and side effects related to polypharmacy. A review of the interventions Individual #213's risk action plan revealed exceedingly limited action steps to reduce her risk of untoward health outcomes. For example, to address her risk of weight loss and promote her gain of 15 pounds, the planned action steps consisted of monitoring her weekly weight and scheduling consultations with her dietician and PKU specialist. To address her risk of complications due to osteoporosis, the planned action steps consisted of bone density tests and direct care staff members should encourage her not to "flop." To address her risk of side effects related to polypharmacy, the planned action steps were for her nurse to complete a MOSES/DISCUS and her pharmacist to conduct a QDRR. Of note, none of the specific action steps recommended and ordered by her physician and/or nurse practitioner to address her health risks, such as calorie counts, appetite stimulant, discontinued PKU diet restrictions, etc. were referenced by her plan.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing	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 facility incorporated competency-based training on the state's Medication Variance Policy into the orientation and annual refresher training schedules. The facility's policy governing the use of certified medication aides (CMAs) was revised, and, as of the review, there were only two CMAs at the facility who administered medications to individuals only during field trips. Both CMAs were trained and deemed competent to administer medications. Also, there were	Noncompliance

#	Provision	Assessment of Status	Compliance
	compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	revisions to the facility's order and transcription policy, procedure, and protocols to help reduce medication variance and ensure that provider orders were accurately received and implemented as prescribed. Consistent with the facility's self-assessment, this provision item, however, was rated as being in noncompliance because there continued to be problems in this area. Observations of medication administration, oral and enteral, were conducted on selected units. During most observations, there were considerable and noticeable improvements in nurses' safe and sanitary administration of medication. During five of the seven observations, nurses administered medications in accordance with standards of practice, but during two observations, they did not. For example, during the five acceptable medication observations, nurses properly sanitized and/or washed their hands, they identified individuals prior to administration to ensure safety, they treated individuals with dignity and respect, and, one nurse, who identified an individual with a health need during his/her medication pass ensured that the individual received adequate and timely follow-up care. Nevertheless, during the two 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; 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; 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 the facility's self-reported increase in medication variance. For example, as noted during the prior review, there continued to be instructions related to the administration of individuals' medications written in permanent ink inside the bins where their medications were stored. 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. The monitoring team remained concerned that new and/or agency nurses may not be aware of the <u>unwritten</u> rule, which was <u>not</u> to follow the instructions written inside the bins. In addition, the MARs were still very confusing. For all individuals reviewed by the monitoring team, there continued to be pages and pages of crossed-out, re-written, and otherwise clarified medication orders on the MARs.	

#	Provision	Assessment of Status	Compliance
		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, 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. The review of 22 individuals' current MARs for the period of 4/1/12-4/30/12 revealed a decline in performance from the prior review. Over one-third of the 22 individuals reviewed had omissions and/or discrepancies in their MARs. These omissions and discrepancies included missing entries for psychotropic, anticonvulsant, diabetic, 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. Since the prior review, a clinical pharmacologist joined the Pharmacy Department. Although the pharmacologist was not new to her role, she was new to the state's system of medication management and the software program in use at the facility. Nonetheless, as of the review, the pharmacologist had implemented, and planned to implement, changes and corrections to errors in the medication management software program. The changes were welcomed by the Nursing Department who had struggled long and hard and worked closely with the Pharmacy Department to correct and improve the almost constant printing/software errors. During the Committee's review of the trends in medication variance, dispensing errors, errors of omission, and incorrect dosages of medications continued to be the top three contributors to the facility's frequency of medication variance. The year-to-date variance data presented during the meeting showed a pattern of increase and subsequent decline in total variance, which was a positive finding. The CNE reported to the Committee that nurses continued with daily counting and reconciling procedures, and, as a result, they were able to identify the who, what, where, when, and how of extra and/or missing doses of medications. The Pharmacist reported to the Committee that he continued to ensure that medications that were "double checked" before they left the pharmacy. Thus, the nurses' daily counts of medications and their close scrutiny and correction of the MARs and the pharmacy's double-checks of medications before they left the pharmacy continued to be the "actions taken" by the facility to reduce medication variance. This was confirmed during the monitoring team's review of the 2011-2012 Medication Variance Trending database. Of note, a review of the monthly report of "Comments/Analysis/Actions Taken Regarding Trends revealed little evidence of the Committee's deliberations regarding possible and/or planned actions to address the	

#	Provision	Assessment of Status	Compliance
		patterns and trends of medication variance beyond conducting more audits and monitoring activities.	

Recommendations:

1. Consider placing a hold, at least temporarily, on developing more tracking systems, spreadsheets, and monitoring activities, and spend that time on identifying and addressing the barriers to compliance with simple solutions that can help you achieve substantial compliance (M1-M6).

2. Develop ways to help nurses understand how they should be using the standardized nursing protocols during their daily routines. (M1–M6).

3. Consider ways to prevent taking key nurses from their positions and using them to train, supervise, or cover other nurses' job duties. This has unfortunate and unintended consequence and may take away from progress toward compliance with the provisions of Section M and the health/safety of the individuals (M1-M6).

4. Consider developing policies and procedures to define, guide, and direct the operations and management of the facility's infirmary (M1).

5. Develop some new and simple, yet creative and inexpensive, ways to recruit and retain nurses to fill vacant positions (M1-M6).

6. Find ways to make sure that the nurses who recently participated and very successfully completed the state's assessment and documentation training course regularly use their newly acquired skill set (M2).

7. Continue to work on ensuring 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).

8. Ensure that nursing assessments are complete and comprehensive and conducted upon significant change in individuals' health status and risks (M1, M2, M5).

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. Once the new QA Nurse is hired, the Nursing Department should seize all opportunities to establish good collegial relationships and reestablish consistent communication and collaboration with the QA Department (M4).

11. Consider letting the investigations of clinical referrals of incidents of alleged abuse, neglect, and/or mistreatment and the QA Death Reviews of Nursing care remain with the QA Department and new QA Nurse (M4).

12. Consider developing additional strategies to improve the collaboration and cooperation between the Nursing and Habilitation Departments, and especially with the PNMT RN, to improve the coordination of individuals' health care (M1-M6)

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

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:** <u>Documents Reviewed</u>: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o DADS Policy #009.1: Medical Care, 2/16/11 o DADS Policy #011: Pharmacy Services, 9/26/11 o DADS Policy #053: Medication Variances, 9/23/11 o LSSLC Self-Assessment for Section N o LSSLC Action Plan 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, 4/5/12 o LSSLC Moses Assessments – For General Medication ide Effects Monitoring, DISCUS Assessments For Tardive Dyskinesia and Extrapyramidal Side Effects Monitoring, 6/8/11 o Pharmacy and Therapeutics Committee Meeting Minutes, 10/31/11, 1/30/12, 4/4/12, 5/3/12 o Medication Error Review Committee Meeting Minutes: 10/31/11, 11/21/11, 12/19/11, 1/20/12, 2/16/12, 3/22/12, 4/30/12 o Daily Clinical Services Meeting Minutes o Single Patient Interventions o Notes Extracts o Adverse Drug Reactions Reports o Drug Utilization Calendar o Drug Utilization Evaluations • Diphenhydramine • Propranolol o Medication Variances 2011 - 2012 o Quarterly Drug Regimen Review Schedule o Quarterly Drug Regimen Reviews for the following individuals: • Individual #339, Individual #288, Individual #105, Individual #344, Individual #422, Individual #229, Individual #252, Individual #465, Individual #158, Individual #301, Individual #257, Individual #135, Individual #435, Individual #494, Individual #132, Individual #395, Individual #318, Individual #380, Individual #226, Individual #185, Individual #170, Individual #451, Individual #437, Individual #506, Individual #127, Individual #431, Individual #121, Individual #225, Individual #414, Individual #485, Individual #31, Individual #27, Individual #93, Individual #57, Individual #39, Individual #74

	o MOSES evaluations for the following individuals: • Individual #261, Individual #339, Individual #382, Individual #160, Individual #103, Individual #513, Individual #529, Individual #556, Individual #471, Individual #210, Individual #285, Individual #547, Individual #392, Individual #587, Individual #565, Individual #134, Individual #542, Individual #188, Individual #234, Individual #562, Individual #258, Individual #157, Individual #458, Individual #521, Individual #172, Individual #569, Individual #492, Individual #271, Individual #490, Individual #213, Individual #592, Individual #555, Individual #336, Individual #482, Individual #221, Individual #145, Individual #401, Individual #473, Individual #469, Individual #176, Individual #162, Individual #138, Individual #322, Individual #203, Individual #504, Individual #126, Individual #354, Individual #453, Individual #290, Individual #479, Individual #317, Individual #480, Individual #363, Individual #572, Individual #252, Individual #430, Individual #99, Individual #39, Individual #28, Individual #85, Individual #14, Individual #60, Individual #64, Individual #93 o DISCUS evaluations for the following individuals: • Individual #339, Individual #382, Individual #160, Individual #103, Individual #513, Individual #529, Individual #556, Individual #471, Individual #210, Individual #285, Individual #547, Individual #392, Individual #587, Individual #565, Individual #134, Individual #542, Individual #188, Individual #234, Individual #562, Individual #172, Individual #492, Individual #490, Individual #213, Individual #592, Individual #555, Individual #336, Individual #482, Individual #221, Individual #145, Individual #401, Individual #473, Individual #469, Individual #176, Individual #162, Individual #138, Individual #322, Individual #203, Individual #504, Individual #126, Individual #354, Individual #453, Individual #290, Individual #479, Individual #317, Individual #480, Individual #363, Individual #572, Individual #252, Individual #430, Individual #99, Individual #39, Individual #28, Individual #85, Individual #14, Individual #60, Individual #64, Individual #93 <u>Interviews and Meetings Held</u>: o David Leeves, RPh., Pharmacy Director o Bertha Inez Sanderson, PharmD, Clinical Pharmacist o Brian Carlin, M.D., Medical Director o James Buckingham, MD, Psychiatry o Mary Bowers, R.N., Chief Nursing Executive o Gale Wasson, Facility Director o Shanni Miceli, CPT, Tech 2 <u>Observations Conducted</u>: o Pharmacy and Therapeutics Committee Meeting o Medication Variance Committee Meeting o Psychotropic Polypharmacy Meeting o Daily Clinical Services Meeting

	o Pharmacy Department
	Facility Self-Assessment: LSSLC completed three documents as part of its self-assessment process. The first document was the one historically known as the self–assessment. In addition to the self-assessment, the facility completed an action plan and another document that detailed all of the actions taken towards substantial compliance with the Settlement Agreement. During the week of the onsite review, the monitoring team had the opportunity to discuss the self-assessment process with staff. For the self-assessment, the facility described for each of the eight provision items, the activities engaged in to conduct the self-assessment, the results of the self-assessment and the self-rating. The previous monitoring tools were not used for the self-assessment. There was no monitoring tool developed that aligned with the current self-assessment. Overall, the monitoring team noted that for many provision items, the facility did not assess the same areas that the monitoring team assessed. In other instances, the facility clearly provided evidence that it was out of compliance, but rated itself in substantial compliance. It was clear that a great deal of work needed to be done. To take this process forward, the monitoring team recommends that the pharmacy director and clinical pharmacist review, for each provision item, the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. Such actions may allow for development of a plan in which the assessment activities provide results that drive the next set of action steps. A typical self-assessment might describe the types of audits, record reviews, documents reviews, data reviews, observations, and interviews that were completed in addition to reporting the outcomes or findings of each activity or review. Thus, the self-rating of substantial compliance or noncompliance would be determined by the overall findings of the activities The facility rated itself in substantial compliance with provision items N1, N2, N5, and N7. For provision items N3, N4, N6, and N8, the facility rated itself in noncompliance. The monitoring team found noncompliance with all eight provision items.
	Summary of Monitor's Assessment: This review was impeded by a lack of documents. The resignation of the clinical pharmacist in late 2011 likely contributed to staffing and resource issues within the department. Nonetheless, documents usually submitted without difficulty were not made available for this review resulting in the inability to adequately assess several areas of this provision. At the time of the onsite visit, the pharmacy department was staffed with a pharmacy director, clinical pharmacist, full time pharmacist, and four technicians. The pharmacist was hired in December 2011 and the clinical pharmacist started on 1/2/12. A part time contract pharmacist worked approximately four days a month.

	The new clinical pharmacist was given the lead role in managing many of the issues related to the Settlement Agreement. She faced many challenges, one of which was just to understand the underpinnings of the system and the requirements of the Settlement Agreement. She reported directly to the facility director. During a very short timeframe, there was an attempt to make multiple significant systems changes. Many of these changes were made without the benefit of the appropriate historical knowledge related to many specific regulatory, state, and Settlement Agreement requirements. The result was a series of missteps that led to little progress and in some cases regression. This result should not be unexpected given an apparent lack of clinical guidance and support for a clinical pharmacist with less than two years of experience at the time of hire. With regards to prospective reviews, the pharmacy department provided little documentation of communication between pharmacists and prescribers. The documentation submitted showed no evidence of resolution for the problems that were discussed. A positive finding was the implementation of the pilot of the intelligent alerts that monitored labs during prescription ordering. It appeared that the facility was not meeting the required timelines for completing QDRRs. The record sample consistently failed to include QDRRs completed in 2012. Moreover, the facility was not able to submit a sample of 60 QDRRs, submitting only 30 with the document request. Those 30 QDRRs did not include the required medication profiles which further limited the ability to assess the QDRRs, as well as Provisions N3 and N4. The facility updated the QDRR process moving to an electronic format. While the concept was forward thinking, the process failed to capture information and present it in the most clinically relevant manner. It also presented numerous opportunities for data and information to be missed. The MOSES and DISCUS evaluations were completed and the physicians signed and reviewed them. There was improvement in the completion rate, but more improvement was needed. The facility did not maintain substantial compliance for completion of DUEs. There was no documentation of the P&T approval of a calendar change and timelines were not met. There was also no clear rationale for the DUE drug selection. The facility made no progress in the development of the ADR reporting and monitoring system. Medication variances continued to be reported inclusive of all pharmacy and physician variances. Problems with pharmacy software were cited as contributing to dispensing and administration variances and no timelines for resolution of these problems were provided. Unit doses were being used for several liquids to increase accountability and the pharmacy had recently implemented a liquid reconciliation system.

#	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.	The pharmacy director and clinical pharmacist reported that prospective reviews were completed for all new orders through the WORx software program. The program checked the standard parameters including therapeutic duplication, drug interactions, and allergies. The monitoring team requested hard copies of all Single Patient Interventions and electronic copies of all Notes Extracts generated since the last onsite review. The facility submitted 54 Single Patient Interventions. Seven of the documents were excluded from the sample because they occurred prior to October 2011. Thirteen documents were duplicates. A total of 34 SPIs were submitted for the period of 10/10/11 – 3/28/12: • 20 of 34 (59%) were related to retrospective QDRRs • 14 of 34 (41%) were related to other reviews such as prospective medication reviews All of the retrospective SPIs were entered in 2011. For the prospective SPIs, one was entered in November 2011, three in January 2012, two in February 2012 and eight in March 2012. Overall, 14 prospective SPIs were submitted. That is, for the time frame specified, the facility submitted documentation of communication of 14 interactions and/or discussions of medication orders between pharmacists and prescribers. The prospective SPIs submitted addressed issues, such as adverse drug reactions, routes of drug administration, and occasionally served to provide drug information. Some documents provided little information or failed to clearly state the concern of the pharmacist. The majority of the SPIs reviewed failed to document problem resolution as demonstrated in these examples: • Individual #57, 3/5/12: The pharmacist noted the following concern "Addition of risperidone is resulting in metabolic effect which is increasing lipid levels." The recommendation was to initiate drug therapy and monitor labs for signs and symptoms of "metabolic syndrome due to risperidone." There was no documentation of the physician's decision regarding this recommendation. This is discussed further in Section N2. • Individual #516, 3/5/12: An order was written for medication for dental sedation. The pharmacist provided recommendations. There was no documentation of the outcome of the decision or how the discussion occurred. • Individual #79, 3/5/12: An order was written for MVI with minerals due to a low Hb/Hct. The recommendation was to add "Vit B labs with iron labs prior to adding iron to diet." There was no indication if the prescriber complied with this recommendation. • Individual #354, 3/20/12: The prescriber was notified of drug interactions and advised that doses of several medications would require lowering. There was no	Noncompliance

		documentation of the outcome of the discussion. The pharmacy director submitted additional SPIs during the onsite review. Those documents were not used for this evaluation since many did not fall within the required timeframes or documented discussions with non-prescribers. The document request clearly stated that other documentation of interactions could be provided and this was reiterated during the onsite review. The facility's action plan noted that the pharmacy director was documenting all interactions between pharmacists and clinicians in a word document inclusive of the problem resolutions. Upon request of this document, it was not available. During previous monitoring reviews, the Notes Extracts provided some evidence of the verification of physicians orders though the many hundreds of pages that indicated that various alerts were being processed. For this review, the electronic document request entitled notes extracts included a bevy of information, such as requests from nurses, QDDPs, and the facility director for drug information. It also included 41 pages of Notes Extracts related to drug interactions, which were limited to relatively few individuals. It did not include the usual listing of the various alerts related to allergies, therapeutic duplications, and drug interactions. Finally, this provision item required 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." In order to meet this requirement, in April 2012, the facility began piloting the use of intelligent drug alerts to ensure that labs associated with drug use were appropriately monitored. Seven drugs were targeted for this new process. When new orders for these drugs were entered, a series of alerts related to laboratory monitoring appeared. The drugs were chosen based on the importance of laboratory monitoring due to risk, therapeutic index, etc. The monitoring team had the opportunity to observe a real time demonstration of the system. It appeared to be a potentially viable solution to meeting the needs of the facility. Obviously, the facility will need to do additional work in collaboration with state office to expand the list of medications monitored to meet the specific needs of the facility. SPIs related to this provision item were not included in the document request and will be assessed during the next review.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results,	The monitoring team encountered numerous challenges in assessing compliance with this provision item. First, for the record sample, 9 of 10 (90%) records had no current QDRRs. That is, nearly six months into the year, only one record in the sample had a QDRR completed in 2012. Thirty QDDRs were provided in response to the document request for 60 QDRRs. The remainders were duplicates. Additional QDRRs were submitted two	Noncompliance

	and identify abnormal or sub-therapeutic medication values.	weeks following the onsite review, but were not assessed. None of the 30 QDRRs included in the document request were completed for individuals in the record sample. The monitoring team noted that the QDRR schedule submitted in the document request was not consistent with the proposed format that had been presented to the monitoring teams by state office. The clinical pharmacist reported that in April 2012, state licensing surveyors had reviewed the proposed scheduled and had some sort of issue with it. The exact concern was not made clear to the monitoring team, but the pharmacy director agreed that there appeared to be a problem. When asked if there were any deficiencies that resulted from this issue, both responded that they were unaware of any. Based on the absence of current QDRRs in the records and the failure to produce the requested 60 QDDRs, it was not clear the facility was meeting the basic requirement to complete this important requirement in a timely manner. This delay may have been related to a lack of a clinical pharmacist for several weeks, but the facility was not able to provide the exact time that the position was vacant. It appeared that there might have been no clinical pharmacist for four to six weeks. Medication/drug profiles were required in order to properly assess the quality of the QDDRs. The last page of every QDRR is the Drug Regimen Review Profile. It list the drug name, dose, route, frequency, indication, and start and stop dates. It is standard procedure to attach it to every QDRR. It is needed to assess the quality of the QDRRs. This was discussed onsite with the clinical pharmacist, pharmacy director, and facility director since it was standard practice to include the medication profile with the report for the document request, but also as part of the individuals record. The medication profiles were requested, but never received. The commentary on the QDRRs was therefore limited to general concerns related to format and overall process. Many of these were significant issues and were discussed with facility management during the week of the review. The facility revised the QDRR process. This involved restructuring the template, streamlining the process, and shifting to a more automated process that used a series of drop boxes that could be easily checked. There were several good attributes to the new document. It was crisp, easy to read and appeared well organized. Nonetheless, the conversion to this new format presented challenges and many problems worthy of correction. The following issues impacted the QDRR either due to content or from a regulatory perspective and should be reviewed and considered for remediation: • The medications were not listed and the drug profiles were not provided or included. • The diagnosis section listed medical conditions and stated conditions were controlled with medications, but there was no information provided to substantiate the statements. • Physicians were not required to sign the document if there were no	

		recommendations made by the clinical pharmacist. The Pharmacy and Therapeutics Committee approved this change on 4/4/12. Documents dated as far back as 2/16/12 included the comment that no physician signature was required. The regulatory standard requires completion of drug regimen reviews on a quarterly basis. Moreover, the pharmacist must report any irregularities in the individual's drug regimen to the prescribing physician and the IDT and consideration must be given to the report provided by the pharmacist. o Given that the signature of the physician is the only documentary evidence available that this review of information has occurred, it is not prudent to remove the requirement to have the physician sign the document. • The facility needs to clarify the standard that is being utilized for laboratory monitoring. The current QDRR cites the DSHS criteria; the lab matrix had been cited in the past. The facility also has numerous other standards, such as those included state issued policies and procedures. Each of these guidelines had slightly different criteria. • The newly revised format did not capture important information, such as weights and BMIs for monitoring of metabolic syndrome. It also did not capture the important aspect of monitoring for eye exams with quetiapine use. This was discussed with the clinical pharmacist who believed commenting on weight and eye exams belonged under the purview of nursing services. These items were previously commented on in the QDRR. The monitoring team <u>strongly discourages</u> the removal of these monitoring parameters because they are strongly associated with the use of new generation antipsychotics. • Lab values were generally presented as ranges included as part of check boxes. Occasionally, a specific value was discussed. The monitoring team encourages the use of specific lab values and not ranges. • The seizure management section listed a checkbox if no seizures had occurred. If seizures had occurred, the date was provided. No qualitative data were recorded. Required labs including Vitamin D and folic acid were listed, but the bone mineral density was not. The monitoring team believes that adding bone mineral density may improve screening for osteoporosis in individuals who only risk is the use of high risk AEDs. • The integrated risk section indicated risk, but it was difficult to understand why the individual was at risk. For example, a checkbox indicated high risk for weight, but the type of weight risk (weight loss or weight gain) was not clear nor was the specific risk factors. Although a lack of the drug profiles prohibited the monitoring team from thoroughly assessing the content relative to the drug monitoring, the recommendations or lack of recommendations observed in some QDRRs requires attention. The following are a few examples found in the sample of QDRRs submitted:	

		• Individual #252, 2/15/12: Comments in the pharmacy review included "WORx indicates diabetes type I and type II. Confirm. Concern: treatment plan and dosing." The specific treatment and dosing issues should have been documented. • Individual #27, 2/14/12: The pharmacy review included the following comment: "Lab values are not significant enough to warrant intervention. Intervention needed if Hct falls to 9% or lower. Concerns: none." This would appear to be an inappropriate comment because intervention would be appropriate before the Hct reaches the drastically low point of 9%, which is nearly incompatible with life. The primary provider did not correct this statement or comment which would lead one to question if the physician actually read the comment. • Individual #57, 3/5/12: The review had boxes checked for abnormal lipids, but did not have this listed under the diagnosis section. Moreover, the SPI completed on 3/5/12, noted concern about development of metabolic syndrome due to risperidone, but that concern is not addressed in the QDRR nor was it reported as an a suspected ADR and it should have been. Reporting of ADRs is discussed in section N6. • Individual #185, 2/28/12: The TSH was reported as "high," but no value was provided and the clinical pharmacist did not make any recommendations for follow-up or report any concerns. A high TSH should have been reviewed by a physician to determine if follow-up was indicated. Overall, the change in format provided an improvement in presentation and readability of information, but content was lacking. The actual clinical relevance of the information was lost with the new format and the process of reporting lab ranges only presented numerous opportunities to overlook abnormal lab values. There was a failure to link information and present it in a meaningful and clinically relevant manner. For individuals who received new generation antipsychotics, there was no clear demonstration of association of drug use with monitoring of labs, weights, and eye exams when appropriate. The use of the drug was identified on one page, lab requirements on another page, and lab ranges on yet another page. Unfortunately, the reviews did not always conclude with a synopsis of the data or any statement of compelling evidence regarding the actual risk for development of metabolic syndrome. The monitoring team recommends that the pharmacy director and clinical pharmacist work with state office to ensure that the revision of the QDRR meets practice standards, all regulatory standards as well as all requirement of state office with regards to the Settlement Agreement.	

N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	The use of stat medications, benzodiazepines, and anticholinergics were all captured in the QDRR template and will therefore be assessed during the next review when the data are provided. The facility had never developed a polypharmacy oversight committee. With the loss of the full time psychiatrist, it was decided that development of a committee was no longer an option. Each psychiatrist, therefore, had a meeting with the clinical pharmacist to discuss polypharmacy. The monitoring team attended one of these meetings during the onsite review. During the course of this meeting, it became apparent that the facility was defining polypharmacy based on dated policy and procedure. There was discussion about drug use, but the format of the meeting did not provide an opportunity for a robust peer oriented justification of polypharmacy. Thus, the practices of the individual practitioners regarding the use of medication polypharmacy were not scrutinized. The lack of a committee also resulted in a system, which produced no polypharmacy aggregate data for the facility, which should be done as a potential quality indicator. Polypharmacy is also discussed in section J. As discussed in sections N1 and N2, it appeared that individuals were having laboratory studies ordered. It was not clear that the information was being assimilated and monitored in the manner that was necessary for appropriate risk monitoring. The approach to monitoring some areas also appeared to be in the process of change since the clinical pharmacist did not believe the QDRR should comment of issues such as weight and eye exams. The monitoring team strongly believes that all criteria for metabolic syndrome should be reported together.	Noncompliance
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Medical providers responded to the recommendations of prospective and retrospective pharmacy reviews. Substantial compliance for this provision item should be determined based on the provider's responses to both prospective and retrospective reviews. For the prospective reviews, the pharmacy department documented relatively few interactions between pharmacists and prescribers and had little evidence that changes accepted were actually completed. The monitoring team could not determine if prescribers responded appropriately to recommendations in the QDRRs due to lack of medication profiles and the lack of QDRRs in the record samples. Thus, the facility remains in noncompliance with this provision item. The facility provided data that indicated acceptance of WORx prescriber acceptance rate was 90%. In moving forward, the pharmacy director and clinical pharmacist should ensure that only data for prescribers should be used in these calculations. Data related to advice given to other staff should not be taken into consideration, as discussed during the onsite review.	Noncompliance

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.	A sample of the most recent MOSES and DISCUS evaluations submitted by the facility in addition to the most recent evaluations included in the active records of the record sample was reviewed. The findings are summarized below: Sixty-six MOSES evaluations were reviewed for timeliness and completion: • 66 of 66 (100%) were signed and dated by the prescriber • 50 of 66 (76%) documented no action necessary • 5 of 66 (8%) documented actions taken, such as drug changes and monitoring • 11 of 66 (16%) documented no prescriber review (blank) Fifty-nine DISCUS evaluations were reviewed for timelines and completion: • 59 of 59 (100) were signed and dated by the prescriber • 43 of 59 (73%) indicated no TD • 2 of 59 (3%) indicated TD present • 14 of 59 (24%) documented no prescriber conclusion (blank) Both evaluations required prescribers complete a review and provide a conclusion. The facility continued to have a relatively high rate of incomplete documents based on the lack of prescriber conclusions. This however, was an improvement in the 33% rate of incomplete documents seen in the last review. The improvement in completion rates was mitigated by increasing problems with timeliness of completion. It was noted that in many instances there were substantial delays of time between the evaluation date and the prescriber review. Delays up to eight weeks were noted in some instances. The facility policy detailed how the documents were routed from nursing to providers, but timelines for the process were notably absent. Reviews of documents such as Annual Medical Assessments, neurology clinic notes, and integrated progress notes indicated that primary providers and neurology consultants were not utilizing information captured in these side effect rating tools when making treatment decisions. Identification of the development or presence of extrapyramidal symptoms and the potentially irreversible tardive dyskinesia has great clinical significance. The MOSES and DISCUS evaluations should be completed in a timely manner and the information promptly provided to the physicians for review. Moreover, the facility should ensure that assessment for tardive dyskinesia occurs with discontinuation and lowering of drug doses due to the potential for unmasking of symptoms. This information should be made available to the IDTs and consultants, such as the neurologist. The facility should also ensure that all staff involved in this process have appropriate training on the requirements for completion of the evaluations. Timelines for the process should be specified in the operational procedure. Under normal circumstances, two weeks would be considered a reasonable timeframe to have the evaluations returned to	Noncompliance

<table>
<tr><td></td><td></td><td>the nursing department.</td><td></td></tr>
<tr><td>N6</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.</td><td>The facility reported seven adverse drug reactions since the last onsite review. Four of these were reported during the four weeks just prior to the review.

<table><tr><th>Reaction</th><th>Suspected Drug</th><th>Report Date</th><th>Outcome</th></tr><tr><td>Galactorrhea</td><td>Invega</td><td>11/18/11</td><td>Per the ADR Form: Abilify was started to counteract the prolactin increasing effects of Invega. No further actions warranted.</td></tr><tr><td>Aggression</td><td>Multiple</td><td>1/18/12</td><td>Discussion deferred from the P&T 1/31/12 meeting; ADR Form not completed.</td></tr><tr><td>Pancytopenia</td><td>Rocephin</td><td>3/7/12</td><td>No ADR Form completed; ADR occurred during hospitalization</td></tr><tr><td>Right upper lip edema</td><td>Lisinopril</td><td>3/29/12</td><td>Discussed in the P&T meeting on 5/3/12</td></tr><tr><td>Right lower lip edema and jaw area</td><td>Lisinopril</td><td>4/11/12</td><td>“</td></tr><tr><td>Active seizure-prolonged 29 minutes</td><td>Diphenhydramine</td><td>4/5/12</td><td>“</td></tr><tr><td>Increased NH4</td><td>Depakote</td><td>4/6/12</td><td>“</td></tr></table>
The ADR reported on 11/18/11 was discussed during the Pharmacy and Therapeutics Committee meeting on 1/31/12. That discussion did not appear to include follow-up of the prolactin levels. The discussion of the ADR reported on 1/18/12 was deferred to the P&T meeting which occurred on 4/4/12.

A review of the SPIs indicated that there were suspected ADRs that should have been reported, but were not. The following are a few examples:
• Individual #169, 3/7/12: The individual had a prolactin level of 103 associated with the use of olanzapine. The recommendation to change to aripiprazole was accepted.
• Individual #591, 10/10/11: The individual had evidence of metabolic syndrome based on elevated triglycerides, increased weight, and elevated blood pressures. The SPI associated the abnormalities with drug use, but an ADR report was not completed. The recommendation was to closely monitor. The clinical pharmacist documented on the SPI that the physician noted on the QDRR “no action required.”

The facility did not appear to have done much work in this area. The ADR policy had not</td><td>Noncompliance</td></tr>
</table>

		been updated and a risk probability threshold had not been established. The number of ADRs reported actually decreased since the last visit. Neither health care nor direct care professionals had received any training on recognition and reporting of adverse drug reactions. The clinical pharmacist fully acknowledged that this area had not been adequately addressed. A fully implemented ADR reporting and monitoring system mandates that all healthcare professionals and others with extensive contact with the individuals have the ability to recognize and report adverse drug reactions. The facility must ensure that all medical providers, pharmacists, nurses, respiratory therapists, and direct care professionals receive appropriate training on the recognition of ADRs and the facility's reporting process. Documentation of this training should be maintained. The apparent lack of reporting, but equally as important, the failure to continue to develop and implement a robust system for monitoring and reporting adverse drug reactions resulted in a continued rating of noncompliance.	
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.	In accordance with the Health Care Guidelines, the facility's DUE policy required that one DUE be completed each quarter. The Pharmacy and Therapeutics Committee determined the order of medication review. Medication specific or patient specific medication reviews could be completed in addition to the scheduled reviews as deemed appropriate. The facility completed DUEs on diphenhydramine and propranolol. The following is a summary of the information included in the written reports. <u>Diphenhydramine</u> The Objective of the Evaluation: To evaluate the adverse effects of combined use of diphenhydramine with anticholinergic antipsychotic medications and to identify the percentages of individuals with this specific combination of high anticholinergic burden loads. - Results: Ten individuals were potentially impacted by anticholinergic effects of diphenhydramine and anticholinergic side effects of psychotropics agents. - Recommendations: This was a baseline DUE. Individual-specific interventions were made for two individuals. <u>Propranolol</u> The Objective of the Evaluation**:** To determine the number of LSSLC individuals using propanol for psychotropic benefit. - Results: Twelve individuals were on propanolol. One individual received the agent for a diagnosis of hypertension, five individuals had dual therapy, and six individuals for psychiatric indications. - Recommendations: One individual was recommended for re-evaluation based on propanolol use.	Noncompliance

		During P&T discussion, the medical director recommended a review of the findings since few individuals received propanol as treatment for hypertension. The monitoring team did not appreciate the clinical relevance of this DUE. The DUE produced very little information and the results could have been obtained by working with the medical staff through clarification of medication indications. It might have been more appropriate to have this as a supplemental DUE, but this should not have replaced the approved DUE. Moreover, propranolol did not fit into any of the targeted prioritized classes of drugs such as high risk, high use, or narrow therapeutic index. Neither of the DUEs completed were approved by the Pharmacy and Therapeutics Committee and were not on the approved DUE calendar. The DUE calendar was approved in 2011; and P&T minutes as of 8/11 documented no agreed upon changes. Changes required formal approval by the committee and should have been recorded in the minutes. Additionally, the timelines for completion were not met. The simvastatin DUE was presented on 10/31/11 to fulfill the requirement for quarter one. The next DUE should have been completed between December 2011 and February 2012, but was not done. The facility's self-assessment noted that the DUE was delayed due to the hiring of a new clinical pharmacist, but felt that substantial compliance was still warranted. Unfortunately, the facility did not maintain substantial compliance for this provision item.	
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.	Medication errors continued to be monitored and reported. In December 2011, the facility began reporting all pharmacy and physician errors. Training related to medication variances was implemented in January 2012. The CNE believed that this resulted in an overall increase in reporting of variances. This increase in reporting may not have truly reflected the actual variance activity in the facility. Per state policy, an event that occurred over many days and resulted in multiple doses of medications being missed or given in error was counted as a single mediation variance. This type of data management minimized the value of medication error rates and made the use of benchmarks non-applicable. The facility's data included several variances noted to occur over several days that were counted as one event. The monitoring team attended the Medication Variance Committee meeting. State policy required that each department provide an analysis of medication variances as well as corrective actions. Each department was also responsible for completion of the variance form based on the criteria set in state policy. The nursing and pharmacy departments presented data and discussed causes related to medication variances. Corrective actions were also discussed. Administration and dispensing accounted for most medication variances. Administration errors included wrong dose, wrong person, extra dose, and omissions. Many of these	Noncompliance

		issues were linked to a series of problems that the facility experienced with MAR and label generation. During the October 2011 visit, it was reported that the MARs were plagued with problems of start and stop dates. These were not insignificant issues because they potentially contributed to administration errors. The problems did not appear fully resolved at the time of this onsite review. There were also pharmacy software programming issues resulting in medications dropping from the MARs and the 182 orders. Nurses were responsible for noting these changes when new MARs were issued. Medication variances were attributed to these technical/programming issues. The reporting of pharmacy errors increased in December 2011, but appeared to stabilized in March 2012. Similarly, the clinical pharmacist reported that a significant number of dispensing errors were related to programming issues, which resulted in extra medications being sent out, or errors in start/stop times, that produced shortages. It was reported that the pharmacy software had not been updated and this was all contributing to the many problems in the department. There was no known timeline for when this would be corrected. It was clear that technical issues would need to be resolved before the extent of human error could be determined. Although there were few prescribing errors, the medical director did not present data on those in the Medication Variance meeting. No information related to corrective actions was presented. The graphs that were presented, unlike the nursing and pharmacy graphs, had no comments. It did not appear that these were discovered through pharmacy reviews. The monitoring team The pharmacy director reported that there was 100% reconciliation of all medications returned to the pharmacy. Data were not maintained on this, but the monitoring team verified the existence of hundreds of reconciliation forms in the pharmacy. The facility also began dispensing unit doses for several liquid medications in order to improve accountability of liquid medications. The pharmacy director stated that a few weeks prior to the review, he began a reconciliation program for other bulk liquid medications. Since it was newly implemented, that process will be examined during the next review.	

Recommendations:

1. The facility will need to take a number of steps in order to move towards compliance with Provision N1. The monitoring team offers the following recommendations for consideration:
    a. The facility should work with state office to expand the drug list used as part of the intelligent alerts.
    b. The facility will need to determine how it will provide documentation that drug monitoring occurs.
    c. The facility will need to define a process to consistently document communication between pharmacists and prescribers including the resolution of the issues. The pharmacy director will also need to have a process for tracking prescriber responses and making referrals to the medical director when appropriate. This would involve having some ability to track the acceptance of recommendations.
    d. The facility must develop a process for management of the various levels of drug interactions. The process must include the responsibilities of pharmacists, pharmacy techs, and prescribers.
    e. The pharmacy director and clinical pharmacist should ensure that the prospective reviews are appropriately connected with other pharmacy monitoring systems such as the ADR monitoring and reporting system such that an SPI that identifies an ADR appropriately triggers the ADR system.
    f. The facility should codify the process for the provision of N1 into policy and procedure and train all staff (N1).

2. The pharmacy director and clinical pharmacist must work with the state office pharmacy services coordinator to ensure that the revision of the QDRR meets all applicable standards discussed in the body of the report (N2).

3. The facility must clarify the standard that will be used for laboratory monitoring. (N2)

4. The facility should develop an operational procedure specific to completion of QDRRs that outlines the process, duties, and responsibilities for pharmacists and the medical staff. This procedure should also include the exact criteria that will be used in the QDRR and what discipline will be responsible for the data. Timelines for document completion should also be provided (N2).

5. Develop and implement a policy oversight committee (N3).

6. The facility should continue to monitor for the metabolic risk associated with the use of the new generation antipsychotics. The risk should be discussed together and presented in the QDRR (N3).

7. The clinical pharmacist should track the responses of the prescribers to the QDRR recommendations. The medical director should review this information and counsel the medical staff as indicated (N4).

8. The facility must ensure that employees have adequate training on completion of the MOSES and DISCUS evaluations. Documentation of training and attendance should be maintained (N5).

9. The results of the MOSES and DISCUS evaluations should be provided to the neurology consultants. The primary care physicians should also review the data and consider documenting scores and findings in annual and quarterly assessments (N5).

10. The facility should take multiple actions with regards to the ADR reporting and monitoring system:
    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. The facility must ensure that all medical providers, pharmacists, nurses, respiratory therapists, and direct care professionals receive appropriate training on the recognition of ADRs and the facility's reporting process. Documentation of this training should be maintained (N6).

11. All disciplines should maintain appropriate documentation of corrective actions related to medication variances (N8).

12. The facility needs to work with stat office to resolve the numerous issues related to the pharmacy software (N8).

13. The pharmacy director should ensure that appropriate reconciliation of all liquid medications is being completed and documentation is being maintained in a format that can be retrieved and reviewed (N8).

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o LSSLC client list o Admissions list o Budgeted, Filled, and Unfilled Positions list o PNMT Staff list o PNMT Continuing Education documentation o Section O Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section)-Physical Nutritional Management o Settlement Agreement Section O: PNMT Audit summaries o PNM spreadsheets submitted o PNMT Assessment template o PNMT meeting minutes o Criteria for Referral to PNMT o Individuals with PNM Needs o PNM Monitoring tool templates o Completed PNMP Monitoring Forms submitted o PNMP monitoring tool spreadsheets o NEO curriculum materials related to PNM, tests and checklists o Hab Camp Book o List of PNMP monitoring completed in the last quarter o List of hospitalizations/ER visits/Infirmary Admissions o Individuals at Risk for Choking, Falls, Skin Integrity, Aspiration, Fecal Impaction (bowel obstruction/constipation), and Osteoporosis o Modified Diets/Thickened Liquids o Individuals with Texture downgrades o Chronic Respiratory Infections o Individuals with Fecal Impaction o Individuals with MBSS in the last year o Poor Oral Hygiene o Pneumonias in the Past Year o Aspiration Pneumonia o Individuals with Choking Incidents and related documentation o Individuals with MBS during the last year o Individuals with BMI Less Than 20 o BMI Greater Than 30

	o Individuals with Greater Than 10% Weight Loss o Falls o List of individuals with enteral nutrition o Individuals Who Require Mealtime Assistance o Individuals with Skin Breakdown in the last 12 months o Fractures o Individuals who were non-ambulatory or require assisted ambulation o Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Wheelchair Assessments for Individual #444, Individual #530, and Individual #68 o Wheelchair seating assessments/documentation submitted o Individuals Who Use Ambulation Assistive Devices o Orthotic Devices o List of competency-based training in the last six months o Caseload information for dietitians o Documentation of competency-based staff training submitted (Dining Plans and PNMPs) o PNMPS submitted o List of risk areas included on the PNMPS o Follow-up documentation submitted for Individual #447 o Documentation related to Individual #47 (5/3/12) o Documentation related to Individual #16, Individual #361, Individual #352, Individual #61 o PNMT Assessment and ISP: Individual #232 o APEN Evaluations: • Individual #262, Individual #402, Individual #470, Individual #24, Individual #236, Individual #214, Individual #388, Individual #245, Individual #419, and Individual #52 o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP 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 (six months including most current), Medication Administration Records (most recent) Habilitation Therapy tab, Nutrition tab and Dental evaluation for the following: • Individual #232, Individual #490, Individual #447, Individual #172, Individual #468, Individual #203, Individual #285, Individual #137, Individual #385, Individual #267, Individual #284, Individual #213, Individual #430, Individual #182, Individual #241, Individual #345, Individual #321, Individual #164, Individual #573, and Individual #161 o PNMP section in Individual Notebooks for the following: • Individual #232, Individual #490, Individual #447, Individual #172, Individual #468, Individual #203, Individual #285, Individual #137, Individual #385, Individual #267, Individual #284, Individual #213, Individual #430, Individual #182, Individual #241, Individual #345, Individual #321, Individual #164, Individual #573, and Individual #161

	o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #232, Individual #490, Individual #447, Individual #172, Individual #468, Individual #203, Individual #285, Individual #137, Individual #385, Individual #267, Individual #284, Individual #213, Individual #430, Individual #182, Individual #241, Individual #345, Individual #321, Individual #164, Individual #573, and Individual #161 <u>Interviews and Meetings Held</u>: o Danielle Perry, AuD, CCC-A o Cheryl Fraser, RN o Misty Johnson, PT o James Moneer, OTR o Rhonda Hamilton, MS, CCC/SLP o Cheri Gonzales-Marini, MS, RD/L o Delisa Smiley, PNMPC o PNMP Coordinators o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas, dining rooms, day programs o PNMT meeting
	Facility Self-Assessment: LSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two other documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. The Presentation Book provided information related to actions taken, accomplishments, and work products. The facility was to describe, for each provision item, the activities engaged in to conduct the self-assessment of that provision item, and the results and findings from those self-assessment activities and a self-rating of substantial compliance or noncompliance with a rationale. This was significant improvement in the overall self-assessment process. There continued to be some difficulty understanding the difference between assessing whether substantial compliance was met versus engaging in activities to work toward achievement of substantial compliance. The activities listed were appropriate self-assessment activities, but were not the only ones that would be necessary to demonstrate substantial compliance in some cases. For example in O1, the activities were limited to review of PNMT member list and alternates, review of weekly meeting notes and sign in sheets, and list of individuals with PNMPs. These were quantitative only, with no assessment of quality, as required in the Settlement Agreement. For example, it would not be sufficient to merely have PNMPs for

	each individual on campus, but the content would have to be consistent, accurate, and appropriate. There were no audits or review of content of these plans. Additionally, the PNMT members were listed, but there was no assessment of their qualifications, training, or experience in working with individuals with complex PNM needs, as also required in the Settlement Agreement. Further, in the case of IDT review, PNMPs were reviewed, annually but there was no self-assessment as to the documentation of those reviews in the ISP. Review of the previous and current monitoring team reports will continue to provide the types of assessments that should be conducted to determine compliance with every aspect of each provision, some of which are complex and must be broken down into the component parts in order to properly assess. The statewide self-monitoring tool may be one of the activities used to self-assess, but will not likely be sufficient for most provision items and the action plans may not always address everything that needs to be addressed. The monitoring team discussed self-assessment with the department director and approaches to this process and it is hoped that this provided a clear direction for the future. The facility self-rated itself in substantial compliance with O1. Actions taken were definite steps in the direction of substantial compliance, but the monitoring team did not concur at this time based on the findings reported below. The monitoring team concurred with the self-ratings of noncompliance with O2 through O8.
	Summary of Monitor's Assessment: There was a fully-constituted PNMT, including a full time nurse. While the team met routinely, attendance was less than adequate until late February 2012 when attendance by all team members improved. A meeting observed during this review showed some improvement since the last review. All team members participated in discussion that reflected active assessment and supports. It was of significant concern, however, that the team had completed only one assessment in the last six months. The assessment was very limited in content and consisted predominately of lists of medical history information. Thus, this was more of an extensive record review rather than an actual assessment of the individuals' current status and issues. It was difficult to discern actions taken, completed, and assessed for their effectiveness. The current system of documentation of meetings and team actions should be reviewed and revised. Team members documented their actions as separate entities rather than reflective of the team process. Comprehensive assessments rather than consults were indicated in most cases. Some PNMT members attended ISPAs to review hospitalizations, other changes in status, and to present assessment findings. The PNMT should examine PNM issues from a system perspective in conjunction with other groups or teams in the facility to ensure there is effective trend analysis of identified issues. These concerns were discussed extensively with the PNMT members. Continued experience with the PNMT process will likely result in further refinement. At this time, the PNMT waited on referrals to initiate assessment or other review. This was not necessary. Key clinical indicators and health risk status should

	drive identification of the need for PNMT supports and services. The PNMT may want to consider initiating review of all individuals with aspiration pneumonia, bacterial/non-classified pneumonia, repeated hospitalizations, choking incidents, or significant or consistent weight loss, for example. An outline of criteria for referral had recently been developed in an attempt to address the absence of referrals. Extensive follow-up related to Individual #447 was noted, documents were submitted and reviewed, and an ISPA meeting was held during this onsite visit. A tremendous effort had been put forth on this individual's behalf since the previous review. The facility is to be commended on its work and support of Individual #447. This demonstrated the ability to work collaboratively as a team to ensure appropriate and timely supports and services are provided to all individuals living at LSSLC. Mealtimes were observed in a number of homes. Overall, there appeared to be improvements related to the environments and implementation of the dining plans, though there were issues noted, many of which should have been identified through monitoring by PNMPCs and professional staff. Staff continued to require coaching and supports for consistency with techniques and there were some food texture issues noted. In some cases, foods were being over-processed for individuals who had the skills to manage higher food textures. These issues should be addressed in collaboration with food service. Positioning continued to be an issue, though, in general, the wheelchairs looked better. Staff continued to need training related to understanding effective alignment and support as well as the elements of transfers. They did not appear to understand key items that would indicate that an individual needed to be repositioned. Staff need to understand that repositioning must be done as often as needed. Staff should be taught to ensure that the individual is positioned and aligned to match the pictures in the PNMP. Issues related to NEO training content were noted and are reported below. The curriculum should be critically reviewed for content and the training should be audited routinely particularly when taught by non-professional staff. Overall, staff did not understand the relationship of individual risks and triggers to their duties and responsibilities. Some staff, however, were better able to answer questions about implementation of the plans, and this was an improvement over previous reviews. A small number were exceptional in their knowledge of the individuals they supported. Monitoring frequency was not consistent, was not determined by the IDT and findings were not consistently reviewed and analyzed to drive staff training and supports.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner,	<u>Core PNMT Membership</u>: The current core team members of the PNMT were Cheryl Fraser, RN, Misty Johnson, PT, James Moneer, OTR, Rhonda Hamilton, MS, CCC/SLP, and Cheri Gonzales-Marini, MS, RD/L. There was no physician core team member. Alternates were assigned for each position and a PNMPC was assigned to the team (Delisa Smiley). Danielle Perry, AuD, CCC-A was listed as an additional member. Each of these team members was a full-time state or contract employee. Only the nurse served full-time on the PNMT. Each of the others had additional responsibilities. <u>Continuing Education</u> Continuing education was documented for each core member of the team during the last year. Each team member attended core PNMT training in August 2011. Continuing education was documented related to assessment of individuals with developmental disabilities, dysphagia management, and/or seating for each team member. This level of continuing education was adequate. It is critical that this team continue to achieve and maintain the highest possible level of knowledge and expertise in the area of PNM. Consideration of PNM-related continuing education opportunities for all team members in addition to the state-sponsored conferences/webinars should be a priority. <u>Qualifications of Core Team Members</u> No resumes were submitted, so it was not possible to verify experience and qualifications other than licensure for team members. <u>PNMT Meeting Frequency and Membership Attendance</u> A table was submitted that reflected documentation of 31 meetings since 7/14/11 and 17 meetings since the previous onsite review. Meetings were generally held weekly, though the interval ranged from two times in a week to over two weeks between meetings. Attendance was generally limited to core team members only, though occasional exceptions were noted on 11/7/11 and 12/14/11. Attendance by core team members from 11/7/11 to 3/29/12 was: • RN: 100% • PT: 35% • OT: 76% • SLP: 88% • RD: 88% • PNMPC: 18% • QDDP: 0% • RTT: 12% • Other: 18%	Noncompliance

#	Provision	Assessment of Status	Compliance
	or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	Other than the PNMT nurse, attendance rates by core team members were not acceptable, on average. There were some lags in staffing that may have contributed to the consistency of attendance particularly by OT, PT, and the SLP. Consistency, however, was noted to be improved as of 2/22/12. No alternates attended meetings in the absence of the core team members prior to that time Ms. Gonzales-Marini was one of two dietitians serving the entire facility. Two dietitians could not adequately meet the needs of 365 individuals, let alone allow for adequate participation as a core team PNMT member. It is critical that all core team members participate in each meeting of the PNMT because this is key to the provision of appropriate and adequate services. Information in the meeting minutes was very general, such as "follow along," "assessment in process," or "update on orthopedic clinic." This documentation reflected little about the actions taken by the PNMT. <u>Ancillary PNMT Members</u> No ancillary team members participated on the PNMT and IDT members (RTTs) attended PNMT meetings on only two occasions. It was reported, however, that the PNMT did attend some IDT meetings, though these were not documented as PNMT meetings. It was of concern that key clinicians, such as a physician, psychologist, QDDP, or nursing case manager did not participate in critical discussions of the health status of these high risk individuals during the PNMT meetings. Other key staff should include, at a minimum, the QDDP, nurse case manager, psychologist, or any other IDT members who know the individual well and could participate in the development of an effective approach to mitigating risks and conditions that resulted in PNMT referral. In summary, attendance by core team members and participation by key IDT members was not consistent through the course of the previous six months, though some improvement was seen since 2/22/12.	
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	<u>PNMT Referral Process</u> Since 11/7/11, the PNMT had reviewed 18 individuals: Individual #218, Individual #232, Individual #161, Individual #467, Individual #201, Individual #504, Individual #546, Individual #573, Individual #47, Individual #137, Individual #490, Individual #172, Individual #102, Individual #213, Individual #447, Individual #106, and Individual #285. Only one of these had received a PNMT assessment (Individual #232), dated 11/1/11. There was no evidence of any further assessments completed for any other individual reviewed by the team.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Anyone should be able initiate a referral to the PNMT, including the PNMT members themselves. Therefore, it was not necessary to necessarily wait for a referral from the IDT in cases where PNMT assessment was indicated. Most of those reviewed by the team were self-referrals (individuals identified by the PNMT rather than referred by the IDT). Very recently, the PNMT outlined some specific criteria to guide the IDTs in the identification of who and when and individual should be referred to the PNMT for assessment and review. Criteria for active or unstable cases outlined included: • Two or more hospitalizations for aspiration in one year. • Two or more Stage II in one year, or any Stage III, IV, or non-healing wound with referral by the Infection Control Nurse. • Significant weight loss (5% in one month, 7.5% in three months, or 10% in six months). • Hospitalization due to bowel obstruction in the past year. • Any consultation that required additional assistance/assessment by PNMT. Exit criteria were listed generically, rather than individual-specific and unique. The PNMT may want to consider two or more hospitalizations for pneumonia because some bacterial pneumonia may actually be unidentified aspiration. Referrals would include three individuals for choking, at least four individuals with staged wounds, and numerous others for weight loss and at least seven individuals with multiple incidences of pneumonia during the past 12 months. The PNMT should identify who meets these criteria at any given time. Criteria for consultations included fracture of long bone, spine, hip, or pelvis; abnormal MBS, upper GI or EGD; hospitalization for GI bleed; choking incident; high risk in five or more categories (Aspiration, Choking, Constipation/bowel obstruction, Infections, GI problems, and/or respiratory compromise); unresolved triggers for aspiration; new tube placement for enteral nutrition; and any nutritional or physical issue not successfully resolved by the IDT for high risk areas. Exit criteria consisted of resolution of issue as per referral. While these were valid criteria, , the referral tool had only been in place since mid-April 2012. As such, there were a number of individuals who met these criteria, but had not yet been referred to the PNMT. A referral to the PNMT indicated that there was an urgent need for specialized supports and services and, as such, the assessment process should be completed in a timely manner. These assessments should be completed in a month or less, and actions to	

#	Provision	Assessment of Status	Compliance
		address identified needs should be implemented throughout the assessment process. There was evidence that Individual #232 had previously been reviewed by the team on 7/25/11, 8/8/11, and 8/15/11. He was the only individual reviewed from October 2010 to 11/29/11 and was continued to be reviewed at every meeting held by the PNMT through 3/21/11. There were meeting notes on 11/7/11, but no other meeting minutes until 12/21/11. At that time, a spreadsheet format was initiated and this was used for all subsequent meetings. A few copies of integrated progress notes were submitted reflecting PNMT actions related to Individual #232 on 11/29/11 and 12/14/11 related to head of bed evaluation and positioning. These actions were identified as completed per the assessment dated nearly a month earlier on 11/1/11. It was not documented when or by whom Individual #232 or any other individuals reviewed were referred to the PNMT. <u>PNMT Assessment and Review</u> As stated above, the only assessment completed by the PNMT since the previous review was for Individual #232. The assessment consisted only of a list of reoccurring hospital admissions (12) over a three year period related to aspiration pneumonia and cellulitis. Treatment was identified as repositioning, suctioning, and a nutrition evaluation with supports, including positioning and a new wheelchair. It was not stated clearly whether these were existing treatments and supports, or new supports and services as a result of the PNMT evaluation. The assessment referenced an attached Risk Action Plan, but this was not submitted. This assessment did not reflect comprehensive assessment by the PNMT to review his current status and develop an effective intervention plan to address each of the concerns identified as well as the rationale for referral listed. • Subsequent reviews indicated that Individual #232 was monitored for rate and intake of enteral nutrition and elbow pads. A notation on 1/27/12 (Campus Physician Referral) related to his weight indicated that his case should have been reviewed on 12/9/11. It was of concern that a key review should have been conducted, but did not occur. The PNMT, however, conducted routine weekly reviews with daily monitoring. • There was no report of his status related to the outcomes or exit criteria documented in the meeting minutes on 4/25/12. Documentation of follow-up was insufficient in the meeting minutes and did not reflect appropriate and adequate supports and services provided by the PNMT to Individual #232. PNMT reviews of other individuals were not well documented. Though listed as consultations, there were no consultation reports, but rather only brief entries under discussion in the meeting minutes. It was not possible to track issues from meeting to meeting or actions taken by the team. For example:	

#	Provision	Assessment of Status	Compliance
		• Individual #201: A change in his PNMP related to head of bed elevation was identified on 12/21/11 and continued to be reported on 1/30/12 without indication that it was ever completed. On 1/30/12 it was reported that he needed a wheelchair to transfer to the dining area (1/9/12) and that the RD was addressing health shakes (1/23/12). The wheelchair was finally issued on 2/23/12, but there was no further follow-up regarding the health shakes. On 3/7/12, it was stated that no further follow-up by the PNMT was needed. • Individual #161: She experienced several hospitalizations for pneumonia in October 2011 and November 2011 with no evidence of referral or review by the PNMT until after she received a new gastrostomy tube on 12/3/12. There was no evidence of further PNMT evaluation in the Integrated Progress Notes. The only status update was that the QDDP reported that Individual #161 was doing well. This was insufficient and inadequate. • Individual #172: He had several hospitalizations in January 2012 and February 2012 related to aspiration pneumonia. He was listed as New-Active, but a comprehensive assessment was not initiated. A risk discussion was documented by the QDDP on 3/6/12, but there was no evidence that any member of the PNMT was present. • Individual #213: There were reports of decreased appetite and weight loss as far back as August 2011 with no evidence of review by a dietitian or the PNMT. There were additional documented concerns related to falls. She continued to experience weight loss and was provided a wheelchair due to unsteadiness. There was no evidence of review by anyone in Habilitation Therapies, the PNMT, or dietitian for either concern. She was referred for consideration of gastrostomy tube placement on 2/17/12. There was no referral to the PNMT during this six month period. The complexity of this case exemplified the need for a comprehensive, multidisciplinary assessment by the PNMT in collaboration with her IDT, particularly psychology. During the PNMT meeting attended by the monitoring team, there was very good discussion and a process of introducing a new individual for review using copies of PowerPoint slides that highlighted history, concerns, and other information. This was an excellent tool, however, the monitoring team spoke extensively with the team to encourage them to ensure that all actions, findings, recommendations and follow-up were adequately and appropriately documented. The team members continued to function as individual entities rather than as an expert team who's competence could help resolve significant health concerns for many individuals.	

#	Provision	Assessment of Status	Compliance
		Risk Assessment Health risks were listed in the one PNMT assessment, but there was no evidence that the PNMT reviewed all risk levels to determine if they were consistent with their evaluation findings or whether any changes to these risk levels were indicated. In the case of the risk rating tools reviewed, an original tool was completed that was supposed to be reviewed on a quarterly basis, post-hospitalization, or if there was any change in status. Risk assessment ratings for the individuals selected in the sample by the monitoring team were requested. There were a number of inconsistencies in the risk ratings for a number of individuals. Though improved since the previous review, there was no rationale provided for a particular rating and ratings were often inconsistent with clinical indicators. Some examples included: • Individual #161 was identified at HIGH risk for osteoporosis, but only at medium risk for fractures. She was rated at MEDIUM risk for skin integrity, but her ISP listed at least 28 incidents of skin breaks, bruises and tears. There was no evidence of quarterly or post-hospitalization reviews by her IDT. It was of concern that her health status changed significantly with no review of her risk ratings or action plan until her ISP on 2/2/12. • Individual #213 was considered to be at Medium risk for falls, though she had numerous falls documented in the IPNs and at least one requiring 11 staples. She was identified with a diagnosis of osteoporosis and was considered to be at high risk for this concern, yet despite documented unsteady gait and numerous falls she was rated at only low risk for fractures. • Individual #137 had recently received a gastrostomy tube and was rated at high risk for GI concerns due to the tube placement, constipation, and fluid imbalance. However, she was rated only at low risk for respiratory compromise. Each of these factors would predispose her to potentials for respiratory compromise. The action plans associated with the risk rating tools generally listed routine care and protocols for the risk concerns identified rather than unique and/or appropriately more aggressive interventions to address the identified risks. Referrals to the PNMT were not made appropriately and in a timely manner.	
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	PNMP Format and Content It was reported that all individuals living at LSSLC had identified PNM needs and were provided PNMPs. Though 12 months of PNMPs were requested, only one month's was submitted; these were presumed to be most current. Comments below relate only to these 20 PNMPs. Improvements in the format and content are needed. Improvement, however, was observed in the implementation of the plans. • PNMPs for 20 of 20 individuals in the sample (100%) included photographs for	Noncompliance

#	Provision	Assessment of Status	Compliance
	and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	positioning or adaptive equipment. • PNMPs for 20 of 20 individuals in the sample (100%) were current within the last 12 months. • PNMPs for 20 of 20 individuals in the sample (100%) were of the same format, though none were consistent with the most current state-established format that included risk levels, triggers and outcomes. • PNMPs for 20 of 20 individuals included a list of high and medium risk areas. • In 20 of 20 PNMPs, photographs of positioning and adaptive equipment were included. The photographs were large and easy to see. Some of the positions shown did not appear to be optimal and were not consistent with the plans. • In 20 of 20 PNMPs reviewed (100%), positioning was addressed. • In 13 of 13 PNMPs reviewed (100%) for individuals who used a wheelchair as their primary mobility, some positioning instructions for the wheelchair were included, though generally minimal. • In 20 of 20 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 20 of 20 PNMPs reviewed (100%), the PNMP had a distinct heading for bathing instructions. • In 20 of 20 (100%) of the PNMPs reviewed, toileting instructions were provided. • In 19 of 20 (95%) of the PNMPs reviewed for individuals who were not described as requiring assistance with mobility or repositioning, handling precaution handling instructions were provided or the individual was listed as independent. There were no handling precautions related to a fracture for Individual #284, but photographs highlighted special handling precautions related to this. • In 20 of 20 PNMPs reviewed (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. • There were 12 of 20 individuals (60%) who had feeding tubes. Both Individual #490 and Individual #203 were identified as NPO, or nothing by mouth, yet they were shown seated at the dining table with adaptive mealtime equipment. • In 20 of 20 PNMPs reviewed (100%), dining position for meals or enteral nutrition was provided via photographs. • In 8 of 8 PNMPs reviewed (100%) for individuals who ate orally, diet orders for food texture were included. Individual #213's PNMP indicated that she received a PKU diet, but there was documentation in her individual record that this had been discontinued. • In 2 of 8 PNMPs for individuals who received liquids orally (25%), the liquid consistency was clearly identified. • In 8 of the 8 PNMPs for individuals who ate orally (100%), dining equipment was specified in the dining equipment section. In three cases, however, the stated	

#	Provision	Assessment of Status	Compliance
		equipment and the photographs were inconsistent (Individual #182, Individual #213, Individual #430 and Individual #241) • In 20 of 20 PNMPs reviewed (100%), a heading for medication administration was included in the plan. These instructions generally referred the reader to the MAR for instructions. • In 20 of 20 PNMPs (100%) adaptive equipment was listed. • In 20 of 20 PNMPs reviewed (100%), a heading for oral hygiene was included in the plan. • 20 of 20 PNMPs (100%) reviewed included a heading related to communication. Specifics regarding expressive communication or strategies that staff could use to be an effective communication partner were absent. There were a number of PNMPs submitted for individuals who were identified as independent in all areas and were verbal communicators. They ate regular diets and did not require modified liquid consistencies. These individuals were provided PNMPs merely because they wore eyeglasses or simple shoe inserts. Others merely had mealtime assistance needs. • This unnecessarily required routine monitoring of the plan and an annual assessment by the therapists. This was an inappropriate and unnecessary application of the concept of the Physical Nutritional Management Plan. There were other systems to adequately address these supports, such as the nursing care plan and the ISP. All of the ISPs in the sample were current within the last 12 months. ISP meeting attendance by team members was as follows for the current ISPs included in the sample for whom signature sheets were present in the individual record (also see section F above): • Medical: 0% • Psychiatry: 0% • Nursing: 100% • RD: 10% • Physical Therapy: 15% • Communication: 20% • Occupational Therapy: 5% • PNMPC: 0% • Psychology: 85% It would not be possible to achieve adequate integration given these levels of PNM-related professional participation in the IDT meetings. In addition, it would not be possible to conduct an appropriate discussion of risk assessment and/or to develop effective action	

#	Provision	Assessment of Status	Compliance
		plans to address these issues in the absence of key support staff and without comprehensive and timely assessment information. PNMPs could not be reviewed and revised in a comprehensive manner by the IDTs. The Physical Nutritional Management Plan was referenced in the majority of the ISPs reviewed most often in the OT/PT assessment portion of the ISP. Actual review of the PNMP by the IDT was not evident in any of those. There was no consistency as to the manner or content of how the PNMP was addressed in the ISPs. In some cases, strategies were included. In others, it was mentioned only that the individual had a PNMP. It would be extremely difficult for staff to locate information needed to further understand the PNMP. The PNMP was not well integrated into the individual's ISP as a result. . The QDDPs continued to require greater guidance as to consistent strategies to incorporate PNMP information into the ISPs and action steps.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	<u>PNMP Implementation</u> PNMPs and Dining Plans were developed by the therapy clinicians with limited input by other IDT members. There was improved evidence of ISPAs for required changes in the PNMPs. Unfortunately, these documents were not readily available to all staff, rather only the annual ISP document was included in the individual notebooks, thereby, creating a potential gap in information for direct support staff. Continued efforts to increase attendance at the ISPs and ISPAs, and continued participation of other team members in this process, should improve IDT involvement in the development of the plans. Dining Plans were available in the dining areas. 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. Wheelchair positioning instructions were generally not specific in the PNMPs. Limited instructions in the PNMP identified that individuals should remain upright. 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 and in individual-specific training provided by the therapists and PNMPCs. <u>Observations</u> There was clear improvement in some homes, and less so in others. Some examples are presented below in hopes that this detail will be useful to the facility: • Individual #31: The monitoring team noted that she was coughing through her meal and stopped to observe. Only at that time did the staff assisting her comment that she was coughing and needed to call the nurse. The nurse arrived, appropriately took her vitals and stayed to observe. She read the Dining Plan and noted that the spaghetti served was not cut into bite-size pieces, as per the Dining	Noncompliance

#	Provision	Assessment of Status	Compliance
		Plan. She coached direct support staff to correct the texture before continuing. • Individual #406: He dropped a cup on the floor. Staff picked it up and allowed him to resume drinking. • Individual #326: He ate a whole meatball in one bite, though his plan said food should be cut into quarter size pieces. These instructions were written at the end of the plan, rather than included with other information about food texture. • Individual #142: His plan instructed that he should have a cup of lemon ice before the meal, a bite during the meal after every two bites of food and two sips of liquid, then one cup at the end of the meal. When asked, staff stated this was needed so he would not choke, though later indicated that it was to help him swallow. Staff was not offering the lemon ice during the meal as instructed. • Individual #345: Staff continued to verbally prompt her to slow down, but this was not effective. Staff did not intervene using any physical prompts and did not provide prompts to correct her Individual #345's posture during the meal. • Individual #366: She was to take only one half teaspoon bites. Staff attempted to scrape food off her spoon, but it was still more than one half teaspoon. Staff answered questions about her plan. • Individual #88: The PNMPC reported that she was assessing the individual for food loss during the meal. This was an inappropriate function for a non-licensed paraprofessional. If assessment was required this should be completed by a professional licensed to do so. • Individual #502 was supposed to be provided a cut out cup, high sided dish, and a built up handle spoon. The adaptive spoon and dish were not provided. Per staff, adaptive equipment was not provided in the day program area for snacks. Staff was also assisting her from the wrong side and did not provide hand over hand assistance also as per her Dining Plan. • Individual #156: She was asleep in her wheelchair in the day program area. Staff had to be prompted to tilt her wheelchair and reposition her. • Individual #468 seatbelt was very loose and did not provide adequate postural support. His head rest appeared to be non-functional and the back was very low. • Individual #530: He was sleeping, slumped in his wheelchair. Staff had taken no action to reposition him. When prompted to do so after some time, they did not apply brakes as per generally accepted practices for safety. • Individual #500: He was taking very large bites without intervention from staff. When asked about his risks, staff reported that he was only at medium risk for choking, not high risk. She also reported that she had other people she was responsible for. She was the charge assigned to the area. • Individual #23 was to be served a chopped diet with ground meats. She received pureed spinach and ground meats, but was not served macaroni cheese as per the menu on that day.	

#	Provision	Assessment of Status	Compliance
		• Individual #482: Staff were to orient her to the food due to a visual impairment and encourage her to use utensils. This was not done • Individual #469: She was on a regular diet, but was served the pureed spinach. • Individual #136 was noted to be out of alignment in her wheelchair and needed to be repositioned. Staff had to be prompted to do so. • Individual #402: Her legs were extended and the pictures with her PNMP dated 3/1/12 showed her with her legs flexed. • Individual #573: He was receiving enteral nutrition, but was not well aligned or supported in his wheelchair. Chewing movement of his mouth was also noted during the feeding. • Individual #546: Staff did not use downward pressure with presentation of food on the spoon as per his Dining Plan. The majority of staff were not able to verbalize the rationale for the strategies included in the plans or questions related to individual health risks, though those staff who did answer the questions did so confidently and accurately. <u>Choking/Aspiration Events</u> Three individuals were listed with choking events in the last year each requiring the Heimlich (Individual #342, Individual #241, and Individual #430). Two of these choked on medication and one (Individual #430) on a food item. There was no evidence of review by the PNMT in the case that occurred in the last six months (Individual #430). It would be expected that the PNMT would review <u>any</u> choking event. There was no evidence of Individual #430 being assessed by Habilitation Therapies or the PNMT in relation to this incident. An ISPA dated 3/13/12 indicated that Individual #430's choking risk should be changed to high with close supervision to minimize or prevent food stealing. Though supervision was listed under mealtime instructions on his Dining Plan, it was not included under precautions, but rather only overstuffing and high risk for choking. Two choking incidents specifically involving medications in one year appeared to be excessive. A review and examination of this issue was indicated.	
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	<u>New Employee Orientation</u> There were approximately 29 hours allotted to PNM related training topics and were taught by Habilitation Therapy staff. Additional related topics included aspiration signs and symptoms, reporting health care status and clinical indicators as well as fall protocols, though these were taught by other LSSLC staff. The breakdown per the schedule was: • Deaf Awareness and Ear Protection (two hours)	Noncompliance

#	Provision	Assessment of Status	Compliance
	nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	• Oral Structures (one hour) • Optimal Eating (2.25 hours) plus a .75 hour practicum • Lifting/Feeding (four hours) • Lifting Practicum (four hours) • Lifting People (1.5 hours) • Flexibility (1.5 hours) • Handling and Positioning (two hours) • Lifting (nine hours) By report, however, Optimal Eating training was 8.0 hours; Lifting People was 8.0 hours of instruction, to include flexibility, lifting, positioning, and transfers; Lifting People Practicum was 8.0 hours, including competency-based drills and check off of the skills learned during the Lifting People instructional day. Training materials were submitted for the Eating Skills class with competency checklists and tests. The content of this course was modified since the previous review. Copies of the PowerPoint slides were submitted and this appeared to be comprehensive with functional information provided to staff. Competencies included thickened liquids quiz, a functional eating skills test and skills-based check-offs for table setup, individual preparation, mealtime techniques, good hygiene and communicating with the individual. Another Eating Skills tests incorporated a sample PNMPs/Dining Plans and the participants were expected to find answers to specific questions using the plan. One of these checklists as submitted listed approximately 51 indicators. Only three of these required demonstration of a skill rather than a verbal response. These indicators involved cutting foods to nickel or quarter size pieces and not standing while assisting an individual with a meal or snack. This ratio would not be considered to be skills-based competency training. The Adaptive Equipment competency checklist was 100% verbal only. The Thickening Liquids checklist was only 12% return demonstration, 6% written and the rest required only a verbal response for 17 indicators. The Thickened Liquids and Functional Eating Skills Competency Evaluation Part 1 quizzes were multiple choice only. Another aspect of the check-off involves the use of four Dining Plans. The participants select a card, complete the setup per the card, and then assist another participant to eat using the techniques and instructions outlined on the cards. This was done once in class as a training tool then again as a competency check-off. This appeared to be a good instructional method to promote improved reference, familiarity, and utilization of the Dining Plans and PNMPs. Lifting competencies included the state-established check-offs for stand/pivot transfers,	

#	Provision	Assessment of Status	Compliance
		two-person manual lift, mechanical lift, repositioning an individual in the wheelchair, and bed positioning. The submitted training materials were thorough with strong content in each. Each of these was skills-based, requiring return demonstration. There was no evidence of training materials related to flexibility as indicated on the schedule. In fact, content noted in the training materials submitted did not appear to reflect the 29 hours of training time allotted. Training materials for the deaf awareness and ear protection course was also submitted. It appeared to be well-organized with good content. It was not known if there were any handouts provided to participants for future reference. Most of the slides in all portions of PNM-related NEO, with the exception of the hearing and ear protection sections, were text- driven rather than well-supported with pictures designed to enhance direct support staff learning. PNMPCs attempted to conduct compliance monitoring of new employees after NEO training in PNM-related skills. This was reportedly difficult to track and many staff quit shortly after NEO. The process included monitoring within two weeks after completion of NEO or within five weeks of the staff hire date. Compliance of 80% or less triggered the need for retraining. Annual retraining included lifting and transfers only (two hours). An iLearn class related to aspiration was also provided annually to staff. A portion of the annual retraining lifting and transfer course was observed by the monitoring team. The primary instructor was a Habilitation Therapy technician with a clear passion for teaching. She was assisted by the PNMPC assigned to the PNMT. While the training content was consistent with generally accepted professional standard of care, the strategies taught by the instructor related to a stand-pivot transfer were not. In fact, some of the steps and strategies were counter to accepted methods and expectations. Good body mechanics and safe practices were not possible using the methods demonstrated. This was not the fault of the paraprofessional technician. These classes need to be observed and critically analyzed for accuracy in content and instructional methods. Extensive training and monitoring of these classes was needed to prevent further reinforcement of ineffective and potentially unsafe practices by staff. Some examples of these issues included the following: • Participants were taught to lift up behind the knee to reposition an individual rather than slightly up on the thigh to avoid damaging the tendons, nerves and blood vessels located behind the knee. • No specific instructions on how tight the seat belt should be to ensure proper positioning were provided.	

#	Provision	Assessment of Status	Compliance
		• The staff assisting in the transfer were instructed to hold the individual's knees together which did not allow for a stable base of support, greater independence, or effective lower extremity weight bearing. • Instructors discussed good body mechanics, even demonstrated this, but did not utilize them during actual transfer setups and demonstrations. Bending at the waist rather than bending at the hips and knees by both instructors and participants was observed by the monitoring team. • Staff were not instructed to individualize the transfer to accommodate the height or weight of the individual being assisted. For example the target chair was positioned too close to the starting wheelchair for very tall individuals. • Staff were instructed to stay up on their tip toes, which creates a very high center of gravity, resulting in poor balance and creating the potential for falls and injuries by both staff and the individuals assisted to transfer. • The instructor should teach that all staff should keep their feet wider than their shoulders, one foot behind the other, with their knees and hips bent to lower their center of gravity and thus creating a stable, but dynamic base of support. <u>Individual-Specific PNMP Training</u> Inservice trainings for changes in the Dining Plans and PNMPs were conducted by therapists, technicians, and PNMPCs. A general inservice was completed with check-offs conducted with home managers and charges. The training sheets described the training content and, in some cases, the plan was attached. Very detailed knowledge and skills were outlined for check-off requiring either return demonstration or a verbal response. Scripts were written to ensure consistency across trainers. This was done for non-foundation training issues only (those skills not provided in NEO) and some was information transfer only when indicated. The home managers and charges were then responsible to train and check-off their own home staff. Afterward, the PNMPCs were to go back to monitor compliance of direct support staff. Retraining was to be provided as indicated. It was policy that staff were not to work with an individual at high risk until they had been trained and checked off. As described below, it was common for staff to report that they had not been trained to implement an individual's PNMP. <u>Trainer Competencies</u> When new equipment was issued, the licensed clinician conducted the initial inservice training on the home and all PNMPCs and techs were checked off. At that time, the therapy technician or PNMPC assigned to the home was to conduct any further staff training. A Hab Camp was conducted in January 2012 and attended by all Habilitation	

#	Provision	Assessment of Status	Compliance
		Therapies staff. Each participant was checked off on all portions of this foundational training. This was an excellent approach to training of all staff. It was planned that this would be done on an annual basis and was also scheduled to be provided in the next month for all QDDPs.	
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.	<u>Monitoring Staff Competency and Compliance</u> Monitoring of staff competency and compliance was documented on a general Compliance Monitoring form. Frequency of this monitoring, conducted largely by the PNMPCs, was reported to be based on risk levels established by the IDT. The Action Plans, however, were not well developed and did not generally address the frequency of monitoring. Individuals at high risk in an area were monitored by the PNMPCs, though frequency appeared to be determined in a rather random manner. Therapy staff were to complete a monitoring form on two individuals per week, though this was not specifically tracked. A database was maintained, but analysis of frequency for monitoring was not conducted. For example it was reported that monitoring was conducted for individuals considered to be at high risk, but Individual #565, at high risk for choking, was not listed as monitored at any time during the last quarter. Individual #156 was also considered to be at high risk for choking. She was monitored on two occasions for positioning, but not at mealtime. Though there was a database related to monitoring and findings, there was no consistent review or analysis to utilize the findings to direct system change, staff training, and other supports. There was no system to ensure that all areas of the PNMP were monitored on a routine and consistent basis. Monitoring findings based on the completed forms submitted for March 2012 (254) were as follows: • 100% (19) • 90% (127) • 80% (50) • 70% (20) • 60% (20) • 50% (2) • 40% (4) • 0% (10) • Incomplete (2) The majority (77%) of the PNMP monitoring sheets submitted reported compliance (80%	Noncompliance

#	Provision	Assessment of Status	Compliance
		or greater) with implementation of the PNMP. This information should be analyzed to determine which areas scored the highest/lowest, to ensure that there is consistency with regard to frequency and activity, and to determine which items consistently scored lower across homes and facility-wide.	
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.	Individual-Specific Monitoring As described above, the current monitoring system for implementation compliance and staff competency was to be based on individual risk levels, but there was no system to ensure consistency. PNMPs were revised as needed throughout the ISP year. Review of the plans occurred during annual assessments. Changes were generally documented via an ISPA. The ISP process was again undergoing changes and it is hoped that this will be addressed via implementation of those modifications. The monitoring team looks forward to seeing improvements with this over the next six months. Effectiveness Monitoring As described above, effectiveness monitoring of the PNMPs was limited to annual assessment, with changes in status, or by request. There was no system of routine quarterly status reviews of individuals with PNMPs or who were at high risk for PNM-related concerns. In most cases, the effectiveness of interventions and supports were not specifically addressed in the annual assessments. This should be a key function of the professional staff clinicians. Validation of Monitoring by PNMPCs Validation of the PNMPCs was accomplished during Hab Camp as described above. However, validation should not be a one-time occurrence or, in the case of non-professional staff, only an annual occurrence. This should be ongoing. Also, there were a number of issues noted by the monitoring team that should have been identified by PNMPCs during their monitoring, such as errors or omissions in the Dining Plans and/or PNMPs. Routine validation should be conducted by professional staff with the PNMPCs at regular intervals to ensure consistency and continued competence/compliance.	Noncompliance
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure	Individuals Who Received Enteral Nutrition There were 67 individuals listed who received enteral nutrition. Individual #137, Individual #203, Individual #161, and Individual #61 were listed as having received new tube placements since the previous onsite review. None of these individuals had been provided a comprehensive assessment by the PNMT before or after tube placement. Each individual who was at risk for tube placement should, at a minimum, be reviewed by the PNMT, if not provided a full comprehensive assessment.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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 10 individuals who received enteral nutrition who were also listed with poor oral hygiene (Individual #323, Individual #68, Individual #44, Individual #353, Individual #203, Individual #117, Individual #502, Individual #505, Individual #298, and Individual #61). The list submitted that identified individuals with pneumonia in the last 12 months included 31 incidences for 23 individuals since 4/1/11. A number of individuals had more than one occurrence of pneumonia, some categorized as aspiration, and included Individual #271 (2), Individual #267 (2), Individual #232 (3), Individual #47 (20), Individual #468 (2), Individual #361 (2), and Individual #161 (2). Those listed with aspiration pneumonia included Individual #267, Individual #468, Individual #361, and Individual #161. Of these individuals, only Individual #232 had received an assessment completed by the PNMT. The others had not yet been evaluated by the PNMT, though Individual #161, Individual #47, Individual #218, and Individual #267 were listed as reviewed by the team. There were 26 cases of bacterial pneumonia or non-classified occurrences that should not necessarily be ruled out as aspiration. An incident was noted by the monitoring team for which follow-up documentation was requested. On 5/3/12, Individual #47 was observed with white milky secretions draining from his nose during his tube feeding. A direct support staff was asked to report this to a nurse. The nurse stopped the feeding and took his vital signs. His oxygen saturation levels were low on room air and he was hypothermic. A breathing treatment and oxygen were administered without sufficient recovery, so he was transferred to the emergency room via ambulance. Emergency efforts were prompt and appropriate, though the monitoring team wondered if the individual's distress would have been identified by staff. <u>APEN Assessments</u> A sample of APEN assessments was requested for 10 individuals for whom these were completed since the previous review. Each of these individuals received enteral nutrition. None were listed with aspiration pneumonia in the last year. Measurable outcomes were not outlined in the assessments, but rather there was reference to the Action Plans (which unfortunately were not attached). There was no analysis of all clinical findings. Further, the reports appeared to be prepared separately by the clinical professionals, rather than as a team process as intended. The initial rationale for enteral eating was identified early in the report, but there was no evidence that all clinical information was reviewed to determine if enteral nutrition continued to be appropriate and medically necessary at the time of the assessment. <u>PNMPs</u> All individuals who received enteral nutrition in the selected sample had been provided a PNMP that included the same elements as described above.	

Recommendations:

1. Collaborate to design a better system to document the actions taken by the PNMT (O1).

2. Devise a system to access the existing data of risk, and occurrence of key clinical indicators and/or diagnoses to drive better identification of a need for PNMT review. This should effectively impact the referrals from the IDT as well as for self-referral (O2).

3. Ensure that the PNMT functions as an assessment team that includes 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. Use caution in the determination as to the need for assessment versus review only. Comprehensive assessments rather than consults were indicated in most cases (O2).

4. An action plan should be developed to drive the assessment and recommendations. A continuation of the plan should be integrated with the IDT in order to accurately and collaboratively complete the health risk assessment and action plan (O1 and O2).

5. Promote participation by the IDT in the PNMT assessment and action plan process (O1).

6. 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 and O7).

7. 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. This may particularly critical to needed improvements in positioning and transfers (O3-O6).

8. The IDTs continue to require support regarding risk assessment and real time modeling to effectively complete risk assessments and action plans. The refinement of this process will also greatly impact the manner in which the PNMT functions to implement interventions to mitigate identified health risks. Frequency of monitoring should be addressed in the action plans (O2, O6, O7).

9. Reexamine the monitoring process to address frequency and assignment of PNMPCs (O6 and O7).

10. Review and revise curriculum for foundational NEO training for content and instructional methods as soon as possible (O5, O6, and O7).

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o LSSLC client list o Admissions list o Budgeted, Filled, and Unfilled Positions list o OT/PT Staff list o OT/PT Continuing Education documentation o Section P Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section P-Physical and Occupational Therapy o OT/PT spreadsheets submitted o Individuals receiving direct OT/PT o OT/PT Assessment template o Individuals with PNM Needs o PNM Monitoring tool templates o Completed PNMP Monitoring Forms submitted o PNMP monitoring tool spreadsheets o NEO curriculum materials related to PNM, tests and checklists o Hab Camp Book o List of PNMP monitoring completed in the last quarter o List of hospitalizations/ER visits/Infirmary Admissions o Individuals at Risk for Choking, Falls, Skin Integrity, Aspiration, Fecal Impaction (bowel obstruction/constipation), and Osteoporosis o Modified Diets/Thickened Liquids o Individuals with Texture downgrades o Chronic Respiratory Infections o Individuals with Fecal Impaction o Individuals with MBSS in the last year o Poor Oral Hygiene o Pneumonias in the Past Year o Aspiration Pneumonia o Individuals with Choking Incidents and related documentation o Individuals with MBS during the last year o Individuals with BMI Less Than 20 o BMI Greater Than 30 o Individuals with Greater Than 10% Weight Loss o Falls o List of individuals with enteral nutrition

	o Individuals Who Require Mealtime Assistance o Individuals with Skin Breakdown in the last 12 months o Fractures o Individuals who were non-ambulatory or require assisted ambulation o Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Wheelchair Assessments for Individual #444, Individual #530, and Individual #68 o Wheelchair seating assessments/documentation submitted o Individuals Who Use Ambulation Assistive Devices o Orthotic Devices o Wheelchair database o List of competency-based training in the last six months o Documentation of competency-based staff training submitted (Dining Plans and PNMPs) o PNMPS submitted o List of risk areas included on the PNMPS o Follow-up documentation submitted for Individual #447 o Documentation related to Individual #16, Individual #361, Individual #352, Individual #61 o OT/PT Assessments for new admissions: Individual #240, Individual #420, Individual #582, o OT/PT assessments, ISPs, ISPAs, and other related documentation for the following individuals receiving direct OT/PT services: • Individual #328, Individual #407, Individual #440, Individual #88, Individual #185, Individual #90, Individual #285, Individual #556, Individual #68, Individual #213, and Individual #154. o OT/PT assessments and ISPs for the following: • Individual #145, Individual #527, Individual #467, Individual #406, Individual #236, Individual #485, Individual #118, Individual #176, Individual #444, Individual #258, Individual #395, Individual #142, and Individual #226. o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP 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 (six months including most current), Medication Administration Records (most recent) Habilitation Therapy tab, Nutrition tab and Dental evaluation for the following: • Individual #232, Individual #490, Individual #447, Individual #172, Individual #468, Individual #203, Individual #285, Individual #137, Individual #385, Individual #267, Individual #284, Individual #213, Individual #430, Individual #182, Individual #241, Individual #345, Individual #321, Individual #164, Individual #573, and Individual #161 o PNMP section in Individual Notebooks for the following: • Individual #232, Individual #490, Individual #447, Individual #172, Individual #468, Individual #203, Individual #285, Individual #137, Individual #385, Individual #267,

	Individual #284, Individual #213, Individual #430, Individual #182, Individual #241, Individual #345, Individual #321, Individual #164, Individual #573, and Individual #161 o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #232, Individual #490, Individual #447, Individual #172, Individual #468, Individual #203, Individual #285, Individual #137, Individual #385, Individual #267, Individual #284, Individual #213, Individual #430, Individual #182, Individual #241, Individual #345, Individual #321, Individual #164, Individual #573, and Individual #161 <u>Interviews and Meetings Held</u>: o Danielle Perry, AuD, CCC-A o Misty Johnson, PT o James Moneer, OTR o Gail Harris, PT o Habilitation Therapy technicians o Delisa Smiley, PNMPC o PNMP Coordinators o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas, dining rooms, day programs o Wheelchair clinic
	Facility Self-Assessment: LSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two other documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. The Presentation Book provided information related to actions taken, accomplishments, and work products. The facility was to describe, for each provision item, the activities engaged in to conduct the self-assessment of that provision item, and the results and findings from those self-assessment activities and a self-rating of substantial compliance or noncompliance with a rationale. This was significant improvement in the overall self-assessment process. There continued to be some difficulty understanding the difference between assessing whether substantial compliance was met versus engaging in activities to work toward achievement of substantial compliance. The activities listed were appropriate self-assessment activities, but were not the only ones that would be necessary to demonstrate substantial compliance in some cases. For example in P1, the activities were limited to a review of new admissions to LSSLC. This provision, however, pertains to any identified need, rather than only individuals newly admitted to the facility. This may include, but not limited to, individuals

	with a change in status. It would be assumed, however, that in the case that the identified issues were urgent that the assessment would be completed in a timely manner rather than the 30 days. The P2 self-assessment identified a qualitative indicator, but it should not be the only indicator of quality. Also, the sample size was small in several provision items in this section and expansion of the sample should be considered in the future. The statewide self-monitoring tool may be one of the activities used to self-assess, but will not likely be sufficient for most provision items and the action plans may not always address everything that needs to be addressed. The monitoring team discussed self-assessment with the department director and approaches to this process and it is hoped that this provided a clear direction for the future. The facility self-rated itself as noncompliant with all aspects of P (P1 through P4). While actions taken were definite steps in the direction of substantial compliance, the monitoring team concurred with this finding.
	Summary of Monitor's Assessment: The level of staffing for OT and PT clinicians was increased at the time of this review, though a number of clinicians were on short term contracts. Some of the staff had extended their contracts. The therapists appeared to be knowledgeable and enthusiastic. The OT and PT clinicians conducted their annual assessments together. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment (e.g., wheelchairs), and to review other supports and services. Despite this, there was a continued concern for continuity. A great deal of on the job training had to occur for new staff and there needed to be a clear plan for orientation to ensure consistency of the information passed on to new therapists joining the facility. Hab Camp was a new concept for providing competency-based training to existing staff across all aspects of PNM. It was planned to continue on an annual basis. The wheelchair clinic process was improved. A number of therapists attended a seating assessment workshop. The concern will be for the rotation of short term contract therapists and the continuity of knowledge and practice of this highly specialized clinical area. A plan should be developed to address this potential problem. Assessments were reviewed and varied in content and format. Some included a section that reported health risk levels. This information was utilized inconsistently for planning interventions and supports. Recommendations for changes to the existing risk levels were not addressed in any of the assessments. Less than a third of the assessments included an analysis section, and each of these did not provide a sufficient rationale for the interventions and supports recommended. None qualified as an acceptable analysis for identifying changes in status, potentials for skill acquisition, needs, or barriers. These are essential elements of an analysis to ensure appropriate rationale for determining appropriate interventions and supports. There was no consistent place to document whether the existing supports had been effective over the last year. None of the plans addressed a PNM monitoring schedule. There were no recommendations as to the needed frequency of other PNMP monitoring by the therapists, IDT or PNMPCs

	There continued to be a small number of individuals participating in direct PT and OT. Documentation was inconsistent and there was insufficient rationale provided to continue or discharge from services. Comprehensive assessments were not routinely conducted for individuals with a change in status.

#	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.	<u>Current Staffing</u> Danielle Perry, AuD, CCC-A continued to serve as the Habilitation Therapies Department director. OT/PT staffing was considerably different from that during the previous review. Physical therapists included Gail Harris, PT, (previous employee), Misty Johnson, PT (new employee, also served on the PNMT), Kimberly Moore, PT (contract), and Aaron Kropp, PTA (contract). OTs included James Moneer, OTR (contract), Bruce Shaw, OTR (contract), Margaret Munroe, OTR (contract), Kristin Wyatt, OTR (contract) and Melissa Coley, COTA (contract). One other OT assistant was out on extended medical leave. There was also one vacant COTA position and 1.4 vacant PT positions. The PTA was working in a budgeted position for a COTA as there were no PTA positions budgeted. Some of the contract staff present at the time of the previous review had extended their contracts and continued to provide services at LSSLC, though several were due for contract completion over the next several months. The census at LSSLC was 365 individuals. Only four OTs and three PTs were available to provide direct supports, plus one PT and one OT assistant currently available for service. One of the OTs and one of the PTs also served on the PNMT, so they were not available full time for caseload supports and services. There was one PT technician, plus 10 PNMPCs. Three technicians were assigned to assist with typing PNMPs, maintaining the adaptive equipment inventory, and taking photographs for plans. Two technicians served as both OT techs and wheelchair shop/clinic technicians. There were four wheelchair technicians. Technicians were largely responsible for staff training through inservices and NEO. The assistants and technicians were not licensed to complete assessments and design interventions supports and, as such, should not be included in the ratio calculations. Their roles were critical, however, in that assistants were able to provide training, supervision of technicians and PNMPCs, assist with data gathering, provide monitoring, and provide direct/indirect supports. Technicians provided critical paraprofessional supports. Thus, ratios based on the current census were approximately 1:122 (PT) and 1:92 (OT) though the OT ratio will also change to 1:122 5/5/12. These ratios were too high to	Noncompliance

#	Provision	Assessment of Status	Compliance
		ensure adequate provision of necessary supports. <u>Continuing Education</u> The following staff reported participation in continuing education in the last six months: Gail Harris, PT, Misty Johnson, PT, Aaron Kropp, PTA, James Moneer, OTR, Kimberly Moore, PT, and Margaret Munroe, COTA. Four had attended the Hab Camp held in January 2012 and all six had attended an inservice related to severe spasticity and the baclofen pump on 2/22/12. Although supporting continuing education may be difficult to justify for the clinicians who fill short term contracts, the facility is commended for promoting this for the current contract staff. Additionally, it will continue to be important that all clinicians be supported to attend PNM-related continuing education opportunities beyond that offered by the state to ensure that they expand their knowledge and skills. <u>New Admissions</u> Six individuals were admitted to the facility since the last onsite review. Though a tracking log of OT/PT assessments was requested by the monitoring team, the response was that the request could not be completed. There was no rationale offered. Samples of new admission assessments (no more than five) were also requested. Only three were submitted (Individual #582, Individual #240, and Individual #420). Each of these three was completed within 30 days of admission. Though all individuals were reported to have PNMPs, there was no reference to a PNMP in the assessment for Individual #240. The evaluation for Individual #582 indicated that a PNMP had not yet been established, though there was no analysis of findings or recommendations to indicate whether one was required. Each of the assessments stated that no risk levels had been established for the individuals, even though there were no statements by the therapy clinicians as to their professional analysis of health risks based on the assessment findings. The analysis of findings sections of these reports were inadequate and did not provide any rationale for the recommendations outlined. Individual #240's assessment indicated that he did not need skilled PT, but there was no indication as to OT needs. There was no indication of his reassessment needs. The assessment for Individual #582 outlined a number of instructions related to mealtime supports, but did not identify her need for subsequent assessments or other OT/PT supports. It was recommended that Individual #420 receive annual OT/PT updates, but there was no analysis of assessment findings and, therefore, no established rationale.	

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		OT/PT Assessments Comprehensive evaluation and OT/PT evaluation update formats were submitted. Only the odd numbered pages, however, were submitted making it impossible to discern what intended content was outlined. The instructions with the Comprehensive Evaluation template indicated that it should provide a current picture of the individual's status, in terms of functional abilities, health risks, and potential for community placement. Therapists were instructed to analyze the clinical information as each section was completed so that reasoning was not lost. Skill acquisition and functional activities were to be considered throughout the assessment process. Functional and measurable objectives were to be outlined as indicated. There was a statement that recommendations for supports and services other than direct therapy that required a licensed professional were to be incorporated into the ISP. This was of significant concern to the monitoring team because all aspects of supports and services should be included in the ISP. The five most current assessments for each clinician and current individual ISPs were requested by the monitoring team for review. Though a number of assessments and ISPs were submitted, eight were duplicated. One was included in another request. Fourteen unique assessments were submitted, and included eight OT/PT evaluation updates and six comprehensive assessments. ISPs were submitted for 11 of those. All were expired at the time of the onsite review and six of those would have been expired also at the time of the monitoring team's original request for documents. Additional OT/PT assessments were included in the sample requested by the monitoring team (20 of 20 were submitted). There were 11 Baseline/Admission Evaluations, one OT Evaluation, two PT Evaluations, one Comprehensive Evaluation, one OT/PT Evaluation, two OT/PT/Speech Evaluations, and 21 Evaluation Updates. The Baseline Evaluations were completed from 1994 (Individual #203) to 2004 (Individual #267). Only two individuals had Comprehensive Evaluations completed within the last two years (though each was not current within the last 12 months). Updates for six other individuals had been completed more than 12 months ago and, as such, were not current. OT/PT/Speech Evaluations for Individual #345 and Individual #490 were current within the last 12 months. Updates for Individual #213, Individual #232, Individual #447, Individual #284, Individual #161, Individual #385, Individual #241, Individual #430, and Individual #182 were current within the last 12 months. An update reviews and updates a previous comprehensive assessment in order to identify the individual's current year status, identify changes since the previous comprehensive assessment or update, and modify or continue supports and services. Without an	

#	Provision	Assessment of Status	Compliance
		adequate comprehensive or baseline assessment, the update is unacceptable. None of the LSSLC updates made any reference to the original assessment that was being updated. Assessments for only 13 of 20 individuals in the sample selected by the monitoring team were considered current and reviewed. Assessments for individuals participating in direct OT and/or PT services were also requested for 11 individuals. It would be expected that any individual participating in direct therapy would have an assessment completed at least within this last 12 months. Only five of these individuals had updates within the last year. Individual #90's most current OT/PT assessment was completed in 1994 and three others in 2009 (Individual #88, Individual #285, and Individual #556). The total number of assessments reviewed was 29. Comments are below: • 24% (7/29) were identified as comprehensive assessments. Consistency with the assessment template could not be established because the template submitted was incomplete. The evaluations varied in format and content. • 66% (19/29) were identified as updates. Consistency with the update template could not be established because the template submitted was incomplete. The updates varied in format and content. • 90% (26/29) of the assessments were dated as completed prior to the annual ISP meeting, though one was done just one day before (Individual #161) and others less than a week prior to the ISP (Individual #226, Individual #385, Individual #395, and Individual #573). Only three were completed 30 days prior to the ISP date (Individual #527, Individual #444, and Individual #467). Assessments for Individual #447, Individual #182 and Individual #430 were completed after their ISPs. Individual #447's update was completed five months after his ISP on 6/15/11 (likely following the last monitoring report). • 0% (0/29) identified the date of the previous assessment(s). • 52% (15/29) were signed copies of the original, though all had undated signatures. The date of assessment was consistently identified, though it was not possible to determine when the report was finalized and signed and, thereby, available to the IDT for review and integration into the ISP. • 86% included a section that reported health risk levels. Some of these reported only high risk concerns and others reported both high and medium risk levels. This information was utilized inconsistently for planning interventions and supports, or for recommendations for changes to the existing risk levels. • 31% (9/29) included an analysis section, and they did not provide a sufficient rationale for the interventions and supports recommended. None qualified as an acceptable analysis of findings to identify changes in status, potentials for skill acquisition, needs or barriers. These are essential elements of an analysis to	

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		ensure appropriate rationale for determining appropriate interventions and supports. There was no consistent place to document whether the existing supports had been effective over the last year. • 90% (26/29) included a recommendations section. This section was titled Considerations in a number of assessments reviewed. • 17% (5/29) included suggestions for direct therapy and/or SAPs for implementation in the home or through OT/PT. The goal was stated in only two of these. • 0% (0/29) included a monitoring schedule. There were no recommendations as to the needed frequency of other PNMP monitoring by the therapists, IDT, or PNMPCs. There was no evidence that level of health risk was considered to drive the frequency of monitoring for individual status, effectiveness of supports and interventions, or implementation of the PNMP. • 86% (25/29) included a reassessment schedule. Thirteen identified that reassessment would occur annually and if there was a change in status or referral. Twelve assessments indicated only that an assessment would be completed upon a change in status, even though most of the individuals received some type of OT/PT and/or PNM services and should receive at least an annual update. Four did not specify when a subsequent assessment would be provided. A number of assessments outlined what would define a change in status, often related to risk indicators, such as fracture (Individual #447), choking (Individual #145), or a fall out of bed (Individual #284). While these incidents would indicate a change in status, there certainly are others. For example, an individual could experience a health issue that would justify a need for reassessment, such as a CVA, a fall with head injury, or aspiration pneumonia without an existing identified risk of this condition. Some of the assessments were more general and identified "medical decline" as indication for the need for reassessment. • 7% (2/29) included factors to consider for placement in a community setting. All but four others included a statement as to whether the individual could be served in a less restrictive environment. It was stated that all could be. • 93% of the ISPs submitted with the assessments were current within the last 12 months. Only one assessment for Individual #226 did not have an ISP submitted with it. • 31% of the 16 ISPs with signature pages submitted were attended by OT. These meetings were attended by either OT or PT, but not both. • 31% of the 16 ISPs with signature pages submitted were attended by PT. These meetings were attended by either OT or PT, but not both.	

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P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	<u>OT/PT Interventions</u> The primary intervention provided was the PNMP. These were addressed in detail in section O above. Direct OT and/or PT services were provided for 13 individuals. Documentation including assessments, ISPs, ISPAs, skill acquisition plans, and progress notes were requested for 11 of these individuals. Documentation was inconsistent related to these direct services. Baselines were not established in most of the assessments. Establishing baseline is a very basic and key standard of practice for both OT and PT. Further, there was insufficient justification documented in the assessment to initiate or terminate therapy. Measureable goals for direct OT or PT were not included in the ISP or addendum. • Individual #213's ISP indicated that she had fallen eight times, including one that required 11 staples. This was not mentioned in the OT/PT assessment. Rather, the assessment reported that her current risk level for falls was medium and identified an arm-in-arm strategy in place to address this risk. There was no analysis of the eight falls, such as whether they occurred outdoors (described as most difficult for her). There was no comparison to the frequency of her falls during the previous year. There were no measurable objectives contained in the ISP or ISPA related to PT for gait training due to unsteadiness. Finally, on 2/2/12, a brief PT assessment was conducted with recommendation for gait training three times a week for two weeks. One of the two objectives for this intervention was written with performance criteria. Baselines were established for each. • Individual #407 was identified in her OT/PT update as receiving direct PT for lower extremity strengthening exercises and gait training from 3/19/to 4/3/12. There was no reference to her progress or effectiveness of the intervention and there was no rationale provided as to why this was discontinued. The assessment was incomplete, so it was not possible to review each of the recommendations. • Individual #68 participated in circulation massage therapy to reduce lower extremity edema so he could fit into his right AFO. An ISPA was held on 7/7/11 to discontinue this activity plan because he was not able to wear the brace due to compromised circulation and tolerance for pressure. There was no report of his current status as to edema and whether any other strategies to address this were in place. The introduction of direct therapy was not addressed in the annual ISP or ISPAs. • Individual #154's ISP did not mention any findings from the OT/PT assessment or his PNMP, though he was listed as receiving PT services and the Tone Inhibition and Relaxation (TIR) program. It was determined that he had previously participated in this program and had showed no decline since 2009. When it was discontinued for six months, his lower extremity range of motion had decreased and the program was reinstated. It was recommended that he	Noncompliance

#	Provision	Assessment of Status	Compliance
		participate three times per week. No measurable objectives were established, however, and there was no mention of this service in his ISP. • Individual #68 was identified in his OT/PT assessment that he presented with right shoulder subluxation with diminished range of motion. It was not mentioned if he experienced any pain with this condition. Skilled OT services were recommended to address this issue and he was listed as receiving this service. There was no evidence of this in his ISP or ISPAs submitted. There were no measurable objectives established as would be expected for someone receiving skilled OT. Change in status was not consistently addressed via an assessment and ISPA. For example, Individual #444's program indicated that she was to be seen twice weekly for a walking program that had been reinstated as of 12/22/11 per an ISPA. However, between 12/22/11 and 2/28/12, she was seen only seven times. Rationale for failure to provide this intervention at the prescribed frequency was not documented. There was no documentation after 2/23/12 related to this plan. There was no documentation of therapy services submitted in the document request for the individuals listed. It had to be presumed that none existed and, as such, did not meet basic standards of practice for OT or PT. Documentation of actual direct therapy interventions was extremely limited or not noted for individuals receiving direct therapy and included in the sample for whom integrated progress notes were submitted: • Individual #137 was listed as currently receiving direct PT for range of motion and lower extremity contractures. There was no documentation in the IPNs related to this service. • Individual #285 was listed as currently receiving direct PT for gait training. Integrated progress notes were dated 2/8/12, 2/16/12, and 3/1/12 only, with no measurable objectives or rationale to initiate or discontinue direct service. • Individual #213 was listed as currently receiving direct PT for gait training. Her goals were updated after one week of therapy via IPN. Re-assessment was again noted after one week (2/17/12) with recommendation to continue therapy for two more weeks (three times a week) and new measurable objectives. She was seen only two times after that until 3/1/12 when it was stated that she had only partially met her goals and that she was to be discharged from PT. DSPs were to provide prescribed assistance for ambulation and transfers as per her PNMP. OTs and PTs did not consistently complete a post-hospitalization assessment for individuals upon return to LSSLC or for other changes in status (e.g., Individual #266, Individual #341).	

#	Provision	Assessment of Status	Compliance
		Occasional issue-specific assessments, such as wheelchairs and positioning were noted as documented in the integrated progress notes or via a consult. The therapists appeared to more consistently address referrals from physicians, though these assessments were not comprehensive and as described above, findings and recommendations were often not integrated into the ISP or via an ISPA.	
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.	Competency-Based Training Competency-based training for, and monitoring of, continued competency and compliance of direct support staff related to implementation of PNMPs was addressed in detail in section O above. No evidence of competency-based training for the implementation of OT- or PT-designed programs by therapy technicians or by direct support staff was submitted to the monitoring team.	Noncompliance
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.	Monitoring A system of monitoring of the PNMPs, and the condition, availability, and effectiveness of physical supports and adaptive equipment was implemented at LSSLC and addressed in section O above. Recommended frequency of monitoring was not included in the OT/PT assessments. Findings of the monitoring conducted were not reported in the assessments. There was no consistent method used to document progress related to OT/PT interventions via SAPs. Although a few progress notes were in the records submitted, these were not consistent across the records reviewed. While there were measureable goals in some cases, the documentation related to these interventions was inadequate in providing sufficient data and comparative analysis of progress. There was also inconsistent justification to continue or discontinue the interventions. Monitoring of wheelchairs, assistive devices for ambulation, and other equipment provided by OT/PT were included in the routine monitoring of the PNMPCs as described above in section O. There were no routine maintenance checks documented to assess the working condition of the wheelchairs, gait trainers, and adapted chairs, other than the PNMP monitoring conducted by PNMPCs. It appeared that responses to requests for repairs, however, were completed in a timely manner. Staff were responsible for cleaning the equipment and this was reviewed by the PNMPCs as well. A log of work orders was generated and tracked for completion and timeliness with orders generated through routine PNMP monitoring, random checks, and reports by direct support and home management staff.	Noncompliance

Recommendations:

1. There was a continued need to develop programs to address increasing or expanding functional skills. 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. Therapists should push forward with the development of more collaborative skill acquisition plans and modeling with groups to enhance the day programs and activities occurring in the homes. A program of this nature could be especially effective if implemented with the SLPs and/or psychology (P1 and P2).

2. Initiate assessment audits to ensure improvement and consistency with the new format and expected content (P1).

3. The assessments should consistently include a review of the efficacy of existing supports and services with concrete justifications for these and all other recommendations in the analysis section (P1).

4. Include oral hygiene status in OT/PT assessments. Consider strategies to address sensory issues that may negatively impact the effectiveness of oral hygiene care (P1).

5. Include recommendations as to the needed frequency of other PNMP monitoring by the therapists, IDT or PNMPCs. Ensure that consideration of the level of health risk drives the frequency of monitoring for individual status, effectiveness of supports and interventions or related to implementation. Results and findings from monitoring during the last year should also be reviewed and summarized (P1).

6. Conduct consistent post-hospitalization assessments for high risk individuals and other PNM-related concerns. Establish guidelines for when a comprehensive assessment was indicated (P1).

7. Documentation of direct therapy services should state a clear rationale to continue the service, modify the plan or discharge. Measureable goals should be clearly stated and integrated into the ISP. Data collected should link to the expected outcomes and progress notes should summarize progress. Close the loop (P2).

8. Implementation of coaching and skills drills with staff was indicated to ensure that they were consistently able to discuss the rationale behind recommended interventions and to recognize their role in management of health risk issues (P3).

9. Conduct routine validation of monitoring and training completed by the PNMPCs and home supervisors (P4).

10. Develop a plan to ensure continuity of knowledge and practice related to seating assessment, a highly specialized clinical area across changes in professional staff (P1).

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, 8/17/10 o LSSLC Dental Services Policy and Procedure, 5/1/12 o Procedure for Suction Toothbrushing, undated o Dental Data: Refusals, missed appointments, extractions, emergencies, preventive services and annual exams o LSSLC Section Q Self-Assessment o LSSLC Section Q Action Plana for Section Q o LSSLC Section Q Presentation Book, Dental o LSSLC Organizational Chart o Dental records for the individuals listed in Section L o Desensitization plans for 16 individuals from homes 557A and 559A o Emergency Treatment documentation for the following individuals: • Individual #4, Individual #105, Individual #279, Individual #411, Individual #580 o IPN documentation for the following individuals: • Individual #160, Individual #218, Individual #312, Individual #97, Individual #380 o Oral Surgery Consultation Notes for the following individuals: • Individual #520, Individual #106, Individual #243, Individual #353, Individual #167, Individual #307, Individual #388, Individual #148, Individual #43 Interviews and Meetings Held: o Charles F. Glazener, DDS, Dental Director o Tina Murray, DDS, Staff Dentist o JoAnne Lancaster, RDH o Marill Gerth, RDH o Frances Tucker, RDH o Evelyn Barnes, Dental Assistant o Nancy DeVore, Dental Clerk Observations Conducted: o Dental Clinic o Desensitization Workgroup

	Facility Self-Assessment: As part of the self-assessment process, the facility submitted three documents: (1) the self-assessment, (2) an action plan, and (3) a list of completed actions. For the self-assessment, the facility described for both provision items, a series of activities engaged in to conduct the self -assessment, the results of the self-assessment, and a self-rating. This was a great improvement in the assessment process. During the week of the onsite review, the monitoring team met with the entire dental clinic staff to discuss the self-assessment process. The self-assessment was reviewed quite thoroughly with the staff. They did a good job with this. In fact, they reviewed the monitoring team's report and, for every section of the report, assessed themselves. The assessment included data for annual dental exams, initial exams, oral hygiene ratings, provision of services, and the various metrics cited in the report. This was a very good start for a self-assessment. To take this process forward, the monitoring team recommends that the dental director continue this type of self-assessment, but expand upon it by adding additional metrics that are specific to clinical outcomes in dentistry. The facility found itself in noncompliance with both provision items. The monitoring team agreed with the facility's self-rating.
	Summary of Monitor's Assessment: The new dental clinic opened in December 2011 providing a much needed improvement for the facility. The new clinic offered ample space for two operatories and provided a soothing ambiance for treatment. The clinic staff remained dedicated to supporting the individuals, but it was clear that they needed to increase dental hours. Since September 2011, the clinic had the services of a dentist for 20 hours each week. A dental director was hired in October 2011, but actually never worked full time. He provided services two days each month. The clinic made progress, but achieving substantial compliance will be difficult at best with the current staffing. Compliance with annual exams failed to recover and the number of appointments available was limited. The full time hygienist and the staff did an excellent job and had taken on numerous tasks. Notwithstanding their efforts, the presence of a full time or even part-time dental director is needed in the clinic to provide oversight and address the issues of dental practice and ensure that the clinic is running as it should. The clinic provided basic services, but the number of clinic appointments decreased to about half of what they were one year prior to this review. Oral hygiene efforts continued and were having good impact based on improved hygiene ratings. Several individuals had poor oral health and required referral to the local oral surgeon for multiple or full mouth extractions due to decay and non-restorable teeth.

	The clinic began reporting annual compliance data with a new standard of "within 30 days." This ostensibly allowed a 30-day grace period from any given calendar date and apparently was a decision made by clinic staff, but compliance rates remained low even with this generous standard. Refusals were recorded, but missed appointments were not, although staff reported they still occurred. Individuals who refused appointment were referred to psychology for assessment, but the monitoring team was unable to determine the status of some individuals who refused treatment. Dental notes indicated a referral was made and emails requested follow-up, but responses seemed vague or absent.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	In order to assess compliance with this provision, the monitoring team reviewed records, documents, and facility-reported data. Interviews were conducted with all members of the clinic staff. The monitoring team also attended the medical and dental desensitization workgroup and had the opportunity to observe the treatment of individuals in the dental clinic. <u>Staffing</u> The dental clinic staff was comprised of a part time dentist, full time hygienist, two part time hygienists, a part time dental clerk, and a full time dental assistant. The dental director who began working in October 2011 worked only two days each month. The part time dentist worked Monday through Friday for a total of 20 hours each week. Clinic was held in the morning. The revised dental services policy and staffing roster continued to state that the clinic was staffed with a full time dental director. While the position may have been allocated, there had been no full time dental director since the end of August 2011 and that loss was certainly more evident during this review. The provision of adequate services cannot be achieved with the current staffing. <u>Provision of Services</u> The dental clinic provided basic dental services, including prophylactic treatments, restorative procedures, such as resins and amalgams, extractions of non-restorable teeth, 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.	Noncompliance

Clinic Appointments 2011 - 2012

	Oct	Nov	Dec	Jan	Feb	Mar
Preventive Care	12	8	4	15	25	27
Restorative	3	4	3	3	4	3
Emergency Care	2	4	5	5	0	2
Extractions	3	2	0	0	6	2
Total Clinic Appointments	64	28	39	87	82	61

#	Provision	Assessment of Status	Compliance
		The loss of a full time dentist significantly impacted the ability to provide dental services. The number of appointments scheduled each month was far less than what the facility scheduled one year prior to this review. The full time hygienist candidly commented in the opening meeting that the clinic was indeed "hurting." <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. Individuals were referred to the local emergency department when necessary. The dental documentation for five individuals was reviewed. It appeared that, for the records reviewed, individuals received appropriate emergency dental treatment and referral to oral surgery when necessary. <u>Oral Surgery</u> The facility continued to refer individuals to the oral surgeon who completed procedures at a local surgery center. Nine individuals were referred for treatment from October 2011 through March 2012. The consultation notes were reviewed. Four individuals had extractions of two or fewer teeth. The operative notes for the other five individuals indicated essentially full mouth extractions or extractions of remaining teeth due to carious and non-restorable teeth. In several instances, the LSSLC referrals indicated that the individuals had a history of refusing dental treatment. <u>Oral Hygiene</u> The Oral Health Maintenance Program 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. Each individual was evaluated every four months. The suction toothbrushing program was expanded to include daily oral care for 52 individuals. Dental hygienists and nursing staff provided training during NEO to direct care professionals in the proper use of suction equipment including the suction toothbrushes. Oral hygiene ratings were documented during annual exams and clinic visits. The table below summarizes the quarterly ratings.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td colspan="4">Oral Hygiene Ratings 2011 – 2012(%)</td></tr>
<tr><td>Quarter</td><td>Good</td><td>Fair</td><td>Poor</td></tr>
<tr><td>1st</td><td>24</td><td>50</td><td>26</td></tr>
<tr><td>2nd</td><td>28</td><td>38</td><td>34</td></tr>
<tr><td>3rd</td><td>47</td><td>30</td><td>23</td></tr>
<tr><td>4th</td><td>42</td><td>34</td><td>24</td></tr>
</table>

It appeared that the emphasis on oral hygiene had a beneficial effect on the oral health of the individuals based on the improvement in oral hygiene ratings.

<u>Staff Training</u>
New 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.

Current employees received ongoing individualized training, but the facility did not maintain a requirement for mandatory annual training.</td><td></td></tr>
<tr><td>Q2</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and</td><td><u>Policies and Procedures</u>
The monitoring team was informed that there were no changes to the dental policies and procedures and, therefore, no polices were submitted with the document request. Following the onsite review, a request was made to submit a copy of the current policy and procedure manual. A revised version, dated 5/1/12, was submitted.

<u>Annual Assessments</u>
In order to determine compliance with this requirement, a list of all annual assessments completed during the past six months along with the date of previous annual assessment was requested. Assessments completed by the end of the anniversary month were considered to be in compliance.
<table>
<tr><td colspan="7">Annual Dental Assessments</td></tr>
<tr><td></td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td></tr>
<tr><td>No. Exams</td><td>28</td><td>15</td><td>11</td><td>37</td><td>27</td><td>28</td></tr>
<tr><td>Compliant Exams</td><td>22</td><td>10</td><td>6</td><td>27</td><td>18</td><td>21</td></tr>
<tr><td>% Compliance</td><td>78%</td><td>67%</td><td>54%</td><td>73%</td><td>66%</td><td>75%</td></tr>
</table>

The facility continued to have problems with timely completion of annual assessments. This pattern began in June 2011 and improved, but compliance never moved past 78%. The clinic reported its compliance in the self-assessment based on a new "within 30 day" standard. This appeared to be an arbitrary standard set by the clinic. The clinic staff reported that they had been instructed to use the 365 day standard to determine</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	assessment of the use of sedating medications and dental restraints.	compliance. The 30 day standard had the ability to artificially improve compliance rates for any given month because it gave a 30 day grace period from the anniversary date. The overall compliance for the six months was 68%. <u>Initial Exams</u> The facility submitted data for five individuals admitted since the last onsite review. Four of the five individuals completed initial dental evaluations. One individual's evaluation was pending, but was not overdue at the time of document submission. <u>Dental Records</u> 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. A new annual dental examination form was developed. It documented dental treatment completed in the past year, a comprehensive assessment, and recommendations made by the dentist. IPN entries were generally dated timed and signed. They were also written in SOAP format. For the 10 records in the record sample, 10 of 10 (100%) included pointer notes in the dental treatment record that pointed the reader to the dated progress note. <u>Failed Appointments</u> 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. The number of missed appointments was essentially zero because it was decided that missed appointments would not be reported until the appointment was missed three times. This was not a decision made by facility management, but was a determination made within the dental clinic. As a result of this, the facility had no data on missed appointments (which were a significant problem for the facility just one year prior to this review). It did not appear that the rapid correction triggered any concerns by the quality assurance department, as should any sudden unexplained change in data. Even with minimal missed appointments, the facility had an average failure rate of 24% for the six month review period.	

#	Provision	Assessment of Status	Compliance

Failed Appointments 2011 - 2012						
	Oct	Nov	Dec	Jan	Feb	Mar
Missed	0	0	1	1	0	0
Refused	21	4	9	20	21	9
Total Failed	21	4	10	21	21	9
Total Visits	64	28	39	87	82	61
% Failed	33%	14%	26%	24%	26%	15%

Dental Restraints

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. A board certified dental anesthesiologist conducted TIVA monthly.

Sedation/General Anesthesia 2011 - 2012						
	Oct	Nov	Dec	Jan	Feb	Mar
Oral Sedation	2	1	0	5	8	3
TIVA	7	7	0	0	7	6
Off-Campus Gen. Anesthesia	0	1	2	3	3	0
Total	9	9	2	8	18	9

Strategies to Overcome Barriers to Dental Treatment

The monitoring team requested evidence that the IDTs reviewed, assessed, developed, and implemented strategies to overcome refusal of treatment. Documents were submitted for five individuals who refused treatment.

- Individual #160 refused treatment. Dental documentation in the IPN noted in October 2011 that the individual was being referred to psychology for an assessment. The dental clinic provided copies of multiple emails sent to the QDDP requesting an update of the individual's status. Copies of the QDDP's responses were not provided. One response, dated 3/15/12, indicated the individual's medical issues at present were more important.
- Individual #218 was seen in dental clinic and refused treatment. Documentation in the IPN indicated the individual was referred to psychology due to refusal of treatment. The note was dated October 2011. The dental clinic again provided emails that were sent to the team requesting follow-up. The monitoring team could not determine the individual's status based on the email request for follow-up.
- Individual #312 refused treatment in October 2011 and was successfully seen in clinic a week after the refusal.
- Individual #97 was seen in clinic on 11/1/11 and refused examination. IPN documentation indicated that the individual was being referred to psychology.

#	Provision	Assessment of Status	Compliance
		There was no further dental documentation. • Individual #380 refused to come to clinic on 2/12/12. The QDDP was notified. An email from the QDDP on 2/14/12 indicated the team was meeting for discussion. On 3/15/12, another email was sent from dental clinic requesting follow-up on this issue. • Individual #547 had very poor oral hygiene and refused treatment. This individual's name did not appear on the refusal list and did not appear on the desensitization list. The individual did not cooperate in clinic in August 2011, but allowed some care at home in February 2012. The status of this individual could not be determined by record review. Individuals who refused annual exams were assigned high priority for psychology assessments. Individuals who refused other dental treatment did not appear to be given the same priority status for assessment by psychology. The records for the individuals above clearly indicated refusal of treatment, yet only two of the individuals appeared on the refusal of treatment list. The majority of the individuals remained without the dental treatment that was needed. The monitoring team expected to find more collaborative efforts in removing barriers for these individuals. An email requesting follow-up for the monitoring team did not appear to fit the collaborative team approach that was presented during the onsite review. The facility has an obligation to take definitive action to provide comprehensive dental diagnostic services at least annually. When there is no response to the emails sent by the dental assistant, further action is warranted. Given the number of individuals who required extensive extractions due to decay and non-restorable teeth, the monitoring team believes it is prudent to provide some additional oversight to this process to ensure that individuals who need treatment are receiving treatment in a prompt manner. Again, this is further evidence that the presence and leadership of a full time dental director is necessary. <u>Desensitization</u> The facility continued to coordinate efforts between psychology medical dental direct care professional and the QDDPs to provide medical and dental desensitization assessments and to determine the need for desensitization, education, rehearsal, simulation, and/or training. The dental department identified 31 individuals who were considered high priority for oral health care and in need of assessment by the psychology department. Twenty four of the 31 individual were assessed at the time of the onsite review and, as a result of the assessments, 17 new and expanded dental SAPs were developed. One individual had a formal desensitization plan. The plans submitted in the document request were	

#	Provision	Assessment of Status	Compliance
		reviewed. They appeared to adequately address the problems of the individuals. There appeared to be value for those individuals who reached this stage. The monitoring team is concerned, however, about the individuals who were considered high priority, but had not had plans developed as well as those individuals who refused treatment but the refusals were not documented. The individuals discussed may have received follow-up, but perhaps the documentation was simply not submitted by the dental clinic. The monitoring team recommends that the individuals be reviewed to ensure that their needs have been adequately addressed. It is not appropriate to engage in an exchange of emails with no real action, no change in status, and no change in plans in the face of progressive dental disease.	

Recommendations:

1. Facility management must consider the need to have a full time dentist and dental director a priority (Q1).
2. The facility director and/or medical director will need to have more involvement with the dental clinic given the absence of a dental director. Weekly or bi-weekly meetings should be held to discuss routine operations, provide guidance, and minimize erroneous decision-making (Q1).
3. The facility should consider an annual requirement for oral hygiene training for direct care professional to ensure that all shifts receive training, not just those that are present when the RDHs work (Q1).
4. A corrective action plan should be developed to address the issue of the low compliance with the annual assessments (Q1).
5. The facility must address the issue of missed appointments (Q1).
6. The facility needs to ensure that all individuals who refuse treatment are being appropriately identified, evaluated and managed (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:** <u>Documents Reviewed</u>: o Admissions list o Budgeted, Filled, and Unfilled Positions list o Speech Staff list o SLP Continuing Education documentation o Section R Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section R-Communication Guidelines o Speech Language Communication Assessment template and guidelines o AAC Screening template o AAC spreadsheet o Individuals with Behavioral Issues and Coexisting Language Deficits o Individuals with PBSPs and Replacement Behaviors Related to Communication o Individuals with PBSPs o List of individuals with AAC o List of individuals receiving direct speech services o Communication Master Plan o Communication Monitoring sheets submitted o Communication Inservice documentation for Individual #447 and documentation of training related to AAC as submitted o Communication Assessments, ISPs, ISPAs, and related documentation for the following individuals who participated in direct speech therapy: • Individual #471, Individual #375, Individual #51, Individual #360, Individual #447, Individual #84, Individual #263, and Individual #248, o Communication Assessments for individuals recently admitted to LSSLC: • Individual #582, Individual #420, and Individual #240. o Communication assessments and ISPs for the following: • Individual #68, Individual #147, Individual #298, Individual #45, Individual #357, Individual #511, Individual #66, Individual #169, Individual #152, Individual #444, Individual #172, Individual #296, Individual #447, and Individual #491. o PNMPs submitted o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP 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

	(six months including most current), Medication Administration Records (most recent) Habilitation Therapy tab, Nutrition tab and Dental evaluation for the following: • Individual #232, Individual #490, Individual #447, Individual #172, Individual #468, Individual #203, Individual #285, Individual #137, Individual #385, Individual #267, Individual #284, Individual #213, Individual #430, Individual #182, Individual #241, Individual #345, Individual #321, Individual #164, Individual #573, and Individual #161 o PNMP section in Individual Notebooks for the following: • Individual #232, Individual #490, Individual #447, Individual #172, Individual #468, Individual #203, Individual #285, Individual #137, Individual #385, Individual #267, Individual #284, Individual #213, Individual #430, Individual #182, Individual #241, Individual #345, Individual #321, Individual #164, Individual #573, and Individual #161 o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #232, Individual #490, Individual #447, Individual #172, Individual #468, Individual #203, Individual #285, Individual #137, Individual #385, Individual #267, Individual #284, Individual #213, Individual #430, Individual #182, Individual #241, Individual #345, Individual #321, Individual #164, Individual #573, and Individual #161 <u>Interviews and Meetings Held</u>: o Danielle Perry, AuD, CCC-A o Rhonda Hampton, MS, CCC-SLP o Kristi Hodges, MS, CCC-SLP o Maegan Melton, MS, CFY/SLP o Christina Pedroni, MS, CCC-SLP o Christina Richbourg, MS, CCC-SLP. o PNMP Coordinators o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas, dining rooms, day programs o Optimal Eating Clinic Communication Skills Clinic
	Facility Self-Assessment: LSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two other documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. The Presentation Book provided information related to actions taken, accomplishments, and work products. The facility was to describe, for each provision item, the activities engaged in to conduct the self-

	assessment of that provision item, and the results and findings from those self-assessment activities and a self-rating of substantial compliance or noncompliance with a rationale. This was significant improvement in the overall self-assessment process. There continued to be some difficulty understanding the difference between assessing whether substantial compliance was met versus engaging in activities to work toward achievement of substantial compliance. The activities listed were appropriate self-assessment activities, but were not the only ones that would be necessary to demonstrate substantial compliance in some cases. For example, in R2 the activities were limited to review of new admission assessments and the Master Plan. There was assessment related to systems involving behavioral supports as stated in the Settlement Agreement. R3 reviewed a small number of speech assessments for self-assessment of this provision item. It was indicated that 100% of the devices recommended in the assessments were implemented. There was inconsistent evidence of consistent implementation, availability, and working order of devices issued. These factors must be considered in any self-assessment of this provision. Consideration of expansion of the samples should also be considered in the future. The statewide self-monitoring tool may be one of the activities used to self-assess, but will not likely be sufficient for most provision items and the action plans may not always address everything that needs to be addressed. The monitoring team discussed self-assessment with the department director and approaches to this process and it is hoped that this provided a clear direction for the future. The facility self-rated itself as noncompliant with all aspects of R (R1 through R4). While actions taken were definite steps in the direction of substantial compliance, the monitoring team concurred with this finding.
	Summary of Monitor's Assessment: Staffing levels were significantly increased at the time of this review and it is hoped that these levels can be maintained. These clinicians appeared to be strong in their knowledge, skills, and enthusiasm for developing effective, functional and meaningful communication supports for individuals. As always, the SLPs were responsible for communication supports and mealtime supports for all of the individuals living at LSSLC, though caseload allocation divided these responsibilities somewhat and at least four of the five clinicians were generally able to focus on communication issues. Though improved, the current ratio continued to be high. There were no SLPAs at the time of this review. Adding positions for speech assistants would be economical and functional as these professional staff were able to provide therapy, staff training, and monitoring. Progress with completion of comprehensive communication assessments per the Master Plan was very limited (less than 8%). The communication assessments were completed outside of the ISP schedule and, as a result, this information was not available to the team during the annual review and development of action steps. Though addendums were generally completed, this created the lack of a comprehensive plan until such time that the assessment was completed. This could take years at the current rate, even for

	those identified with the highest needs and potentials related to AAC. The clinicians continued to report difficulties with implementation of AAC related to maintenance and consistent use throughout the day. There were no Communication Plans for staff reference. A number of systems were recommended in the communication assessments, but without ongoing and consistent support provided by speech clinicians. This should not be the sole responsibility of direct support and day program staff. 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. An effort to initiate this was noted and had appeared to be well-received by the day program staff and should continue and even expanded. Overall, the monitoring team was very encouraged by the current strategies and plans in place to address communication supports for individuals living at LSSLC and looks forward to continued progress.

#	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.	Staffing: At the time of this review, there were five full time SLPs: Rhonda Hampton, MS, CCC-SLP, Kristi Hodges, MS, CCC-SLP, Maegan Melton, MS, CFY/SLP, Christina Pedroni, MS, CCC-SLP, and Christina Richbourg, MS, CCC-SLP. Each was a full time state employee. Rhonda Hampton was assigned to address dysphagia concerns and was a member of the PNMT. The other four clinicians were primarily responsible for communication services at LSSLC. There were no SLPAs employed, and there were no vacant positions. Per the documentation submitted by the facility, there were seven FTE positions for speech therapy, two of which were for audiologists, one of whom was the Habilitation Director. As a result the calculated ratio of 1:52 was not accurate. The audiologist only provided hearing testing and other hearing-related services and did not provide communication assessments or supports. The audiology caseload consisted of all 365 individuals because Dr. Perry did not generally provide direct audiology services. Thus, actual communication services caseloads were about 1:91. This continued to be high given that 256 individuals were identified as nonverbal and another 69 individuals as having only limited speech, that is, overall, 82% of the individuals at LSSLC. Continuing Education There was no reported continuing education specifically related to communication attended by the SLPs since the previous review. Rhonda Hampton, MS, CCC-SLP, Kristi Hodges, MS, CCC-SLP, Maegan Melton, MS, CFY/SLP, and Christina Pedroni, MS, CCC-SLP,	Noncompliance

#	Provision	Assessment of Status	Compliance
		each listed state consultants as completed continuing education. Ms. Hodges and Ms. Hampton listed an iLearn program, Preventing Aspiration. Ms. Richbourg and Ms. Melton listed LSSLC new employee orientation and Ms. Hampton, Ms. Hodges, and Ms. Richbourg also listed Hab Camp during which sections were taught related to communication skills and AAC use and care. Participation in advanced communication-related continuing education during this last review period was limited. Ongoing participation is critical to ensure improved clinical assessment and program development skills for AAC and language for individuals with developmental disabilities.	
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.	Assessments: The Master Plan was submitted as requested (undated). The total number of individuals included in the Master List was 367 (though at least 13 had been discharged or had died in the last six months). An additional 16 were also identified as discharged or deceased per the list of completed assessments. Individuals were categorized into four priority levels based on their needs. The Master List outlined the priorities for completion of assessments (numbers below adjusted per discharges or deaths): • Priority 1: 119 (individuals who were nonverbal with BSPs) • Priority 2: 124 (individuals who were nonverbal without BSPs) • Priority 3: 61 (individuals with limited speech) • Priority 4: 63 (individuals with very little communication difficulties) A handwritten note at the end of the list contained in the Presentation Book for this section identified completed assessment totals as: • Priority 1: 18 • Priority 2: 6 • Priority 3: 4 • Priority 4: 2 Only 11 individuals identified as priority level 1 had completion dates listed, and six individuals had received communication screenings upon their admission to LSSLC. Each of the assessments had been completed, just since 2/22/12, and there were no dates for the new admission screenings. No other individuals had assessment dates listed. Other lists varied slightly as to the number of individuals included in the Master Plan as well as the number of assessments completed. All individuals were to receive a new comprehensive assessment with subsequent comprehensive assessments every three to five years dependent on identified needs, with updates in the interim. The previously completed assessments were not likely	Noncompliance

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		comprehensive and the current clinicians had concerns about some of those completed in the last year. It was reported that the current completion rate was approximately 10%, though the numbers above suggested it was actually less than that. The self-assessment stated the completion rate was 7.6% as of 4/1/12. The most current communication assessments for individuals identified at Priority 1, 2, and 3, or those with the most significant communication needs were completed as follows: **Year / Priority 1 / Priority 2 / Priority 3** 2010: 28 / 29 / 15 2009: 45 / 43 / 25 2008: 42 / 42 / 17 2007: 7 / 12 / 7 A significant number of individuals continued to require an appropriate communication assessment. Four of the five therapists had begun to work in December 2011 and a fifth began in February 2012. It would be expected that the rate of completion would be higher than it was at the time of this onsite review. As stated above, the fifth clinician provided dysphagia and PNMT services and did not complete communication assessments. These databases were inconsistent in the data they presented and each was not dated, so it was not possible to discern which was most current. Even so, there appeared to be at least 331 assessments incomplete across all four levels based on the Master Plan and the tracking log of assessments. Based on the spreadsheet submitted with the Presentation Book alone, approximately only 8%, 5%, 7% and 3% of assessments had been completed for Priority 1 through 4, respectively. Approximately 92% of the assessments were still incomplete and approximately 92% of those were for individuals with the greatest identified needs for communication supports. Communication assessments were being completed per the Master Plan regardless of the ISP schedule. It was intended that the clinicians would request an addendum upon completion of an assessment for each individual. There were 14 assessments submitted as most current for each SLP. Each of these had been completed since 2/22/12. However, duplicates were submitted for Individual #68 (2), Individual #298 (2), Individual #385 (2), and Individual #511 (3). Of the nine unduplicated assessments submitted as most recent, seven had evidence of ISP addendums. None of these were originals and so were without signatures, making it impossible for the monitoring team to determine attendance at a meeting to discuss the findings of the communication	

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		assessments (Individual #147, Individual #511, Individual #385, Individual #285, Individual #68, Individual #298, and Individual #447). Addendums were not submitted for Individual #45 or Individual #357. In addition, assessments for individuals included in the sample selected by the monitoring team for the sections O, P, and R were requested. Assessments were submitted for 19 of 20 individuals in this sample. No communication assessments were submitted for Individual #161. Assessments for only three individuals were current within the last 12 months (Individual #447, Individual #285 and Individual #385) each of which was duplicated in the document submission described above. Other assessments were dated as follows: Priority 1 • Individual #321 (11/12/07), Individual #490 (9/22/08), Individual #468 (10/29/08), Individual #213 (1/7/08), and Individual #430 (11/14/08) Priority 2 • Individual #573 (7/3/08), Individual #164 (1/28/08), Individual #232 (11/5/07), Individual #172 (3/10/05), Individual #137 (6/17/10), Individual #284 (12/1/09), Individual #182 (11/26/08), and Individual #241 (11/13/08) Priority 3 • Individual #267 (4/30/10) and Individual #203 (9/23/09) Priority 4 • Individual #345 (9/16/08) Only two had been completed in the last two years (Individual #137 and Individual #267), neither of whom were Priority 1 and others were completed as long as seven years ago, including Individual #172, who was identified as Priority 2. Four of the individuals who were considered to be Priority 1 had not received an assessment since 2008. The assessment submitted for Individual #321 was a one page document stating that she was not evaluated due to her current medical status. She was to be seen for an assessment when she was medically stable, though there was no evidence of this in nearly five years. Ultimately, there were a total of 25 assessments available for review. These included Communication Skills Evaluations (16) and Update Assessments (9). The assessment for Individual #267 was incomplete (missing pages). Fourteen of the updates were signed also by the audiologist. Assessment templates for Speech-Language Comprehensive Assessment was submitted as requested. The assessments completed in 2012 generally matched this format. The	

#	Provision	Assessment of Status	Compliance
		assessment updates previously completed were not considered to be comprehensive in content. Issues noted in the assessments reviewed relative to this template were as follows: • Diagnosis and Pertinent History: In four of nine assessments, the diagnoses were listed, but the relevance to the assessment or impact on the individual's health or function was not stated. • Medical History: In four of nine assessments, medical history was not reported. The individual's health status over the last year was not addressed. • Medications: In most cases, the medications were listed with general side effects, though the purpose was not (Individual #447, Individual #385, Individual #45, Individual #511, and Individual #298). The relevance of medications was generally not addressed and, in some cases, it was only stated that the medications speech, language and/or swallowing, but did not describe how these areas might be affected (Individual #357, Individual #298, and Individual #147, among others). In one case, medications were merely listed (Individual #357). • Behavioral Considerations and Communication History: There were considerable differences across assessments in the content in these sections. Some described, but did not make reference to, the PBSP (Individual #357), while others referred only to the PBSP and did not describe the individual's behavior in other ways (Individual #511, Individual #298, and Individual #385). • Augmentative/Alternative Communication and Assistive Technology: Content in this section varied across assessments, though most demonstrated an improvement in this area. Some of the assessments continued to state that the individual did not present with necessary prerequisites for AAC (Individual #385) even though contemporary thinking is that there are no prerequisites relative to AAC use. Though more extensive evaluation was conducted for AAC use, the rationale for no recommendations for AAC appeared to be based on a one time session. There was limited discussion regarding opportunities for participation in the individual's daily routine. • Environmental Control: There was no assessment in this area. In a number of cases the clinician merely referred the individual for an OT assessment to address this. There was no reference to previous OT assessment findings in this regard. • Risk Levels: This was addressed in each of the current year assessments reviewed, though only the current risk level assignments were reported. The guidelines required that the clinician not merely list the risks, but also describe supports and services to mitigate these, with rationale, as well as any proposed changes to these, noted based on assessment findings. This was not reported in	

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		any of the assessments submitted. • Clinical Impressions: The analysis sections of these reports were generally improved, though not all provided sufficient rationale for the recommendations identified. • Measurable Objectives: This section was present in the assessment's recommending Skill Acquisition Plans (four of nine individuals). • Reassessment Schedule: The timeframe for reassessment was stated in eight of nine assessments and was included as a recommendation in the other. Each indicated that an assessment would be conducted as needed or upon a change of status and that an annual update would be provided. This was the case for all individuals in the sample with recently completed assessments regardless of need status. There was no rationale presented. • Factors for Community Placement: All of the assessments contained a statement that the individual could be served in a less restrictive or community setting. The assessments did not identify important life activities or inventory ways for greater meaningful participation in them. There was a section for the identification of preferences, likes, or dislikes. These were important to establishing contexts for communication opportunities, but there was no clear link between these and functional participation in the daily routine consistently established via the clinical analysis and recommendations (Individual #511). Skill acquisition plans were outlined for six of the nine individuals (Individual #447, Individual #68, Individual #285, Individual #45, Individual #357, and Individual #298). Some of these were intended for direct communication services and others were diagnostic in nature. There were 24 individuals who were listed as participating in a communication skill acquisition therapy plan. Each had some type of AAC system with the exception of Individual #285 and Individual #298. It appeared that Individual #298 was provided a communication book, but this was not included on the list of AAC. There were approximately 32 individuals with listed with AAC systems and a variety of general use systems including posters (in at least 30 areas), Put 'em Around devices (several in at least five homes), Express One devices (several in at least four homes), Talking Brix (1), and a communication dictionary (switchboard). The clinicians continued to report difficulties with implementation of these devices due to maintenance problems. There were no communication plans or instructions that included use and care of AAC or to outline other communication strategies. There was no specific screening or assessment process for those with behavioral concerns and the potential need for AAC, even though the current comprehensive	

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		assessment had a content area to identify specific communication-related behavioral challenges. The guidelines indicated that the assessment should include observations of behavior, affect, responsiveness to the assessment, habits or mannerisms, and discussion of the PBSP and communication-related behavioral issues. There were considerable differences across assessments in the content in these sections. Some described, but did not make reference to, the PBSP (Individual #357), while others referred only to the PBSP and did not describe the individual's behavior in other ways (Individual #511, Individual #298, and Individual #385). There was no available list of individuals with PBSPs and replacement behaviors related to communication, but it was reported to be in development. There were approximately 122 individuals listed with co-existing behavioral concerns and severe language deficits. There were only eight of these listed with a current communication assessment, though these were each identified as Priority 1 for communication needs. • There was no clear evidence that the clinicians considered any relationship between communication deficits and challenging behaviors. Further, there was no department or facility policy related to the identification of behavioral challenges and related communication deficits. Substantial compliance in this area will not be achieved by merely stating that there was a PBSP in the communication assessment. Collaboration between SLPs and psychology, related to assessment and analysis of associated communication and behavioral concerns, as well as in the development and implementation of related training objectives to improve and enhance communication skills, is required. It was reported that collaboration did occur with psychology and other IDT members during the ISP and ISPA meetings. This was not evident in the ISPs. Kristi Hodges attended the BSP Committee meetings to review assessments and BSP strategies and by report, her contribution was important and meaningful. These were appropriate, but merely first steps toward collaboration with psychology for assessment, program development, implementation, and monitoring.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication	<u>Integration of Communication in the ISP</u> ISPs, ISPAs, assessments, and documentation were included in the sample records (onsite request) reviewed. All ISPs were current for 20 of 20 ISPs included in the sample. Representation by a speech clinician was documented for only 25% of the sample ISPs. Because the communication assessments were being completed as per the Master Plan rather than the ISP schedule, ISP addendums meetings were to be held to integrate assessment findings and recommendations into the ISP. These were noted for three individuals in the sample who had received a recent communication assessment (Individual #447, Individual #385, and Individual #285). SLP signatures were noted on each addendum. The addendum content did not contribute to the description of the	Noncompliance

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	interventions that are functional and adaptable to a variety of settings.	individual's communication abilities nor did they outline strategies for staff use as communication partners. Each of the ISPs made some minimal reference to the individual's expressive communication skills, but receptive abilities were not outlined. There were no descriptions of strategies for staff use as communication partners. There were no summaries of communication assessments in 20 of 20 ISPs reviewed. In some cases, skill acquisition plans were outlined related to communication, but these were not based on appropriate and comprehensive assessment of the individual's skills or needs (Individual #284, Individual #321, Individual #573, Individual #172, and Individual #241). <u>AAC Systems</u> The individual AAC systems were intended to be functional, though some were located in programming areas and were not necessarily portable or meaningful across settings. As described above, consistent implementation continued to be a concern and, as such, meaningful and functional use by the individual often did not occur. As described above there were only 32 individuals with AAC, including a variety of general use systems such as posters, Put 'em Around devices, Express One devices, Talking Brix, and a communication dictionary at the switchboard. This represented only 13% of individuals who were identified as nonverbal (Priority 1 and 2). The design of AAC systems was dependent on an appropriate assessment, but the rate of assessment completion was very slow and many individuals who were nonverbal and had the potential to benefit from communication supports, did not receive them. As stated above, some SAPs had been developed in day program areas and the homes, though these were not necessarily communication-based or developed via sound assessment findings (Individual #284, Individual #321, Individual #573, Individual #172, and Individual #241). Other concerns noted in the ISPs included: • Individual #490's communication skills were considered a barrier, yet there were no action steps related to the development of these skills. She was nonverbal and was at high risk for challenging behaviors. Action Plans in the ISP focused rather on making a purchase with money in a coin purse and placing a hand vibrator on her face with gestural prompts. • Individual #182's ISP indicated that he was nonverbal and that he required a communication evaluation to improve his skills. An Action Referral was to be sent to Habilitation Therapies. Individual #182 was identified as Priority 2 and his last communication assessment had been completed in November 2008. There was no evidence that this concern had been addressed. • Individual #232's ISP indicated that he had advanced Parkinson's Disease that compromised his speech. It was reported that the previous year, speech had	

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		recommended assessment for use of a Dynavox Imax, but that there was no evidence this had been conducted. A follow-up was to be requested. Individual #232 was identified as Priority 2 and his last communication assessment had been completed in November 2007. It was of concern that re-assessment had not occurred given his change in health status and that there was failure to follow-up on a previous recommendation for assessment. • Individual #267's ISP indicated that he had a talking photo album issued to him before he became so ill and was admitted to the hospital. It was reported that he tried to talk, but held his throat as though it hurt him to speak. Speech was notified of the changes in his status and an ongoing assessment was reported to be in progress in order to identify his needs. There was only one entry in the integrated progress notes by an SLP, though it was unrelated to his communication or speech skills. There were no consultations and the most current communication assessment in his individual record was dated 4/30/10. <u>Direct Therapy</u> There were 24 individuals identified as receiving direct speech services with 23 of them listed with AAC systems of some kind. A random sample of these was selected by the monitoring team with documentation of ISPs, ISPAs, assessments, plans, and all other documentation related to direct speech services for Individual #471, Individual #375, Individual #51, Individual #360, Individual #447, Individual #84, Individual #263, and Individual #248. AAC and measurable programming objectives listed for these individuals were the same or nearly the same for all and did not reflect an individualized approach to supports. • Individual #471: Will answer questions, maintain social interactions, and request information or action (Talking Photo Album) • Individual #375: Will answer questions, maintain social interactions, and request information or action (Dynavox) • Individual #51: Will answer questions, maintain social interactions, and request information or action (Communication Builder) • Individual #360: Will initiate communication with two or more partners, will cross a room to retrieve picture and complete a request, discriminate between PECS symbols and exchange the correct symbol (PECS) • Individual #447: Will point to a picture and answer informational questions when provided a choice to two pictures ((Big Mack, communication poster, Express One, communication lap board) • Individual #84: Will answer questions, maintain social interactions, and request information or action (Communication Builder) • Individual #263: Will answer questions, maintain social interactions, and request information or action (Dynavox)	

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		• Individual #248: Will answer questions, maintain social interactions, and request information or action (Dynavox) Extensive documentation was submitted for Individual #447 reflecting considerable efforts in the provision of communication services, clearly as a direct result of the findings of the monitoring team during the last onsite visit. This focus was commendable and was evidence of the potential that LSSLC had for the provision of comprehensive and appropriate services by an IDT and SLPs. Application of the same knowledge, skills and effort should be applied in the provision of supports and services for all individuals with communication needs. Some examples below exemplified this need: • Individual #51 was listed as receiving direct speech services, but his most current communication assessment was 12/3/10. Recommendations indicated that a Communication Builder would be purchased for him and direct therapy would be provided. There was no evidence submitted related to training and supports for using this device. An undated memorandum requested consideration of direct therapy services at Wilson McKewen. There was no documentation submitted reflecting that this was pursued. His current ISP, dated 1/11/12, was not attended by an SLP. A communication wallet was listed as an aspect of his PNMP, but no specific description of his communication skills or strategies for staff as communication partners were outlined in his ISP. There was no communication assessment information contained in the ISP. • Measureable objectives outlined in the addendum to Individual #84's ISP dated 4/7/11 did not match those in the Skill Acquisition Plan currently being implemented by the SLP. Her most current communication assessment was dated 2/24/11 with no more recent update though this would be expected given that she participated in direct speech services. The last progress note written on the SAP was 4/16/12 with no evidence of services since that time though the plan indicated that she would participate in two to three sessions per month. There was no communication assessment information or measurable objectives related to communication contained in her ISP, dated 10/12/11. • Individual #360 had a Communication Skills Annual Update on 2/27/12. Recommendations were to extend his direct speech programming, though no measurable objectives were outlined in the ISP on that same date. SAP documentation was submitted through 2/29/12 only at which time staff had called to report that his PECS cards were missing. There was no documentation that they had been found or replaced or that direct therapy had been resumed as of the time of this onsite review by the monitoring team. • Individual #375's most current communication assessment was 9/17/08. At the time of this review, she used a Dynavox Vmax and participated in direct speech services two to three times a month via an SAP. These were not included into	

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		her ISP dated 9/13/11. No communication assessment information was outlined in the plan. There was no SLP in attendance at her ISP meeting. Documentation of the SAP implementation was submitted for February 2012, March 2012, and April 2012. It indicated that she was seen three times in February 2012, but did not have her Dynavox with her. As of the time of this onsite review, there was no evidence that the Dynavox device was available to Individual #375 for her use or that direct speech services had been resumed. A Performance Improvement Team was established on 1/19/12 to address AAC device use throughout the facility. This was an interdisciplinary group that included the Habilitation Therapies Director, the Director of Psychology, a Unit Director, a Home Manager, SLP, the Employment/Day Services Director, and a psychologist. Findings of the group were to be reported to the QAQI Council by 2/15/12. Minutes were submitted for 1/30/12 and 2/9/12 and it appeared that there was still some unfinished business. With appropriate and timely follow through this was a great way to address the implementation of communication supports in an integrated manner. <u>Staff Training</u> According to the schedule for NEO submitted, there was only a two hour time period available for deaf awareness and ear protection. There was no evidence that general communication strategies or AAC use was addressed. As a result, there would be no way in which to effectively establish staff competency in these areas. Curriculum materials were submitted for a Communication Skills class. The stated focus was related to the importance of communicating with individuals throughout the day, what AAC was, how to use it, how to care for it, and what to do if it was lost, broken, or in need of additional pictures. NEO participants were provided an opportunity to try various communication devices. The content was limited and appeared to be largely didactic in nature. There were verbal response competencies related to policies and procedures, but no hands-on skills based competencies for actual use of the devices. There was no content related to general communication strategies or how to be effective communication partners. • This content was insufficient to provide adequate competency-based training for staff to implement communication supports in a functional and meaningful manner. Inservice training was provided by the SLPs upon the introduction of a new communication system and return demonstration of implementation was required. Because the foundational training was lacking and had only been provided to new employees, it provided little foundation upon which to build competency with regard to more specialized or individualized systems for all staff. Staff training related to communication was not included as an aspect of annual retraining.	

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		The Hab Camp materials were also submitted and included detailed skills-based competencies related to AAC devices for professional, therapy technician, and PNMPC staff. There was no more general content related to being an effective communication partner. Additional training was provided to workshop staff and home managers related to basic AAC policy and procedure information, but not specific to particular devices or individuals. Additional training materials were submitted for inservices conducted on every home (communication posters), and homes with other general use devices such as Put 'em Arounds, Express Ones, and Talking Brix. There was again no content related to communication strategies or how to be an effective communication partner. There was no content as to how staff could incorporate strategies of participation to enhance communication skills. Individual-specific inservice training materials were very specific to permit inservice training by therapy technicians and PNMPCs. It also ensured consistency across speech clinicians. There was generally a combination of verbal responses and return demonstration of specific skills required in order to establish competency. While the interactions of staff with the individuals 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. Many more varied activities were observed being provided in the homes, and staff were talking to the individuals, but most did not appear to understand how to facilitate better engagement and participation with the individuals. 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. It was reported that the speech clinicians had initiated these supports in day program areas and this should be expanded. 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. Participation by DSPs in the Communication clinic sessions with the SLPs is a potentially important opportunity for modeling and coaching effective communication partnering strategies with individuals assessed in this environment.	
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	<u>Monitoring System</u> The monitoring system consisted of periodic PNMP monitoring that included communication. These were generally conducted by the PNMPCs to check for availability, condition, working order, and staff implementation of AAC devices and communication dictionaries.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>Three months of PNMP monitoring was requested for individuals in the sample. A spreadsheet with the findings was submitted and reviewed related to communication. Communication monitoring was completed for only four individuals: Individual #213 (2/9/12 and 4/12/12), Individual #447 (2/21/12 and 2/29/12), Individual #285 (2/29/12), and Individual #385 (3/19/12). Documentation submitted for Individual #447 indicated that he should be monitored related to communication weekly. Clearly this was not being done at this time.

Monitoring results indicated that communication plans were implemented appropriately for these individuals, though in two cases staff reported not being trained to do so.

Additional completed monitoring sheets (64) were submitted for 34 individuals for the month of March 2012. Results were as follows:

<table>
<tr><th>100%</th><th>90%</th><th>80%</th><th>70%</th><th>60%</th><th>50%</th><th>40%</th><th>30%</th></tr>
<tr><td>7</td><td>18</td><td>9</td><td>15</td><td>6</td><td>3</td><td>1</td><td>2</td></tr>
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These monitoring sheets were very generic and, as such, did not provide meaningful information about actual implementation. For example, these did not identify the communication activity being monitored, though some had written in the type of AAC provided to that individual.

This monitoring appeared to be more of a required task, rather than a system that yielded relevant information about the implementation of communication programs. Only 53% of the monitoring was considered in compliance (80% or above, missing one or two items). In all cases reported as 80% or 90% compliance, it was reported that staff indicated they had not been trained related to the PNMP/communication plan. In the cases reporting 80% compliance, the other items missed included presence of the plan (2), equipment broken (3), staff identified individual triggers (1), staff knew who to contact with problems or concerns (1), staff explains risks of not implementing the program (1). It was not clear how the monitoring for individuals with broken equipment could be scored at 80%. The item stated that materials/equipment were present, working and utilized (item #1). If the equipment was broken and not in use, the plan could not be performed as written (item #3) and this would reduce compliance at least to 70%.

Sixteen monitoring sheets completed by PNMPCs were deemed to be ineffective programs. This, however, is a clinical judgment that should be determined only by a licensed clinician.</td><td></td></tr>
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		Other options included noncompliance due to staff competency or implementation, each of which would have been appropriate options for the PNMPCs to document because each of these involved staff competency and/or implementation. Concerns related to effectiveness should be referred to the SLPs for direct observation and review. Of the 70 completed monitoring forms reviewed, only two had been completed by a licensed SLP (i.e., less than 3%; Individual #319 on 2/9/12 and Individual #84 on 3/20/12). Therapists were assigned to complete monitoring two times a week; one individual from their own caseload and one other from Woodland Crossing. If the clinician was assigned to Woodland Crossing then she completed two monitorings a week in that home. Monitoring was done by random selection only and there was no system to determine how often each individual was monitored on a routine basis. This was also not based on individual levels of health risk. Documentation from a PNMPC meeting held on 2/29/12 documented issues related to consistency of PNMPC monitoring of communication. It was reported that issues were identified during a random walk through of homes, but not identified by the PNMPCs during their routine monitoring. These included broken devices, devices in offices for long periods of time, missing pictures, and devices uncharged and not available for use. Very clear guidelines were outlined for these key monitors. Each item on the monitoring sheet was reviewed which should begin to address some of the issues identified above by the monitoring team though the sheets reviewed had been completed since this inservice and clearly the PNMPC were not yet competent in this area. Reliability checks were to begin on 3/8/12 and should further improve PNMPC competency and compliance with this process. Communication supports were generally reviewed on an annual basis prior to the ISP. Frequency of monitoring required in the interim was not identified in the assessment. Licensed clinicians should conduct routine reviews of the efficacy of the communication supports provided and observe and validate consistent implementation. Monitoring of communication programs and systems should be based on level of needs related to communication, though increased monitoring for an individual with changes in risk level would likely warrant monitoring across all areas to assess the impact of health status on functional performance.	

Recommendations:

1. Consider adding SLPA positions to expand supports, services, staff training, monitoring and real-time modeling of effective communication strategies and partner roles and responsibilities. These positions would stretch the services available to individuals, permit more timely completion of assessments and ensure that all individuals who would benefit from communication supports and service would receive them in a timely manner (R1).

2. There continues to be 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).

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

4. Communication assessments should shift to ensure completion in line with ISP schedule whenever possible.

5. Current communication abilities, staff strategies, objectives to expand existing skills and a discussion of the effectiveness of communication supports should be addressed consistently in the individual ISPs (R3).

6. Communication plans and staff training is indicated to ensure appropriate and consistent implementation of recommended AAC systems (R3).

7. It is vital that there be a greater collaboration between psychology and speech clinicians throughout assessment, program development, training and monitoring aspects of supports and services (R2).

8. Consider including training materials to address how to be an effective communication partner in the existing foundation training for new employees and expanded to include existing staff. The time allotted for staff training was unclear. A segment for annual re-training should be considered as well (R3).

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Individual Support Plans (ISPs) for: • Individual #524, Individual #97, Individual #367, Individual #469, Individual #365, Individual #587, Individual #413, Individual #131, Individual #170, Individual #308, Individual #463, Individual #139, Individual #470, Individual #136, Individual #465, Individual #221, Individual #327, Individual #213, Individual #133, Individual #586 o Skill Acquisition Plans (SAPs) for: • Individual #322, Individual #136, Individual #470, Individual #463, Individual #139, Individual #327, Individual #213, Individual #133, Individual #586 o SAP data for past 6 months for: • Individual #322, Individual #136, Individual #470, Individual #463, Individual #139, Individual #327, Individual #213, Individual #133, Individual #586 o Dental Desensitization Plans for: • Individual #387, Individual #131, Individual #319 o Quarterly reviews of SAP data for: • Individual #288, Individual #567, Individual #465, Individual #292, Individual #10, Individual #137, Individual #332, Individual #328, Individual #400, Individual #500 o SAP Peer Review Monitoring Tool, dated 8/10 o Active Treatment Quality Ratings, dated 4/3/12 o Section S Self-Assessment, dated 4/20/12 o Section S Action plan, dated 4/20/12 o SAP format, undated o A list skill training provided in the community, undated o Medical and Dental Desensitization Pilot Plan: Woodland Crossing Unit, undated o Community outings for the last six months o A list of Individuals who are employed on- and off-campus, undated o A list of all Individuals with dental desensitization plans, undated o List of individuals returned to LSSLC from LISD, including date and reason, 11/3/11-5/1/12 • Graph of these data with monthly data points o LISD LSSLC classroom schedule o ARD/IEP, LISD progress report, and LSSLC ISPs for • Individual #475, Individual #587, and Individual #162

	Interviews and Meetings Held: o Luz Carver, QDDP Coordinator and LSSLC Liaison to LISD o Delaina Dearing, RTT IV o Suzanne McWhorter, QDDP Coordinator Assistant o Robin McKnight, M.A., Behavior Analyst I o Lisa Curington, Director of Employment and Day Services o LISD classroom on the LSSLC campus Observations Conducted: o SAP peer review meeting (5/2/12) o Dental and Medical Desensitization Solution Group meeting (5/2/12) 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.
	Facility Self-Assessment: LSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. Overall, the self-assessment included relevant activities in the "activities engaged in" sections. For example, S1 included a review SAPs that focused on the same components that the monitoring team reviews. Not all activities described in the self-assessment, however, were consistent with what the monitoring team reviewed. For example, for S2 the self-assessment reported that the facility reviewed some measures that were similar to those described in the report below (e.g., the presence of assessments of preference, strengths, skills, and needs), however, it also reported on several measures that, although clearly relevant to quality care, were not covered in this provision item (e.g., the quality of meetings, participation of all team members). To take this process forward, the monitoring team recommends that the facility review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead the department to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." Then, the activities engaged in to conduct the self-assessment, the assessment results, and the action plan components are

	more likely to line up with each other. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the facility on this much-improved self-assessment. This was a good first step. LSSLC's self-assessment 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 self-assessment 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 recommends 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 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 included: • Initiation of SAP peer review meetings to ensure that SAPs contained all necessary components (S1) • Reorganization of active treatment, including a new coordinator and additional staff to support individual engagement in all treatment settings (S1) • Expansion of the training methodology (S1) • Development of a new engagement tool (S1) • Initiation of the collection of inter-rater reliability for engagement (S1) • Established a dental desensitization area (S1) • Improved the collection of data regarding training of SAPs in the community (S3) • Continued support for individuals who were entitled to educational services and coordination with the local independent school district. The monitoring team suggests that the facility focus on the following over the next six months: • Expand the 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 the

	individual's needs/preference (S1, S2, S3) • Ensure that each SAP has an individualized plan for maintenance and generalization (S1) • Collect and track SAP integrity measures (S3) • Establish acceptable percentages of individuals participating in community activities, and training on SAP objectives in the community, and demonstrate that these levels are achieved (S3).

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision required an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at LSSLC. As indicated below, 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> Individual Support Plans (ISPs) 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 professionals). Active treatment coordinators trained direct care professionals (DCPs) in the implementation of SAPs, and monitored progress. Vocational SAPs were written and monitored by employment services personnel. As discussed in the last report, an important component of effective skill acquisition plans is that they are based on each individual's needs identified in the Individual Support Plan (ISP), adaptive skill or habilitative assessments, psychological assessment, and individual preference. In other words, for skill acquisition plans to be most useful in promoting individuals' growth, development, and independence, they should be individualized, meaningful to the individual, and represent a documented need. The facility 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. Forty SAPs across nine individuals were reviewed to determine if they appeared to be functional and practical. In 21 of the 40 SAPs reviewed (52%), the rationale appeared to be based on a clear need and/or preference. For example: • The rationale for Individual #139's SAP of brushing his teeth was that he had a history of poor oral hygiene, and that he would benefit in training that improved his oral health. • The rationale for Individual #327's SAP of applying sunscreen was that he enjoyed spending time outside, and would benefit from having sunscreen on his arms.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The rationale for Individual #463's SAP of brushing her hair was that she liked to look nice. In 19 of the 40 SAPs reviewed (48%), however, the rationale was not specific enough for the reader to determine if it was practical and functional for the individual. For example: • The rationale for Individual #136's socialization SAP of counting was that the IDT determined that Individual #136 would benefit from gaining socialization skills. • The rationale for Individual #470 was "(Individual #470) needs to participate in social activities." LSSLC should ensure that the rationale for the selection of each individual's SAP is specific enough for the reader to determine if the SAP was practical and functional for that individual. Additionally, the monitoring team encountered many SAPs in the homes that were still in the old format. It is recommended that the new SAP format be expanded to all SAPs. Once identified, skill acquisition plans need to contain some minimal components to be most effective. The field of applied behavior analysis has identified several components of skill acquisition plans that are generally acknowledged to be necessary for meaningful learning and skill development. These include: • A plan based on a task analysis • Behavioral objectives • Operational definitions of target behaviors • Description of teaching behaviors • Sufficient trials for learning to occur • Relevant discriminative stimuli • Specific instructions • Opportunity for the target behavior to occur • Specific consequences for correct response • Specific consequences for incorrect response • Plan for maintenance and generalization, and • Documentation methodology This represented another area where the facility made improvements since the last review. The new SAP training sheets contained all of the above components. None of the SAPs reviewed, however, included an acceptable plan for maintenance, and only two (Individual #470 SAPs of socialization skills and applying lotion) of 40 (5%) included an acceptable plan for generalization.	

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		All of the SAP training sheets reviewed combined generalization and maintenance, and did not describe how generalization and maintenance of the new skill would be accomplished. The following example was typical: • Individual #213's plan for generalization and maintenance stated "…will show progress for one month and show maintenance for three consecutive months to ensure adequate understanding of training objectives." A maintenance plan ensures that the newly acquired behavior occurs following the end of formal training, while a generalization plan ensures that the behavior occurs in all the appropriate situations and circumstances outside of the specific training situation. An example of a generalization plan for an individual with a SAP of independently purchasing items from a vending machine could be "The individual will be encouraged to generalize these skills to the purchase of snacks in the canteen and the purchase of desired objects in the community." An example of a maintenance plan for this same individual and SAP could be "After mastering the use of the vending machine and the termination of the SAP, he will continue to make purchases in order to maintain this skill." It is recommended that all SAPs contain individualized generalization and maintenance plans that are consistent with the above definitions. An area of improvement was the expansion of the methodology used to teach SAPs. The monitoring team encountered examples of forward chaining (e.g., Individual #470' SAP of participation in an activity) and backward chaining (e.g., Individual #586's SAP of going on an outing). It was not always clear, however, from the training sheet as to whether training was to be on one specific step or the total task. In addition to the improvements discussed above, the facility recently began a SAP peer review, which is a weekly interdisciplinary meeting where selected SAPs are reviewed to ensure they contain all of the above components. The monitoring team was encouraged by the improved SAPs at LSSLC, and looks forward to seeing the new format expanded to all SAPs. <u>Desensitization skill acquisition</u> LSSLC continued to make improvements in this area. The interdisciplinary group, consisting of dentistry, psychology, and rehabilitation, that was discussed in the last report, continued to meet monthly. Additionally, LSSLC recently created a room specifically designated for dental desensitization. Since the last review, the dental department identified 31 individuals as high priority for oral healthcare, and the psychology department assessed 24 of these individuals. As a result of these assessments, 17 new dental SAPs had been developed. Three (Individual #387,	

#	Provision	Assessment of Status	Compliance
		Individual #131, and Individual #319) 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. The dental desensitization SAPs reviewed shared the same strengths and weakness discussed in detail above. The monitoring team was very pleased with the progress LSSLC was making in this area. Outcome data (including the use of sedating medications - there were 26 applications of sedation for dental procedures since the last review) from desensitization plans, and the percentage of individuals referred from dentistry with desensitization plans, will be reviewed in more detail during future onsite 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. One of the PBSPs reviewed (i.e., Individual #285) indicated the need for training of replacement/alternative behaviors (see K9). The monitoring team was pleased to find that, as recommended in past reviews, the training of this replacement behavior was written as a SAP. <u>Communication and language skill acquisition</u> The monitoring team encountered only one example (i.e., Individual #285's SAP of signing for food) of a SAP targeting the enhancement or establishment of communication and language skills. This was only slightly better than the last review when no communication SAPs were encountered. 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	

#	Provision	Assessment of Status	Compliance
		that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. Specific engagement information for each residence and day program are listed in the table below In the last report the monitoring team noted a substantial decrease in engagement at LSSLC. Since the last review, however, the facility had restructured active treatment services. This restructuring consisted of: • A new supervisor of active treatment services (a QDDP coordinator assistant) • Eleven active treatment coordinators (whose work schedules include evenings and weekends, as recommended in the last report) • A new active treatment measure with seven categories of engagement • The beginnings of engagement inter-observer agreement • Initiation of the graphing of engagement data by home Although these changes were relatively recent, the monitoring team noted some improvements in engagement during the onsite review. The average engagement level across the facility was 47%, a considerable increase from the last review (i.e., 38%), and back to the level of previous reviews (the April 2011 review reported an engagement level of 48%). 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. Additionally, although there continued to be considerable variability in engagement across homes and day programs, the monitoring team was encouraged by the fact that they encountered several active treatment coordinators across the facility working with DCPs to achieve meaningful individual engagement. There were some particularly good examples of engagement, such as in home 557A where several individuals were engaged in arts and crafts, and the day programming in the 550 building for the individuals who resided in Woodland Crossing. 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 monitoring team recognizes the efforts LSSLC is making to improve engagement, and looks forward to further improvements in future reviews.	

#	Provision	Assessment of Status	Compliance
		Engagement Observations:	

Location	Engaged	Staff-to-individual ratio
550	3/4	3:4
550	4/7	2:7
550	5/6	2:6
550	2/3	1:3
506	4/7	3:7
506	2/10	2:10
524	2/3	2:3
563 B	2/3	2:3
563 B	3/8	2:8
563 B	2/3	1:3
563 A	3/8	3:8
563 A	4/6	1:6
559 B	2/8	1:8
550	0/3	1:3
557 A	6/8	2:8
557 A	1/1	0:1
557 A	5/7	2:7
549 D	1/5	1:5
549 D	0/8	2:8
550	1/5	1:5
550	0/4	1:4
550	2/2	1:2
550	2/4	1:4
550	0/3	1:3
Workshop	11/13	5:13
Workshop	5/7	3:7
560	2/10	2:10
560	1/3	1:3
560	3/6	1:6
560	0/4	2:4

#	Provision	Assessment of Status	Compliance
		Educational Services LSSLC and LISD continued to have a very good working relationship. The LSSLC liaison to LISD also continued to make progress in advocating for educational services for LSSLC individuals. Twenty-six individuals were students; 16 were at the LISD high school, three were at the LISD middle school, and seven were assigned to the LISD classroom on the LSSLC campus. The working relationship was evident in many ways. First, QDDPs attended all IEP/ARD meetings at LISD and their input was welcomed. Second, the monitoring team spoke at length with the LISD director of special education. She described her positive relationship with LSSLC, including frequent communication via emails and phone calls. She reported that LSSLC often sent staff to help support students, especially if they were on one to one supervision. She said that staff were very respectful. She also noted that the students were always dressed appropriately and were well groomed. On the other hand, there were some serious problems with communication between LISD school staff and LSSLC staff when a student was ill. This may have played a role in the speed in which one student received medical attention (Individual #157). This was investigated by the facility and by DADS state office coordinators of medical and nursing services. As a result, a corrective action plan and new procedures were put into place. Over the past two years, LSSLC and the monitoring team have discussed a number of other important aspects of educational services for students at LSSLC. One was the high frequency of students being returned mid-day to LSSLC. The LSSLC liaison worked on this and improvements occurred. Moreover, since the last onsite review, the LSSLC liaison began to graph the frequency per month across three different categories (behavior, medical, other). Based on the data recorded, the liaison (and the monitoring team) believed that students were being sent back to LSSLC for reasonable causes. Second was the incorporation of activities at LISD into the ISP and into programming on campus at LSSLC, such as IEP/ARD objectives being worked on at home, and reviews of LISD progress reports during the ISP quarterly reviews. This continued to be an area in need of additional improvement. To that end, prompts within the new ISP template and the new ISP quarterly review template may help to greater support this integration. Third, students are entitled to educational services through the school year in which they turn 21 years old, depending upon their educational needs. The LSSLC liaison and the LISD special education director both reported that they worked together, along with the ARDs and the IDTs, to have students graduate when appropriate to do so. Fourth, students are entitled to receive a commensurate school day. The LSSLC liaison	

#	Provision	Assessment of Status	Compliance
		achieved good outcome over the past two years in gaining longer, fuller school days for many students. The attendance of students at the on campus school, however, appeared to be very low. The monitoring team visited the classroom three or four times during this onsite visit and there were never any students in the classroom. This was a change from the last onsite review when at least one student was in the classroom throughout each day. The monitoring team understands that behavior problems and refusals to attend school were the reasons many of the students were assigned to this classroom rather than at the LISD school buildings. Nevertheless, the monitoring team recommends that the facility collect data on student attendance at the on campus classroom. This may help IDTs, QDDPs, and psychologists to focus on increasing attendance. Fifth, the LSSLC liaison continued to discuss extended school year service discussions with the LISD special education director. Sixth, during the last onsite review, the LSSLC 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. This had not occurred, but no longer seemed necessary because the psychologists assigned to the students appeared to be filling this role and an explicit assignment of one psychologist no longer seemed necessary. This seemed reasonable to the monitoring team, too.	
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, although the facility was beginning to make improvements in the documentation of how this information impacted the selection of specific program objectives, more work in this area is need. At the time of the onsite review, the facility was using the Functional Skills Assessment (FSA) in place of 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 (also see comments regarding the FSA in sections F and T of this report). Finally, while the ISP identified individual preferences, no evidence of systematic (i.e., experimental) preference and reinforcement assessments (when potent reinforcers or preferences are not apparent) was found. Subsequent monitoring visits will continue to evaluate the tools used to assess individual preference, strengths, skills, needs, and barriers to community integration.	Noncompliance

#	Provision	Assessment of Status	Compliance
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 continued to make progress on this provision item. More work, however, in the demonstration that SAPs are implemented as written was 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. Ten quarterly reviews representing the outcome data of 61 SAPs were reviewed to determine compliance with this provision item. Twenty-seven of those reviews (44%) indicated SAP progress or the achievement of sustained high levels (i.e., above 90%) of SAP performance. This represented a slight decrease from the last review when 53% of SAPs reviewed showed progress. Additionally, as found in the last review, there was evidence of data based decisions concerning the continuation (e.g., Individual #332's SAP of placing a peg in a pegboard), modification (Individual #500's SAP of money management), or discontinuation (e.g., Individual #567's SAP of identifying the worth of money) of SAPs. There was, however, no action documented for 34 of 61 (56%) SAPs reviewed that showed no progress or regression (e.g., Individual #400's SAP of teeth brushing). It is recommended that data based decisions be documented for the continuation, modification, or discontinuation of all SAPs at LSSLC. As during the last review, the implementation of SAPs was observed by the monitoring team to evaluate if they were implemented as written. The monitoring team was pleased to find that all of the SAPs observed appeared to be conducted as written (e.g., Individual #296 SAP of touching an object), and staff were able to explain how to implement the plans. Nevertheless, the only way to ensure that SAPs are implemented 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 also reviewed nine SAP data sheets to evaluate if data were	Noncompliance

#	Provision	Assessment of Status	Compliance
		completed as scheduled. All nine SAP data sheets documented the training of SAPs as specified in the SAP schedule. This represented an improvement in the documentation of SAPs from the last review when 87% were completed as scheduled.	
	(b) Include to the degree practicable training opportunities in community settings.	LSSLC improved the collection of data regarding the training of SAPs in the community. Data presented to the monitoring team indicated that the majority of individuals at the facility participated in various recreational activities in the community, and were provided training opportunities in the community. In order to achieve substantial compliance with this provision item, the facility now needs to establish acceptable levels of activities and training in the community, and demonstrate the that those levels are consistently achieved. The facility began a new tracking of training of SAP objectives in the community prior to the onsite review. The documentation revealed that the majority of individuals participated in training of SAPs in the community. The range was large from one (e.g., Individual #484) to 26 (e.g., Individual #60) SAP community-training activities in any given month. It is recommended that the facility now establish acceptable percentages of individuals participating in community activities and training on SAP objectives, and demonstrate that these levels are achieved. At the time of the onsite review, three individuals at LSSLC worked in the community. This represented a decrease in the number reported during the last onsite review (i.e., five).	Noncompliance

Recommendations:

1. Ensure that the rationale for the selection of each individual's SAP is specific enough for the reader to determine if the SAP was practical and functional for that individual (S1).

2. It is recommended that all SAPs contain individualized generalization and maintenance plans that are consistent with the above definitions (S1).

3. Expand new SAP format to all SAPs (S1).

4. It is recommended that the facility expand the number of communication SAPs for individuals with communication needs (S1).

5. Working on carryover from LISD instructional activities to the individuals' homes at LSSLC (S1).

6. Incorporate review of the LISD progress reports during quarterly ISP reviews (S1).

7. Collect data on student attendance at the on campus classroom (S1).

8. The facility should conduct systematic preference/reinforcer assessments when asking care givers/self reports do not identify practical or potent preferences/reinforcers (S2).

9. It is recommended that data based decisions be documented for the continuation, modification, or discontinuation of all SAPs (S3).

10. It is recommended that a plan be developed to collect and graph integrity data to ensure that SAPs are conducted as written (S3).

11. The facility should establish acceptable percentages of individuals participating in community activities and training on SAP objectives, and demonstrate that these levels are achieved (S3).

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, attachments, January 2012 o LSSLC facility-specific policy, Client Management-38, Most Integrated Setting Procedures, 9/20/11 o LSSLC organizational chart, 4/10/12 o LSSLC policy lists, 2/23/12 o List of typical meetings that occurred at LSSLC, 3/28/12 o LSSLC Self-Assessment, 4/20/12 o LSSLC Action Plans, 4/20/12 o LSSLC Provision Actions Information, 4/19/12 o LSSLC Most Integrated Setting Practices Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 4/30/12 o Community Placement Report, last six months, through 4/30/12 o List of individuals who were placed since last onsite review (8 individuals) o List of individuals who were referred for placement since the last review (7 individuals) o List of individuals who were referred and placed since the last review (0 individuals) o List of total active referrals (12 individuals) o List of individuals who requested placement, but weren't referred (2 individuals) • Documentation of activities taken for those who did not have an LAR (0 individuals) • List of individuals who requested placement, but weren't referred solely due to LAR preference (1 individuals) o List of individuals who were not referred solely due to LAR preference (107 individuals) o List of rescinded referrals (3 individuals) • ISPA notes regarding each rescinding • Special Review Team minutes for each rescinding o List of individuals returned to facility after community placement and related ISPA documentation (0 individuals) o List of individuals who experienced serious placement problems, such as being jailed, psychiatrically hospitalized, and/or moved to a different home or to a different provider at some point after placement, and a brief narrative for each case (6 individuals) o List of individuals who died after moving from the facility to the community since 7/1/09 (2 individuals, 1 since the last onsite review) o List of individuals discharged from SSLC under alternate discharge procedures and related documentation (2 individual)

	o APC weekly reports, five, 2/21/12 through 3/27/12 and 5/1/12 • Statewide weekly enrollment report (none) • Detailed referral and placement report for senior management (five) o Variety of documents regarding • Community tours, November 2011 through March 2012 (14) and ISPAs for some (6) • Trainings for facility staff, January 2012 and March 2012 (2) • Meetings with local LA (0) • CLOIP and permanency plan tracking documents, November 2011 through April 2012 o Description of how the facility assessed an individual for placement o List of all individuals at the facility, indicating the result of the facility's assessment for community placement (i.e., whether or not they were referred) o List of individuals who had a CLDP completed since the last review (8 individuals) o Completed checklists used by APC regarding submission of assessments for CLDP (<u>not</u> within the CLDP) o DADS central office written feedback on CLDPs (0 individuals) o Various bar graphs of section T statewide monitoring tools results, 10/1/11 through 4/1/12 o Completed section T statewide monitoring tools, for living options discussion (5), CLDP (2), and post move monitoring (2) o Two section T statewide monitoring tools for living options discussion completed by the post move monitor and a QA staff member for an ISP observed by the monitoring team, 5/1/12 o Summary of community placement obstacles (none submitted) o State obstacles report and LSSLC addendum, October 2011 o PMM tracking sheet, 4/6/12 o Transition T4 materials for: • Individual #449, Individual #195 o New-style ISPs and assessments for: • Individual #156, Individual #567, Individual #136, Individual #290 o New-style ISPs for: • Individual #463, Individual #139, Individual #470, Individual #465, Individual #221, Individual #327, Individual #213 o New-style ISPs and PMM completed self-monitoring tool: • Individual #367, Individual #51, Individual #229 o CLDPs for: • Individual #525, Individual #498, Individual #426, Individual #77, Individual #256, Individual #92, Individual #198, Individual #244 o Draft CLDP for: • Individual #114 o In-process CLDPs for: • Individual #103, Individual #253, Individual #114 o Pre-move site review checklists (P), post move monitoring checklists (7-, 45-, and/or 90-day reviews), and ISPA documentation of the IDT meetings that occurred after each review, conducted

since last onsite review for:

- Individual #21: 90
- Individual #233: 90
- Individual #557: 90
- Individual #565: 90
- Individual #491: 45, 90
- Individual #434: 45, 90
- Individual #379: 45, 90
- Individual #244: P, 7, 45, 90
- Individual #92: P, 7, 45, 90
- Individual #198: P, 7, 45, 90
- Individual #77: P, 7, 45, 90
- Individual #256: P, 7, 45, 90
- Individual #426: P, 7, 45 (post move monitoring completed by Denton SSLC)
- Individual #498: P, 7
- Individual #525: P, 7

Interviews and Meetings Held:

- Lisa Pounds Heath, Admissions and Placement Coordinator
- Leigh Anne Hall, Post Move Monitor
- Donnie Wilson, DADS Continuity of Care Coordinator
- Malorie Thompson, QDDP
- Gale Wasson, Facility Director
- Managers and staff at D&S community group home, Longview, TX

Observations Conducted:

- CLDP Meeting for:
  - Individual #114
- ISP Meeting for:
  - Individual #262, Individual #326
- Community group home visit for:
  - Individual #498: 45-day post move monitoring

Facility Self-Assessment

LSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement.

For the self-assessment, the facility described, for each provision item, the activities the facility engaged in

	to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. During the week of the onsite review, the monitoring team engaged in lots of discussion with facility staff regarding the new self-assessment. Facility staff appeared interested and eager to implement this new process correctly and in a way that would be beneficial to them. The most difficult aspect of this appeared to be understanding the somewhat subtle difference between assessing whether substantial compliance was met versus engaging in activities to meet substantial compliance. There were numerous problems with the three tools being used by the facility to self-monitor (i.e., self-assess) substantial compliance with provision T. These problems included content, administration and implementation, interpretation of data, and reliability. The state office was aware of these problems and reported that new tools were being developed. It is possible that the new tools might include everything that comprises the self-assessment, or (more likely) it may be that the new tools are a part, but not all, of the self-assessment. Overall, the self-assessment should look at the same types of activities, actions, documents, and so forth that the monitoring team looks at. This can be determined by a thorough reading of the report. For example, the self-assessment completed by the APC for this review relied heavily on the current self-monitoring tools. As a result, in one part of T1a, she reported on the ratings given by the raters as to whether the transfer/referral was consistent with the determination of professionals. A reading of T1a in the report, however, shows that the monitoring team looks at if and how this was addressed in IDT assessments, ISP meetings, and ISP documents. Thus, the item in the current self-monitoring tool is insufficient for assessing this aspect of T1a. Similarly, in T1e, the APC only reported on whether essential and nonessential supports were identified in the CLDP whereas the monitoring team also looked at whether a full set of supports was generated by the IDT, if they were worded in observable and measureable terms, and if adequate types of evidence were specified. Further, the self-assessment (and possibly the new self-monitoring tools) should be modified after each monitoring report is issued. For example, for T1d, the facility self-assessment looked at whether assessments existed and if they were within 45 days of the individual's move to the community. In T1d below, the monitoring team describes other criteria related to the quality of these assessments, such as whether the assessments specifically focused upon the individual's move to the community. On the other hand, the tool for T1b looked at facility-specific policies for transition and discharge and it looked at training requirements. These were appropriate for the self-assessment of T1b. Similarly, the items self-monitored for T1h and T4 were also appropriate. T1b1 has a lot of overlap with section F and the activities of the QDDPs. Therefore, it might make sense to

	coordinate the self-monitoring of some aspects of T1b1 with the QDDP department. T2b might be self-monitored if the APC should conduct any observations of the PMM while she is completing an onsite post move monitoring. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the APC and believes that the facility was proceeding in the right direction. This was a good first step. The facility self-rated itself as being in substantial compliance with five provision items: T1c2, T1c3, T1d, T1h, and T2a. The monitoring team agreed with all five of these. In addition, the monitoring team rated T1c, T2b, and T4 as being in substantial compliance.
	Summary of Monitor's Assessment LSSLC continued to make progress towards substantial compliance. The specific numbers of individuals who were placed and who were in the referral and placement process, however, remained low given the size of the facility. The number of individuals placed was at an annualized rate of 4% (eight since the last review) and the number on the referral list was 3% (13 individuals). This was a reverse in trend. The list of individuals not being referred solely due to LAR preference contained 107 names. This was a more accurate list than ever assembled. The facility continued to maintain a transition home, but no one was living in the home and a second home was still in development. There appeared to have been numerous problems with many individuals' experiences at the transition home. The facility should do an assessment and review of the transition home so that it is more likely to have beneficial outcomes. LSSLC continued to make progress in including professional determinations in ISP planning, meetings, and documentation, building from the time of the last onsite review. More detail should be included in the LOD section of the ISP so the reader has a good understanding of the IDT's opinion and how it was arrived at. One LAR asked if her son moved to the community, could he come back to LSSLC if it didn't work out. Unfortunately, the LA representative and the QDDP said that it couldn't be guaranteed. This had the untoward effect of ending all discussion about a community referral. This question needs to be resolved. The new style ISPs showed a number of areas of improvement. They did not, however, address obstacles to referral or to placement. The monitoring team was of the understanding that these types of obstacles were supposed to be addressed in the ISP. LSSLC was engaging in some, but not yet all, of the activities required towards educating individuals and their family members and LARs.

	CLDPs were done in a timely manner, initiated shortly after referral. IDT members actively participated in the placement process. The CLDP meeting observed by the monitoring team showed improvement from the one observed last time. Each post move monitoring visit was followed by an IDT meeting to review the individual's status. In the CLDPs, more detail was needed to be specified regarding the training of provider staff, and collaboration between the facility clinicians and the community clinicians. Assessments in preparation for the individual's upcoming move needed to focus upon the new residential and day setting. The monitoring team recommends that the assessment section of the CLDP be similar to what was being done at Mexia SSLC. That is, each of the assessment sections should have two sub-sections, one to describe the deliberations (i.e., discussion) of the IDT regarding the assessment, and the other to list the recommendations that result from these deliberations. If a recommendation in an assessment does not make it into the ENE supports, it should be documented as to why. LSSLC made progress in identifying essential and nonessential (ENE) supports, however, additional improvement was still needed. The five bulleted points describing problems with the ENE supports in the previous monitoring report still applied. The APC should make this a priority area given the importance of this activity and the continued need for improvement. Many of the ENE supports needed to be written in more measureable, observable terms. Evidence to show the provider's implementation of ENE supports needed to be shown in the lists of ENE supports. There were many problems with the statewide self-monitoring tools for provision T. Further, there were differences in the scoring between the PMM and QA staff, indicating reliability issues, too. This was not lost on the APC and the state office continuity of service coordinator. To address this, state office was developing new tools and a new self-assessment for all of provision T. The facility did not present any data regarding obstacles to individuals' movement to more integrated settings, other than that which was described in the state's annual report of data through August 2011. A current action plan and action steps provided a realistic plan for addressing this. LSSLC maintained substantial compliance with item T2a. There were 28 visits required for 15 individuals and all were done timely. The residential and day sites were visited every time. The visits were documented correctly and thoroughly. The PMM did a good job of following up when there were problems. Of the 15 individuals who received post move monitoring, seven appeared to be doing very well and having a great life. This was well reflected in their post move monitoring reports. Two others had experienced some problems, but these were not unexpected. The other six individuals had, or were having, serious issues with their placements. Of these six, three were exhibiting serious problem behaviors and three had to be re-placed due to serious problems with the

	provider. Thus, 40% of the placements were very problematic. The facility needs to go back and revisit their transition planning processes as recommended in T1a, that is, to do a root cause analysis and/or sentinel event-type review.

#	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 substantial compliance with the items of this provision. Lisa Pounds Heath, the facility's Admissions and Placement Coordinator (APC) continued as the lead for this provision. The monitoring team remained impressed by her detailed knowledge of the individuals at LSSLC who were involved in the placement and referral process. She continued to be assisted by the post move monitor, Leigh Anne Hall. The APC anticipated that there would be new two transition specialists appointed to the facility sometime in the next few months. The new APC and PMM from the San Antonio SSLC were present at LSSLC during the week of this onsite review as part of their orientation and training to their new roles. 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. The number of individuals placed was at an annualized rate of 4% and the number on the referral list was 3% of the individuals who lived at LSSLC. This was a reverse in trend from the previous onsite reviews. Below are some specific numbers and monitoring team comments regarding the referral and placement process. • 8 individuals were placed in the community since the last onsite review. This compared with 13, 9, 8, and 5 individuals who had been placed during the periods preceding the previous reviews, respectively. o This demonstrated a decreasing trend. o The eight individuals were from three of the four units (Oak Hill, Castle Pines, Woodland Crossing), ranged in age from 16 years old to mid-60 years old, and had been at the facility for a few years or for a number of decades. Also, the eight individuals varied widely in the amount and intensity of services and supports needed. Thus, even though the numbers were lower than they had been, LSSLC appeared to continue to work with individuals from across the facility regarding opportunities for community placement. • 7 individuals were referred for placement since the last onsite review. o This compared with 14 who were newly referred at the time of the previous review. o 0 of these 7 individuals were both referred and placed since the last onsite review.	Noncompliance

		• 13 individuals were on the active referral list. This compared with 17, 20, 25, and 17 individuals at the time of the previous reviews, respectively. o This was the lowest number of individuals on the active referral list since monitoring began at LSSLC. • 8 individuals were described as having requested placement, but were not referred. This compared with 6, 6, and 9 individuals at the time of the previous reviews, respectively. o The APC ensured that each of these cases was reviewed. o All 8 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 Special Review Team. There were no individuals to whom this applied during the six months since the last review. • The list of individuals not being referred solely due to LAR preference contained 107 names (compared to 6, 3, and 17 individuals at the time of the previous reviews, respectively). o The number of names on this list was more accurate than in any previous reviews and was a good beginning to the creation of a more accurate list. • The referrals of 3 individuals were rescinded since the last review. This compared to 4 and 4 at the time of the previous reviews, respectively. o Each individual's IDT met and an ISPA report was issued that provided information indicating that the decision to rescind was reasonable. One was rescinded by the individual herself, and the other two were rescinded by the IDT due to escalations in behavior problems. o A special review team meeting was also held for each of these rescinded referrals. o As recommended in previous reports, however, 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 ISPA and the SRT notes provided a lot of detail regarding the 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 0 and 2 individuals at the time of the previous reviews. • 7 individuals who had moved to the community over the past year had a variety of problems with their placements. Some were due to serious problems with the community provider and some were due to challenges that arose after the individual moved to the community (see T2a below). o A detailed review/root cause analysis should be conducted for each of	

		these cases to assess the referral and placement processes. • 0 individuals had died since being placed since the last onsite review. • 2 individuals were discharged under alternate discharge procedures (see section T4 below). As also recommended in previous reports, each of the above bullets should be graphed separately. In the last report, the monitoring team noted that some progress had been made, however, this was not maintained. The monitoring team recommends using 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). The facility continued to maintain a transition home, as described in the previous report. At the time of this review, no one was living in the home and the second home was still in development. Although a seemingly good idea, there appeared to have been numerous problems with many individuals' experiences at the transition home over the past six months, such as having to return to live on the main campus before transitioning to the community, exhibition of serious behavior problems, and allegations of abuse. The facility should do an assessment and review of the transition home so that it is more likely to have beneficial outcomes, as it did for at least one individual (Individual #244). <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 ISP assessment process, occur during the annual ISP meeting, and be documented in the written ISP. LSSLC continued to make good progress, building from the time of the last onsite review. First, for the written assessments (for a sample of annual ISPs reviewed by the monitoring team), the professionals who conducted the assessments included an explicit statement regarding his or her opinion about whether the individual could be supported in a less restrictive, more integrated (i.e., community) setting. This was the case for most, but not yet all, of the assessments. Second, the monitoring team reviewed a set of completed ISP documents and found that there was discussion of living options in every one of them. Within this discussion, each professional member of the IDT was asked to, and provided, an explicit statement regarding his or her opinion of whether the individual could be supported in a less restrictive, more integrated setting. The level of detail in the description of these statements, and any ensuing discussion, varied across the ISPs reviewed. The description was in the ISP section called Living Option Determination. Some of the more	

		detailed descriptions documented the types of concerns held by members of the IDT or what the IDT would do next before considering referral, such as more community tours. On the other hand, many of the Living Option Determination sections merely said that the IDT was following the LAR's preferences. More detail should be included in the Living Option Determination section of the ISP so that the reader has a good understanding of the IDT's opinion and how it was arrived at. In many of the ISPs, the LAR and many of the IDT members noted that the individual was happy living at LSSLC. This was good to see and is acknowledged by the monitoring team. Third, in all of the ISP meetings observed during the week of the onsite review, living options were discussed and professionals were asked to give their opinions. Topics always included referral and/or further exploration of living options. <u>Preferences of individuals</u> The preferences of individuals continued to be sought and met by LSSLC IDT members. <u>Preferences of LARs and family members</u> LSSLC attempted to obtain the preferences of LARs and family members and to take these preferences into consideration. This was very important to the management and clinical staff at LSSLC. During one ISP meeting, the LAR (on speakerphone) was adamant about not wanting to be repeatedly told about community options. She said she had made her decision and didn't want to discuss it further. The QDDP did an excellent job of respectfully hearing the LAR's concerns and then moving ahead with the other important topics of the ISP meeting. In another ISP meeting, the LAR made similar comments, including statements about her own observations of some community group homes. The QDDP in this meeting also did a nice job of listening to the LAR's concerns. In addition, the QDDP said that there were many different providers. Surprisingly, the LAR then said she might consider visiting some. She asked, if her son was to move to the community, could he come back to LSSLC if it didn't work out. Unfortunately, the LA representative and the QDDP said that it couldn't be guaranteed. This had the untoward effect of ending all discussion about considering community referral. The monitoring team followed up with the facility director and the APC and it appeared that this might not be the case. The facility director agreed to follow-up with DADS central office and the family. These can be very difficult conversations for QDDPs to have with LARs and family members. They are required to bring up the topic while maintaining respect for LARs and their opinions and preferences. To that end, the monitoring team's understanding was that additional training was to be provided for QDDPs so that this discussion could	

		be done in a sensitive and appropriate manner for all involved. <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 completed and the DADS state office was expecting to disseminate it in mid May 2012. The admissions and placement staff reported that the facility followed the state's policy. The facility-specific policy was unchanged since the last onsite review and comments from the previous report were still applicable. Implementation of the new state policy will require updating of facility policies to make them in line with the new state policy.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	A new-style ISP was designed to address the many items that were required by the Settlement Agreement, ICFMR regulations, and DADS central office. Further, the new ISP was supposed to include items that had been missing from previous ISP formats, such as professional's opinions (T1a), the identification of protections, services, and supports (T1b1), and the identification of individual obstacles (T1b1). <u>Protections, Services, and Supports</u> Overall, LSSLC continued to make progress in the development of ISPs that contained a range of protections, services, and supports. Based on observation of annual ISP meetings during the week of the onsite review, and review of numerous completed annual ISP documents, the monitoring team has the following comments. • There was good progress regarding discussion and documentation of discussion regarding most integrated settings. More work was needed as reported in T1a above. • The new process was being implemented by all of the many QDDPs. • The monitoring team particularly liked two of the sections newly added to the format: o List of any injuries, incidents, or abuse/neglect allegations. o Review of the past year's skill acquisition plans (SAP). • It was helpful when the list of action steps clearly indicated if the action step was	Noncompliance

		to be a SAP. This was done in some, but not all, of the ISPs. • The FSA never mentioned in any ISP meeting or document. It was not clear if or how it was used in the identification of protections, services, and supports. • Many action steps were not written in measureable terms. • Each action plan had a number of action steps. Many action steps were duplicated under more than one action plan. This artificially inflated the list of action steps and will likely create unnecessary duplication of paperwork, such as during the monthly and quarterly reviews of the ISP. • There were many action steps in the action plan section that were not mentioned anywhere else in the ISP document. Likely, these were from assessments and/or carried over from previous ISPs. This was acceptable to the monitoring team, however, the QDDP coordinator should ensure that this is acceptable practice and in line with policy. • All of the ISPs reviewed were of a similar format except for one. Individual #290's ISP had a lot of the information in list format, with frequent use of bullets and templated language rather than the narrative found in the other ISPs. Further, action plans and action steps did not appear integrated in this ISP as they did in the other ISPs. Instead, they only appeared at the end of the document in the action plan section. Additional comments regarding the facility's ISPs are provided in many other sections of this monitoring report, particularly in sections F and S. After reviewing the completed CLDPs and the sample of in-process CLDPs, it did not seem that any special actions were taken after an individual was referred to ensure that training objectives were considered and developed based upon the individual's referral to the community. The monitoring team recommends that, upon referral, the APC seek out the IDT, QDDP, QDDP coordinator assistant, and/or active treatment coordinators to talk about what training objectives might be considered now that the individual was referred for placement. This should be documented in the CLDP. If this type of discussion occurred during the ISP meeting in which the individual was referred, it should be explicitly documented in the ISP, too. Note, however, that during the development of the CLDP list of essential and nonessential supports, the IDTs did support (and require) providers to carry forward many of the training objectives that the individuals were working on while at the facility. This was good to see. <u>Obstacles to Movement</u> This aspect of this provision item (the identification and addressing of obstacles for each individual) continued to be inadequately addressed at LSSLC. The ISPs did not address obstacles to referral or to placement. The monitoring team was of the understanding	

		that these types of obstacles were supposed to be addressed in the ISP. The APC should also see sections F1e and F2a2 of this report for additional information relevant to this provision item.	
	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, DADS central office, and DOJ recently agreed on the specific criteria for this provision item. The monitoring team expects that DADS will soon provide more specific direction to the APC and the facility regarding the expectations for achieving substantial compliance. LSSLC was engaging in some, but not yet all, of these activities towards educating individuals and their family members and LARs. Below are the agreed-upon activities (the closed and open bullets) followed by LSSLC's status for each. The bulleted lists can be used for the facility's next revision of its self-assessment. <u>Individualized plan</u> • There is an individualized plan for each individual (e.g., in the annual ISP) that is o Measurable, and provides for the team's follow-up to determine the individual's reaction to the activities offered o Includes the individual's LAR and family, as appropriate o Indicates if the previous year's individualized plan was completed. <u>LSSLC status</u>: The new ISP format included a section titled Living Options-awareness/education. This sets the occasion for all the QDDP to address all three of the bullets listed immediately above. This was being done somewhat. Some ISPs described what the individual had done, whereas others described what the individual might do during the upcoming year. Some questions or prompts within this section of the ISP may help to ensure all three of the above bullets are adequately addressed. <u>Provider fair</u> • Outcomes/measures are determined and data collected, including o Attendance (individuals, families, staff, providers) o Satisfaction and recommendations from all participants • Effects are evaluated and changes made for future fairs <u>LSSLC status</u>: The annual provider fair was held in March 2011 and discussed in the April 2011 monitoring report. The next provider fair was postponed from March 2012 until May 2012 due to numerous competing activities at LSSLC, including the annual ICFDD review and this onsite monitoring review. <u>Local MRA/LA</u> • Regular SSLC meeting with local MRA/LA <u>LSSLC status</u>: The APC appeared to have a good working relationship with the local authority, however, no documentation of any meetings or activities was provided for the past six months.	Noncompliance

		Education about community options • Outcomes/measures are determined and data collected on: o Number of individuals, and families/LARs who agree to take new or additional actions regarding exploring community options. o Number of individuals and families/LARs who refuse to participate in the CLOIP process. • Effects are evaluated and changes made for future educational activities LSSLC status: LSSLC had not yet started to address this activity. The APC should consider summarizing the data from all of the CLOIP reviews, including the recommendations made by the MRA/LA CLOIP workers. Tours of community providers • All individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours). • Places chosen to visit are based on individual's specific preferences, needs, etc. • Individual's response to the tour is assessed. LSSLC status: Based on review of information given to the monitoring team, it appeared that there were 14 tours of community providers that involved 23 individuals and no family members. This compared with 4, 39, and 40 individuals who had been on community tours during the previous reviews, respectively. The facility's self-assessment, however, reported 90 individuals, 2 families, and 119 staff had been on community tours since the last review. The monitoring team could not determine how these numbers were calculated. The APC also reported that there were fewer requests for tours from IDTs, but she noted that this might be due to there being many new QDDPs. ISPA meetings were held and ISPA documents created following six of these tours. The documents provided information about the individual's experience on the tour and what, if any, actions the IDT would next take. IDT discussion following a tour was a good idea. The QDDP coordinator should ensure that this is not an overly cumbersome and time consuming activity for IDTs and QDDPs. Further, there may be other ways to better track each individual's participation on tours to meet the three bullets immediately above, such as via the use of a spreadsheet. In addition, a simple graph showing the number of individuals who participated in a tour should be created (also see T1a). Visit friends who live in the community LSSLC status: LSSLC was not yet implementing this activity in any organized manner. Education may be provided at • Self-advocacy meetings	

		• House meetings for the individuals • Family association meetings or • Other locations as determined appropriate LSSLC status: There was little activity reported related to the above bullets other than a note about a parent association meeting that was held. No documentation about this meeting was provided to the monitoring team. A plan for staff to learn more about community options • management staff • clinical staff • direct support professionals LSSLC status: LSSLC made good progress on this activity. For instance, a training on living options was held in March 2012 and 40 staff attended. In addition, newly hired QDDPs were now expected to attend a community tour within their first six months of employment and all IDT members were expected to go on at least one community tour each year, though this had not yet begun as of the time of this review. Individuals and families who are reluctant have opportunities to learn about success stories • As appropriate, families/LARs who have experienced a successful transition are paired with families/LARs who are reluctant; • Newsletter articles or presentations by individuals or families happy with transition LSSLC status: The APC was not yet implementing this activity.	
	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	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 ISP meeting, or at any other time if requested by the individual, LAR, or IDT member. In addition, a listing was given to the monitoring team showing every individual and whether the IDT referred the individual for community. The monitoring teams have been discussing this provision item at length with DADS and DOJ. To meet substantial compliance with this provision item, the facility will need to show that: • Professionals provided their determination regarding the appropriateness of referral for community placement in their annual assessments. o Progress was made as noted in T1a. • The determinations of professionals were discussed at the annual ISP meeting,	Noncompliance

	practices.	including a verbal statement by each professional member of the IDT during the meeting. o This was occurring at LSSLC. • Living options for the individual were thoroughly discussed during the annual ISP meeting. o This was evident during the observed ISP meetings at LSSLC, however, as noted in T1a, more training and support for QDDPs will be necessary. • Documentation in the written ISP regarding the joint recommendation of the professionals on the team regarding the most integrated setting for the individual, as well as the decision regarding referral of the entire team, including the individual and LAR o Although there were statements at the end of the ISP, in a section titled Living Option Determination, these were not yet written adequately or in with enough detail.	
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:	The APC submitted eight CLDPs to the monitoring team for the eight individuals placed since the last review. This was 100% of the CLDPs completed since the last review. Of these eight, three had their CLDP meetings before (or during) the last onsite review and their CLDPs were in draft format, near completion, at the time of the last review. Therefore, the comments in below in T1c through T1e are based upon the five CLDPs developed and implemented since the last onsite review. <u>Timeliness</u>: All of the CLDPs indicated that they had been developed in a timely manner. There were multiple entries describing the ongoing activities of the APC and the IDT. The APC started a new data graph that showed the length of time that each individual was on the referral list. This was a good piece of data. She should do a secondary graph that shows the same information for all individuals who were placed. This would allow for a comparison that might likely show a decrease in amount of time. Any review of length of time from referral to placement has to take into account the individual case. At LSSLC, there were some very good reasons why the amount of time was lengthy for some individuals, such as due to challenges in finding an accessible home within a limited geographic area, plus unexpected medical problems occurring immediately prior to the originally scheduled move date (e.g., Individual #77). Once an individual is referred, a lot of focused activity around the CLDP and the transition must occur. The APC and the QDDP were the staff who had the most responsibility for this. At LSSLC, there were many new QDDPs. Learning the details of the transition and placement process, in addition to learning their regular duties as a new QDDP, might result in the transition activities being delayed. To that end, the facility might consider assigning one QDDP to all individuals who have been referred. This might help CLDP and transition activities occur in a more efficient manner.	Substantial Compliance

		Initiation of the CLDP: Rather than waiting until right before the individual moved, the CLDP document should be created at the time of referral. This was now occurring regularly at LSSLC, usually at a meeting called the APC-PMM-IDT meeting. This typically occurred at the ISP meeting (if a referral occurred then) or within a week or so after the referral. The CLDP contents were then developed and completed over the months during which referral and placement activities occurred. Three of these in-process CLDPs were reviewed for referrals that occurred two, three, and four months ago. The CLDP was in place and contained some relevant information. The oldest of the three CLDPS, as expected, had the most information of the three. IDT member participation: IDT members continued to be very involved in the placement activities of the individuals. By being highly involved, and with the leadership of the APC, every one of the placements was individualized and the path that each individual took to placement was based around his or her needs and preferences. To accomplish this, there were many visits to providers, overnight trials, and IDT meetings to review and discuss. In some cases, the visits did not go well, or the individual or IDT was not satisfied with the available options. The IDT then looked for other possible providers. In some cases, family members were highly involved, in others, less so. Examples were evident not only in the CLDPs, but in the planning for individuals who were on the current referral list (e.g., Individual #103) or who might be referred (e.g., Individual #587). CLDP meeting prior to move: The monitoring team attended the CLDP meeting for Individual #114. The APC did a nice job of leading the meeting and encouraging (and obtaining) participation from all attendees. The individual's mother was on the speakerphone. A lot of information was covered and the APC was efficient in her use of time. She had made improvements compared to the CLDP observed during the last onsite review, including handing out the draft CLDP to all participants, being better prepared with a list of possible ENE supports, and attending to important comments from participants. Participant comments were very much focused upon his new home and day program. This, however, was not reflected in their discharge assessments (see T1d). The monitoring team had some comments during the meeting regarding specific ENE supports (see T1e). The monitoring team wishes to acknowledge the community provider's complete flexibility and willingness to do whatever the IDT asked (e.g., data collection, activities, supports). The monitoring team has found community providers to be extremely receptive to IDT requests for actions, activities, training objectives, and so forth.	

		Post post-move monitoring IDT meetings: IDT meetings occurred after every post move monitoring visit, even if there were no problematic issues. The monitoring team was given documentation for 100% of the 28 post move monitoring visits conducted since the last review (see T2a).	
	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.	Five CLDPs developed and completed since the last onsite review 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 LA and community provider. Some comments regarding the actions in the CLDP are presented below. • The CLDPs identified the need for training for community provider staff. The CLDPs included some detail on the content of what was to be trained, but more detail was needed regarding this training. o The specific community provider staff who needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff) were not identified. ▪ This is very important. For example, for Individual #244, day program staff, including the day program director, were not trained by the facility. This was not discovered until almost two months after her move. For other individuals, ISD staff reported that they had not received proper training. o The method of training was not indicated, such as didactic classroom, community provider staff shadowing facility staff, or showing competency in actually implementing a plan, such as a PBSP or NCP. o Training should have a competency demonstration component. This was not often included. If a competency component is not required, a rationale should be provided. • Collaboration between the facility clinicians and the community clinicians (e.g., psychologists, psychiatrists, medical specialists) was not addressed. • The CLDP contained a somewhat standardized list of items and actions to occur on the day of the move. The content of this list was appropriate, however, it did not identify who was responsible for these actions, and how their completion was to be monitored and ensured. • Actual implementation of ENE supports by staff should be required in the essential and nonessential support sections, not only inservicing. This needed a lot of improvement (see T1e). • The CLDP documents were presented in an organized manner with the same attachments in in the same order (e.g., assessments, PBSP, PNMP, ISPA meetings). • The assessment section of the CLDP was merely a cut and paste from the	Noncompliance

		professional assessments, which were already attached to the CLDP (see T1d). • Also see comments in T1e below. DADS central office reported that it continued to conduct reviews of CLDPs at LSSLC, however, no written feedback reports were given to the monitoring team. Feedback from central office had been very helpful to the facility and should continue.	
	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. This included ENE supports and other pre- and post-move activities.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	The CLDPs contained evidence of individual and LAR review. Individuals and their LARs were very involved in the process. The monitoring team was impressed with this aspect of LSSLC's referral and placement program. Many examples were provided in the CLDPs reviewed by the monitoring team.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	The APC continued the process that was in place at the time of the last review, that is, in preparation for the CLDP meeting, assessments were updated and summarized. Therefore, the CLDP document contained these updated/summarized assessments, rather than full assessments. This was an adequate process. The APC created, and used, an assessment checklist to track submissions and updates of the assessments. Some of the newer checklists included two dates, one indicating the date she received the assessment, the other indicating the date the assessment was completed. Including both dates seemed to be a better way to track this important aspect of transition planning. The assessment 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 five CLDPs indicated that the sets of assessments of all were within 45 days prior to the individual leaving the facility. Even so, there were problems with the assessments and the way they were handled in the CLDP. These must be corrected or this item will not remain in substantial compliance. • The assessments need to focus upon the individual moving to a new residential and day setting. All of the staff who wrote assessments were well aware of where the individual was moving (as evidenced in the CLDP meeting), however, their assessments usually made no reference to the new home or day program	Substantial Compliance

		and provided no recommendations for these new settings. Instead, there were references to SSLC activities, such as having a PNMP. Moreover, many of the assessments included a recommendation for the individual to move to the community. This made no sense because the individual <u>was</u> moving to the community. The monitoring team recommends that the assessment updates have prompts to the writer, such as "Instructions to provider" and/or "Recommendations in the community setting." These sections can help focus the professionals on the individual's specialized needs in his or her upcoming new home and day settings. • In the CLDP section for reviewing assessments, the bulk of the text from the professional assessment was cut and pasted from the assessment into the CLDP, often with different fonts, font sizes, tables, and charts. This made it difficult to read, disrupted the flow of the CLDP document, and duplicated what was already attached to the CLDP. o Instead, the monitoring team recommends that the APC make the assessment section similar to what was being done at Mexia SSLC. That is, each of the assessment sections should have two sub-sections, one to describe the deliberations (i.e., discussion) of the IDT regarding the assessment, and the other to list the recommendations that result from these reviews and deliberations. Often, but not always, the list of recommendations will be identical to what was in the assessment. On the other hand, in some cases, the deliberations will generate additional recommendations or changes/deletions to the assessment's recommendations. By doing this, it is less likely that important ENE supports will be overlooked. • If a recommendation in an assessment does not make it into the list of ENE supports, it should be documented as to why (perhaps in a deliberations paragraph as recommended immediately above). Examples included desensitization techniques (Individual #525) and counseling (Individual #426). • The assessments and the assessment section of the CLDP should be proofread for important errors, such as using the wrong individual's name (e.g., see Individual #525's speech assessment).	
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	LSSLC made progress in identifying essential and nonessential (ENE) supports, however, additional improvement was still needed. All seven bulleted points regarding positive aspects of the CLDPs that were listed in the previous report still applied at the time of this review. This was good to see and contributed to the progress that LSSLC had made in this provision item. In particular, more preferred activities and more training objectives were included. For example: • The CLDP for Individual #498 included ENE supports for her daily heart rate monitoring, her favorite foods, community activities, listening to her radio, going	Noncompliance

	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.	outside, having a communication poster, and receiving training on a number of skills. • Individual #426's CLDP included eight training objectives and ENE supports for volunteering, reading, church, and other preferred and important activities. • Individual #77's CLDP included a variety of training objectives. That being said, the five bulleted points describing problems with the CLDP ENE supports also still applied. Thus, even though progress continued to occur, more work needed to be done regarding the identification of the full set of ENE supports for each individual. The APC should make this a priority area given the importance of this activity and the continued need for improvement. The APC should also again review the contents of section T1e in previous LSSLC monitoring reports for more detail, examples, and direction. The lists of ENE supports still needed more work because a number of important supports and services, based on the individual's preferences, safety needs, and personal development needs were not included. The amount of items missing, however, was improved since the last onsite review. Some examples are below. • Individual #525 had a history of aggression and flight (running away). These problems had occurred very recently, while he was living in the LSSLC transition home, so much so that he was moved back to campus. Nothing in the CLDP or in the list of ENE supports addressed this recent problem other than for staff to be trained and for him to see a community psychologist. There should have been ENE supports around the implementation of what was in his PBSP to increase appropriate behaviors, such as gaining attention appropriately and saying "no" rather than becoming aggressive. Further, his documentation indicated that he needed a high calorie diet and a seizure protocol, but these were not addressed. Merely saying staff will be inserviced is insufficient. • Individual #498 was receiving an older antipsychotic, Thorazine. There were no ENE supports around side effects, psychiatric symptoms, or behavioral manifestations, other than setting up an appointment with a local psychiatrist. • Individual #426 was more than 72 pounds overweight, had a history of refusing to participate in programming, and a long history of psychiatric disorders that included three 30-day psychiatric admissions. The ENE supports did not include counseling (which was reported to be important) or the other positive approaches that were included in his PBSP. • Similarly, Individual #77 had a history of depression and serious behavior problems. These, and their treatment, were not addressed. • At Individual #114's CLDP meeting, his strong preference for root beer was discussed and noted, but not given the importance it should have by being an ENE support.	

		• There were no specific references to the use of positive reinforcement, incentives, and/or other motivating components to an individual's success, even though these were indicated as being important to these individuals. To help further improve the identification of important ENE supports, the monitoring team has some specific recommendations and comments: • The APC should create her own list of important items to bring to the CLDP meeting for possible inclusion as ENE supports based on her reading of the assessments, other documents, and her knowledge of the individual. She was doing this to a certain extent, but her doing so will be welcomed by the IDT. • Various members of the admissions and placement staff should engage in the same activity as in the bullet immediately above in an attempt to achieve an inter-reader agreement on the generation of ENE supports. This might also be done with the DADS central office staff who review CLDPs and/or with APCs at other facilities. Many of the ENE supports needed to be written in more measureable, observable terms. • Terms such as "assist" and "access" should not be used. • Leisure activities in the home should be listed as separate ENE supports from leisure activities in the community. • Inservice ENE supports should not have all of the detail in the table in the CLDP. Important topics should be listed, but not the three or four pages that were in the LSSLC CLDP ENE lists. Evidence to show the provider's <u>implementation</u> of ENE supports needed to be shown in the lists of ENE supports. For ENEs requiring implementation, the support description needs to provide detail about what it was that was supposed to implemented, such as the important components of the BSP, PNMP, dining plan, medical procedures, and communication programming that would be required for community provider staff to do every day. • Any ENE support that calls for an inservice should have a corresponding ENE support for <u>implementation</u> of what was inserviced. A rationale should be provided for any ENE inservice support that does not have a corresponding ENE support for implementation. • Evidence should be described in observable terms and should have criteria when appropriate. Evidence such as random interviews and daily progress notes are insufficient. A staff checklist, as discussed with the APC and PMM might be one way to address this. 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 PMM. The PMM might consider bringing an IDT member along as well. Each review indicated that each essential support was in place. • Each of the nonessential supports should have an implementation date. All of them did. Rather than a due date, the CLDP noted during which of the three post move monitoring visits the support would be evaluated. This was insufficient. A specific date should be provided. This will help the provider to know exactly when the supports needs to be initiated and it will allow the PMM to know the start date that needs to be evident via documentation. • Some facilities hold an IDT meeting immediately following the pre-move site review before the individual moved. LSSLC might consider this.	
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.	The APC, PMM, and QA staff member assigned to this provision completed statewide self-monitoring tools that were developed for the living options discussion, the CLDP, and post move monitoring. The monitoring team was given seven completed forms (five for living options discussions, two for CLDPs, and two for post move monitorings). In addition, the monitoring team reviewed two living option discussion forms that were completed simultaneously by the PMM and the QA staff member during an ISP meeting attended by the monitoring team during the week of the onsite review. Problems with the statewide tools are discussed in section E above. Further, there were differences in the scoring between the PMM and QA staff, indicating reliability issues, too. This was not lost on the APC and the state office continuity of service coordinator. To address this, state office was developing new tools and a new self-assessment for all of provision T. The APC provided some bar graphs of the data from their completed provision T statewide self-monitoring tools. The graphs seemed to be a summary of data collected for a six-month period, but there was no trending, the number of cases reviewed was not stated, and the items reviewed were not included. To create a more organized (and thereby more effective and useful) process, the state office and APCs should align their activities with the content of the Settlement Agreement and with the content of the monitoring team's report. That is, the APC, when self-assessing provision T, should be looking at the same activities and documents that the monitoring team looks at. The APC should then judge both the occurrence/presence and the quality of those activities and documents. This means that the department will need to self-assess its performance on every provision item by observing, collecting data, reporting data, and making changes based upon these data. The APC would benefit from working closely with the QA department.	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 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.	Activities at the state and facility levels demonstrated some progress towards substantial compliance with this provision item. The facility, however, did not present any data regarding obstacles to individuals' movement to more integrated settings, other than that which was described in the state's annual report of data through August 2011. It seemed that the facility was not collecting or reviewing these data regularly even though this was the plan as written in the annual report. The current action plan and action steps for this provision item, however, provided a more realistic plan for addressing this provision item. Although data on obstacles were not collected or reported, the APC and QDDP Coordinator did create a list of individuals for whom LAR preference was the only reason they were not referred (see T1h). There were 107 names on this list, providing at least some information regarding the reason why some individuals had not been referred. The narrative and data tables presented in the LSSLC addendum to the state's report provided some additional information and insight into the referrals and community placements at LSSLC over the past few years. The information supported the APC's recent finding that (at least) 107 individuals were not referred due to LAR preference. As duly noted by the APC in that addendum, more work was needed (e.g., data collection system, analyzing of data) before the facility could complete an adequate comprehensive assessment of obstacles. The facility should also consider a data system that needs to be able to separate out the difference between an obstacle to referral and an obstacle to placement. Assistance from the QA department and from state office might be helpful in analyzing data once it is collected. At the state level, DADS created a report summarizing obstacles across the state and included the facility's report as an addendum/attachment to the report. The statewide report was dated October 2011. • The statewide report listed the 13 obstacle areas used in FY11. DADS will be improving the way it categorizes and collects (and the way it has the facilities collect) data regarding obstacles. • DADS indicated actions that it would take to overcome or reduce these obstacles o Eleven numbered items were listed. Five were related to the IDT process and upcoming changes to this process, three were related to working with local authorities and local agencies, two were related to improving provider capacity and competence, and two were related to funding initiatives regarding slot availability and the new community living specialist positions. In general, these were descriptions of the early steps	Noncompliance

		of activities related to addressing obstacles to each individual living in the most integrated setting. o DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). Improvements in data collection and analysis, implementation of new ISP processes, and actualization of the planned activities to overcome or reduce obstacles will be necessary for substantial compliance to be obtained.	
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	The monitoring team was given a document titled "Community Placement Report." It was dated for the six-month period, 11/1/11 through 4/30/12. It included a list of those individuals who would be referred by the IDT 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. There were 107 names on this list.	Substantial Compliance

	Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	LSSLC maintained substantial compliance with this provision item. <u>Timeliness of Visits</u>: Since the last review, 28 post move monitorings for 15 individuals were completed. This was 100% of the post move monitoring that was required to be completed. All of these were completed by the PMM, Leigh Anne Hall. All 28 (100%) were reviewed by the monitoring team. All 28 (100%) occurred within the required timelines. The PMM visited both the residential and the day program sites, even if it required her to go back a second day due to time of day or if the day program was closed that day. Furthermore, the PMM visited and spoke with public school ISD staff of those individuals who were school aged. The PMM maintained a chart that listed all of the individuals who had moved, their move date, and what would be the 7th, 45th, and 90th dates from their move date. The monitoring team recommends that the PMM add three additional columns to show when post move monitoring was actually conducted. In this way, it will be easy to see when post move monitoring was due and when it was actually conducted. <u>Content of Review Tool</u>: All 28 (100%) post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement. • Post move monitoring report forms were completed correctly and thoroughly. Good information was included. • The PMM added comments into the evidence box, so that this box described not only what she was to look at, but additional information as well. This was good. • The monitoring team also very much liked that the PMM wrote detailed comments throughout the report, especially those that were included under the "Additional Questions" and/or "Recommendations to PST" sections. This helped provide a broader picture of the PMM's overall opinion of the placement. Please continue to provide this. The post move monitoring reports for Individual #77 were good examples. Post move monitoring for Individual #426 was done by another facility, the Denton SSLC. The Denton SSLC PMM conducted post move monitoring correctly. This, however, was outside DADS own standard of practice and was especially problematic given that this	Substantial Compliance

		individual was having serious problems with his placement, including severely injuring his new housemate, and being kicked out of his day program for behavior problems. Substantial compliance was maintained by LSSLC. Even so, the following comments should be considered as the PMM and APC move forward with ongoing post move monitoring: • The Denton SSLC PMM included, on page one, a list of all of the people whom she interviewed or spoke with during the conduct of the post move monitoring. This addition was helpful to the reader. • The monitoring team recommends that the individual's psychiatric diagnoses, psychiatric medications, and medical conditions be inserted right into the post move monitoring form within the series of additional questions. This will make it easier for the PMM as well as for the reader to understand the individual's issues and what it is that the provider staff were expected to be informed about. • The following are items related to the development of the CLDP and, therefore, did not impact the rating of this provision item, however, the monitoring team recommends that the PMM take an active role in helping improve these aspects of the CLDP because they will improve the process and outcome of post move monitoring. o Ensure the ENE supports and the evidence are written in measureable observable terms. Terms such as "assist" or "access," and requiring "random interviews" or "observation" will usually be insufficient. The creation of a chart or checklist for use by provider staff will likely be helpful and welcomed by the provider (T1e). o Ensure that the nonessential supports include actual dates of required implementation, not just an indication of post move monitoring periods (T1e). o Evidence should include the evaluation of the implementation of ENE supports, such as daily use of a shower chair and application of the positive aspects of behavior plans (T1e). o The list of ENE supports in the post move monitoring form was filled with the detailed content of inservicing. Sometimes there were three or four pages in the essential supports section followed by the same three or four pages in the nonessential supports section. This may not be necessary. o Ensure that the CLDP indicates which staff will need to receive inservice training. Some staff had not received proper training (T1c1). Of the 15 individuals who received post move monitoring, seven appeared to be doing very well and having a great life. This was well reflected in their post move monitoring reports. Two others had experienced some problems, but these were not unexpected.	

		The other six individuals had, or were having, serious issues with their placements. Of these six, three were exhibiting serious problem behaviors (Individual #233, Individual #426, Individual #525) and three had to be re-placed due to serious problems with the provider. Thus, 40% of the placements were very problematic. The facility needs to go back and revisit their transition planning processes as recommended in T1a, that is, to do a root cause analysis and/or sentinel event-type review. For example, it was probably not surprising that Individual #525 exhibited problem behaviors shortly after his move given that he was exhibiting these same behaviors right before his move. Moreover, after he'd only been there only five days, there was a note in his record indicating a need to "discuss the possibility of him being placed in another home." This indicated some very likely problems in planning for his transition. The problems for the other three individuals were due to the provider who turned out to be incompetent and perhaps criminal in his actions. Even so, the APC should conduct a review. <u>Use of Best Efforts to Ensure Supports Are Implemented:</u> IDTs, the APC, and the PMM put a lot of effort into these placements. The PMM did a good job of following up when there were problems. She did so in a number of ways. First, she asked the provider for follow-up immediately after the post move monitoring visit. Second, she elicited help from the APC, and even from state office (in one case). Third, she called for meetings with the provider, LSSLC staff, and the LA. Fourth, she did extra post move monitoring visits after the 90-day period if there were issues that were still unresolved at 90 days. In fact, it seemed to the monitoring team that important supports would not have been put in place for a number of the individuals (even though the provider had agreed to do so via the CLDP process) if not for the actions of the PMM. Examples included admission to a vocational program, implementation of training objectives, access to activities, and provision of proper vehicles. IDT meetings were held following 28 of the 28 post move monitoring visits (100%).	
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	LSSLC maintained was rated in substantial compliance with this provision item. The monitoring team accompanied the PMM on a 45-day post move monitoring visit to the home of Individual #498. The PMM was thorough, that is, she covered all of the ENE supports, asked a lot of questions, and looked for evidence. The home was in a nice neighborhood, but was not	Substantial Compliance

	10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	cared for very well. A screen was off a window and lying by the front door, there were leaves and broken glass around the house, and Jessica's room was bare and painted an odd type of pink color. The PMM raised this to the program manager and most likely noted it in her report for follow-up. She then went through the ENE supports one by one, talking with the program manager and/or house manager. The PMM, however, appeared somewhat apologetic in her style of asking questions, and also used leading questions at some points. The monitoring team spoke with the PMM about this following the home visit. The monitoring team understands that the observation of the monitoring team, the APC, and two staff from the San Antonio SSLC made this atypical and may have affected what might have otherwise been a more natural question and answer session.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.	This item does not receive a rating.	
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of	Two individuals were discharged under this T4 provision. One of the individuals moved out of state (T4a) and the other individual transferred to another SSLC. The discharges were done properly as per the requirements of this provision item as evidenced by documents submitted to the monitoring team.	Substantial Compliance

	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. The APC should do a detailed review (i.e., root cause analysis) of each rescinded referral and any other post move serious incidents, such as hospitalizations, psychiatric admissions, housemate changes, or moves to different homes or apartments, to determine if anything different should be done in future transition planning to reduce the likelihood of these types of problems occurring (T1a).

2. Data for individuals who were hospitalized for psychiatric reasons, incarcerated, had ER visits or unexpected hospitalizations, transferred to other group homes or to a different provider, or who had run away from their community placements were not available. These data should be obtained, for at least a one year period after moving (T1a).

3. The APC and facility director should conduct a review the transition home and why there have been so many problems (T1a).

4. Each of the data sets listed in T1a should be graphed separately, and included in the facility's QA program (T1a, T1f).

5. Written ISP assessments need to include an explicit statement regarding the professional's opinion about whether the individual could be supported in a less restrictive, more integrated (i.e., community) setting (T1a, T1b3).

6. More detail should be included in the Living Option Determination section of the ISP so that the reader has a good understanding of the IDT's opinion and how it was arrived at (T1a, T1b3).

7. Determine how to respond to LAR questions of whether the individual can be guaranteed a return to LSSLC if the community placement does not work out (T1a).

8. Facility-specific policies will need to be revised or perhaps totally re-written once the new state policy is finalized and disseminated (T1b).

9. In ISPs,
    a. Clearly indicate when an action step is to be a SAP,
    b. Indicate if and how the FSA was used,
    c. Write all action steps in measureable terms, and
    d. Don't duplicate action steps; don't have the same action steps under more than one action plan (T1b1).

10. Address obstacles to referral and placement at the individual level (T1b1).

11. Upon referral, the APC should seek out the IDT and others as noted in T1b1 to talk about what training objectives might be considered now that the individual was referred for placement (T1b1).

12. Attend to the detail provided in T1b2. The bulleted lists might be used in the facility's self-assessment process (T1b2).

13. The CLDP should describe:
    a. Which community provider staff are to receive training,
    b. The method of training,
    c. A competency demonstration component to training,
    d. Collaboration between the facility clinicians and the community clinicians (e.g., psychologists, psychiatrists, medical specialists), and
    e. Who was responsible for the day of move actions, and how their completion was to be monitored and ensured (T1c1).

14. CLDP Feedback from central office had been very helpful to the facility and should continue (T1c1).

15. The assessments need to focus upon the individual moving to a new residential and day setting (T1d).

16. Make the assessment section similar to what was being done at Mexia SSLC. That is, each of the assessment sections should have two sub-sections, one to describe the deliberations (i.e., discussion) of the IDT, and the other to list the recommendations that result from these reviews and deliberations (T1d).

17. If a recommendation in an assessment does not make it into the list of ENE supports, it should be documented as to why (T1d).

18. The lists of ENE supports needs to include all of the individual's important supports and services, based on the individual's preferences, safety needs, and personal development. Suggested activities to improve this are in T1e (T1e).

19. The ENE supports
    a. Needed to be written in more measureable, observable terms.
    b. Should separate out leisure activities in the home from leisure activities in the community.
    c. For training do not need to include all of the detail in the LSSLC CLDPs (T1e).

20. There needs to be evidence to show the provider's implementation of ENE supports (T1e).

21. A specific due date for implementation of each nonessential support needs to be included (T1e).

22. Develop an organized QA program for section T (T1f).

23. Add columns to the post move monitoring table to show when post move monitoring was actually conducted (T2a).

24. Include in the post move monitoring report page one, a list of all of the people whom she interviewed or spoke with during the conduct of the post move monitoring (T2a).

25. Insert the individual's psychiatric diagnoses, psychiatric medications, and medical conditions right into the post move monitoring form within the series of additional questions (T2a).

26. The PMM should take an active role in helping improve the aspects of the CLDP listed in T2a (T2a).

27. The PMM should not be apologetic in her style of asking questions, and should not use leading questions during post move monitoring (T2b).

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o LSSLC Client Management: Guardianship Procedure o LSSLC Client Management: Legally Adequate Consent/Authorization for Treatment Procedure o LSSLC Section U Presentation Book o LSSLC Priority List for Adults without Guardians dated 3/28/12 o Individual Support Plans: • Individual #494, Individual #166, Individual #170, Individual #139, Individual #567, Individual #242, Individual #119, Individual #322, Individual #430, Individual #290, Individual #156, Individual #136, Individual #167, and Individual #238. Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Luz Carver, QDDP Coordinator o Royce Garrett, Consumer and Family Relations Director Observations Conducted: o Observations at residences and day programs o Castle Pine Morning Unit Meeting 5/2/12 o Incident Management Review Team Meeting 5/2/11 and 5/4/11 o Annual ISP meetings for Individual #252 o QDDP meeting 5/3/12 o Human Rights Committee Meeting 5/2/12 o Restraint Reduction Committee Meeting 5/2/12
	Facility Self-Assessment: LSSLC submitted its self-assessment. It was updated on 4/20/12. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct meet compliance with Section U. The self-assessment did not describe the process that he facility used to determine a compliance rating. The facility had implemented an audit process using the tools developed by the state office to measure

	compliance with the Settlement Agreement. Results of this audit were not included in the self-assessment. The self-assessment action taken by the facility to address section U did not indicate that an adequate audit system was in place to self-assess compliance. The facility self-assessment did not describe criteria used to evaluate compliance for each item or details on specific findings. For example, for item U1, activities engaged in included: added prompts to the ISP document addressing the need for advocate/guardian. The results of the self-assessment noted: the action referrals, along with the prompts in the ISP have established a reliable list of individuals who need advocates/guardians. It will be important to look at the self-assessment activities in more detail and determine if the audit process is an effective way to assess compliance. Compliance self-ratings were in agreement with compliance ratings given by the monitoring team.
	Summary of Monitor's Assessment: Some positive steps that the facility had continued in regards to consent and guardianship issues included: • 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 Director of Consumer and Family Relations continued to work with families applying for guardianship and maintained contact with community resources for guardians and advocates. • Guardians were found for nine individuals. • The HRC membership had been expanded to include additional family members and representation from other disciplines at the facility. • The Director of Consumer and Family Relations met with the QDDPs to review the requirements of section U and discuss the referral process. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. The facility had not yet developed a priority list of individuals needing an LAR based on an adequate assessment process. IDTs were not adequately addressing the need for a LAR or advocate. • Provision item U2 was determined to be in noncompliance. 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 IDT. At the HRC meeting relevant discussion occurred, but did not adequately address important aspects of restrictions, informed consent, and LAR involvement.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The facility did not have an assessment for developing a prioritized list of individuals lacking both functional capacity to render a decision and an LAR. A list had been developed that included 188 individuals at the facility, eight of whom had been prioritized as priority 1 (high) need for guardianship. Prioritization was based on the following criteria: • Not having a correspondent, • Financial resources under $1200, • Determined high risk by medical staff, • Receiving psychotropic medication, • Having rights restricted by the IDT, • Having a behavior support plan, and • Ability to communicate desires and wishes. A sample of 14 ISPs was reviewed for evidence that the team had discussed the need for guardianship. Eight (57%) individuals in the sample did not have guardians. There was evidence in all (100%) of the 14 ISPs reviewed that teams were discussing the need for guardianship, however, discussion was not based on an adequate assessment of the individual's functional capacity to render a decision regarding health or welfare. For example, • The ISP for Individual #238 noted that his parents are able to advocate for him to the best of their ability, therefore, referral was not necessary at this time. There was no documented discussion of his capacity to render informed decisions. • The ISP for Individual #156 noted that her family had almost no contact with her family and they had no desire to pursue guardianship. The ISP did not document adequate discussion regarding her ability to give informed consent. IDTs 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	The facility continued to make efforts to obtain LARs for individuals through contact and education with family members. The Director of Consumer and Family Relations also provided information to community agencies on guardianship and advocacy opportunities at the facility. It was evident that the facility was taking steps to actively pursue guardianship when deemed appropriate by the IDT. A guardian had been procured for nine individuals at the facility in the past six months after the individual's IDT had determined the need for	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.	guardianship. Five other individuals had pending guardianships. The facility did have some rights protections in place, including an independent assistant ombudsman housed at the facility, and a rights officer employed by the facility. There was a Human Rights Committee (HRC) at the facility that met to review all emergency restraints or restrictions, all behavior support plans and safety plans, and any other restriction of rights for individuals at LSSLC. A letter was mailed to family members expressing a desire to have family involvement in the HRC process. Membership of the HRC had been expanded to include additional representation on the committee. 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. Maintain a prioritized list of individuals that need a guardian (U1).
3. Document meaningful efforts to include LARs in decision making (U1)
4. Assist individuals that need guardians to obtain a guardian (U2).
5. 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 LSSLC organizational chart, 4/10/12 o LSSLC policy lists, 2/23/12 o List of typical meetings that occurred at LSSLC, 3/28/12 o LSSLC Self-Assessment, 4/20/12 o LSSLC Action Plans, 4/20/12 o LSSLC Provision Actions Information, 4/19/12 o LSSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 4/30/12 o List of all staff responsible for management of unified records o Description of how documents flow from being produced to filing in the records, 3/14/12 o Tables of contents for the active records and individual notebooks, updated 3/14/12, and master records, updated 3/10/12 o A note stating that the facility did not use any other types of binders or books to record information that was not recorded in the individual notebooks o A one paragraph description of the shared folder that was managed by the data processing department o Emails and email threads on various relevant topics related to recordkeeping practices, most initiated by URC, 29 thread topics, 12/8/11 through 3/23/12 o Note from residential director regarding at-risk information in individual notebooks, 5/3/12 o A spreadsheet that showed the status of state and facility policies for each provision of the Settlement Agreement, 3/14/12 and updated 4/26/12 o 12 new facility-specific policies, new since the last review, some with attached staff training logs o Email regarding state office expectations for facility-specific policies, from central office SSLC assistant commissioner, Chris Adams, 2/15/12 o Blank tools used by the URC o List of individuals whose unified record was audited, November 2011 through April 2012 o Completed unified record audit tools for 18 individuals, from February 2012 through April 2012: • Active record and individual notebook • Master record • Statewide self-monitoring tool • V4 questionnaire • Emails from auditor requesting corrections be made o LSSLC unified records audit tracking form, entries through 3/9/12, 17 pages o Review of active records and/or individual notebooks of:

	• Individual #344, Individual #226, Individual #544, Individual #586, Individual #511, Individual #68, Individual #424, Individual #9, Individual #351, Individual #492, Individual #185, Individual #261, Individual #469, Individual #145, Individual #60 o Review of master records of: • Individual #394, Individual #175, Individual #251, Individual #122 <u>Interviews and Meetings Held</u>: o Stormy Tullos, Unified Records Coordinator o Todd Miller, Interim Director of Quality Assurance o Keith Bailey, Director of Residential Services o Tracy Syzdek, Assistant to Kenneth Self, Unit Director o Debbie Sage, Emma Strait, Records Clerks <u>Observations Conducted</u>: o Records storage areas in residences o Master records storage area in administration building o Shared drive
	Facility Self-Assessment: LSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. During the week of the onsite review, the monitoring team engaged in lots of discussion with facility staff regarding the new self-assessment. Facility staff appeared interested and eager to implement this new process correctly and in a way that would be beneficial to them. The most difficult aspect of this appeared to be understanding the somewhat subtle difference between <u>assessing</u> whether substantial compliance was met versus <u>engaging</u> in activities to meet substantial compliance. After the discussion, the URC said that she now had a better understanding of what to do for the section V self-assessment. Overall, the self-assessment should look at the same types of activities, actions, documents, and so forth that the monitoring team looks at. This can be determined by a thorough reading of the report. Section V is one of the only provisions of the Settlement Agreement that contains a provision item requiring a self-assessment of another provision. That is, to a certain extent, the activities to meet V3 might be, in large part, the self-assessment of V1. Then, the self-assessment of V3 would be to determine if the self-

	assessment activities were being conducted correctly (i.e., a self-assessment of the V3 self-assessment process). The statewide self-monitoring tool should also be re-evaluated as to whether it is providing the recordkeeping department with adequate information related to self-assessing the facility's performance with the four provision items of this section. Further, the self-assessment (and possibly any new self-monitoring tools that might be developed) should be modified after each monitoring report is issued. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the URC and believes that the facility was proceeding in the right direction. This was a good first step. The facility self-rated itself as being in substantial compliance with two of the four provision items: V3 and V4. The monitoring team, however, rated all four items as being in noncompliance. That being said, as is evident in the report below, much progress was made in V3 and it is very possible that substantial compliance will be obtained soon. More detail is presented below regarding the requirements for substantial compliance in V4.
	Summary of Monitor's Assessment: LSSLC demonstrated continued progress with this provision item. The majority of recordkeeping responsibilities had fallen to the URC, Stormy Tullos. She was doing a very good job maintaining good recordkeeping practices and moving the facility forward. Good work was also being done by the record clerks. The end of the month transfer of documents from the individual notebooks to the active records had continued. Overall, the active records were organized and well maintained. IPNs and observations notes had improved. Even so, there was still further improvement needed as identified in the facility's own reviews and in the monitoring team's reviews of a sample of records as per Appendix D. The URC and record clerks now had a list of medical consultations they could use when auditing that portion of the active record. Infrequently, there were items in the IPNs or in the observation notes that did not belong there, such as neurological checklists, post hospitalization forms, and injury reports. The facility should consider dating all forms so that clinicians, reviewers, readers, etc. will know if they're looking at the latest one. This may require the creation of a database of all forms to be maintained by the recordkeeping department. LSSLC continued to use individual notebooks exclusively for the recording of individual information throughout the day and month. Overall, this seemed to be working satisfactorily. In addition, they added a tabbed section to the front of each individual notebook that was titled At-Risk,

	and which included the integrated risk rating form and the risk action plans. A new master records table of contents was created in March 2012 and about half of the master records had been converted to this new, updated format. There was a one-page spreadsheet that indicated the status of state policies for each provision of the Settlement Agreement, and the facility-specific policy that related to each of these state policies. It should be expanded to include relevant aspects of the DADS memo from the assistant commissioner. A system to show training of relevant staff on both the state policies and the facility-specific policies was needed. Monthly audits were conducted for five to eight unified records each month. The reviews were done in a consistent and thorough manner and consisted of five components. Overall, the monitoring team was very satisfied with the audit procedures at LSSLC. Results of the reviews were written on the table of contents form and on the facility-wide Audit Tracker. Emails were sent out to the relevant staff, managers, and/or clinicians. The URC maintained a copy of every email and the response. Some of the items on the statewide self-monitoring tool did not have a corresponding item on the table of contents tool and, therefore, if incorrect, did not make it onto the list of items that needed to be corrected. Additional follow-up on items needing correction was needed. The monitoring team recommends that the URCs create a set of graphs as described in V3, and that these graphs be included in the LSSLC QA program. The URC recently received the list of actions and topics that were now to comprise V4. The monitoring team discussed these at length during the onsite review. The actions should now set the occasion for LSSLC to be able to more directly address the requirements of V4.

#	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. State policy and facility-specific policies remained the same since the last onsite review and, therefore, no new comments are provided here. At LSSLC, recordkeeping was under the supervision of the QA department, however, LSSLC had only an interim QA director and was awaiting the start of the newly hired QA director. Further, one of the two unified records coordinators (URC) had retired since the last onsite review. The facility had temporarily filled this position and was actively recruiting to fill it permanently. As a result, the majority of recordkeeping responsibilities had fallen to the URC Stormy Tullos. She was doing a very good job maintaining good recordkeeping practices and moving the facility forward. She worked extremely well with the facility's many directors, clinicians, and staff. This was evident in interactions observed by the monitoring team, comments in a variety of meeting minutes across the facility, and in a set of emails between the URC and other facility staff (e.g., QDDPs, QDDP Coordinator,	Noncompliance

#	Provision	Assessment of Status	Compliance
		Medical Director, CNE, Assistant Director of Administration, Clerk Coordinator). The monitoring team read 29 different email threads, all on relevant topics related to recordkeeping practices. Some of the topics were regarding practices that resulted in a facility-wide change (or initiation) in process. In the previous report, the monitoring team highlighted three aspects of recordkeeping practice at LSSLC. The first was the good work being done by the record clerks. They continued to be supervised by the residential director's office and continued to work very well with the URC. Further, trainings for record clerks were documented and shared with the monitoring team (e.g., regarding medical and other abbreviations). The monitoring team spoke with some of the clerks during the onsite review and found them to be knowledgeable, organized, and proud of their work. Second, the end of the month transfer of documents from the individual notebooks to the active records had continued since the last review. This required the record clerks, clerk coordinator, and URC to come in around 11 p.m. to help facilitate this. Third, summarizing and graphing of data on URC and record clerk activities had unfortunately not maintained since the last review. This should be restarted (see V3). As a result of the efforts of the URC, record clerks, and staff across the facility, overall, the unified records were in pretty good shape, though more work was needed to bring all of the items of this provision into substantial compliance. <u>Active records</u> Overall, the active records were organized and well maintained. The URC and the record clerks did a good job of managing the active records. Since the last review, there were improvements as follows: • IPNs and observations notes had improved in meeting the requirements of Appendix D. Entries were neater and followed the requirements more so than during the previous review. Even so, there was still further improvement needed as identified in the facility's own reviews and in the monitoring team's reviews of a sample of records as per Appendix D. o One question that came up during the onsite review was regarding blank lines between entries. There should be no blank lines between entries, but if there is a blank line <u>within</u> an entry, the entry can still be considered to be within acceptable guidelines. The monitoring team, however, recommends that the facility ask that the physicians do not skip lines. • The URC updated the table of contents for the active record. Some documents and tables were not being used at all, so these were deleted. Other areas required more detail, so those sections of the table of contents were expanded (e.g., two additional medical consultation tabs, more detail under each medical	

#	Provision	Assessment of Status	Compliance
		consultation tab). • The URC and record clerks now had a list of medical consultations so that they could look at to know for which types of specialties there should be documentation of the consultation appointment. o One aspect to clarify was whether the list included consultations that were ordered, but hadn't been completed yet, or if it only included completed consultations. To move forward with the active records, in addition to continuing to improve the IPNs and observations notes as noted above: • Infrequently, there were items in the IPNs or in the observation notes that did not belong there, such as neurological checklists, post hospitalization forms, and injury reports. These should be corrected. • Consider dating all forms so that clinicians, reviewers, readers, etc. will know if they're looking at the latest one. This may require the creation of a database of all forms to be maintained by the recordkeeping department. • Some consents should be asterisked on the table of contents. <u>Individual notebooks</u> LSSLC continued to use individual notebooks exclusively for the recording of individual information throughout the day and month (i.e., there were no other types of binders that one often finds in facilities, such as a single binder of seizure records). Overall, this seemed to be working satisfactorily. The individual notebooks were, for the most part, in good shape and available to staff. There was, as might be expected, variability in the quality of the appearance and upkeep of the individual notebooks. For example, Individual #9's individual notebook was in better shape than Individual #424's individual notebook. There was also variability in whether data were up to date in the individual notebooks. For example, when the monitoring team looked at individual notebooks on the homes, the PNMP and PBSP data for Individual #261 were up to date, but the PBSP data for Individual #60 had only been completed through the end of the previous day. Further, in some individual notebooks, there was unnecessary information, such as a full psychological evaluation (e.g., Individual #145). These should be removed. The residential director and unit directors embarked on an activity since the last onsite review to make at-risk information more readily available and useful to direct care staff. They found that it was difficult for staff to find relevant information about risk in the individual notebooks. They worked with the Lone Pine Unit staff and managers to come up with a better way and ended up adding a tabbed section to the front of the individual	

#	Provision	Assessment of Status	Compliance
		notebook that was titled At-Risk, and which included the integrated risk rating form and the risk action plans. It was relatively new and the effects/benefits for direct care staff were still being evaluated. <u>Master records</u> The URC continued to make progress in updating all of the master records to a new format. A new table of contents was created in March 2012 and about half of the master records had been converted to this new, updated format. The new format required a yes, no, or not applicable rating for each item. This was a good improvement. For any items scored no, the URC kept a list and did follow-up, such as filing for a birth certificate. Sometimes, even after some effort, a document could not be obtained. If so, the URC should document her efforts in the master record. <u>Shared drive</u> The URC showed the monitoring team the shared drive system of documents. This will be reviewed in more detail at the next monitoring visit. <u>Overflow files</u> 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 two-page spreadsheet that indicated the status of state policies for each provision of the Settlement Agreement, and the facility-specific policy or policies that related to each of these state policies. Not all state policies were yet in place, though continued progress was evident. The spreadsheet, however, should be expanded to include any relevant aspects of the DADS memo from the assistant commissioner, dated 2/15/12, such as, at a minimum, whether or not the facility-specific policy was reviewed by state office (though this was no longer a DADS requirement). In addition, the facility presented 12 new/updated facility-specific policies along with training signature logs for three (medication variance, PNMT, and at-risk). This was good to see. This was a small sample, however, and the monitoring team could not determine if training occurred (or was necessary) for all of the 12 new/updated policies, if everyone who should have received training did indeed receive it, and so forth. To better show implementation and training of relevant staff on both the state policies and the facility-specific policies, the facility should develop a policy and procedure that: • Incorporates mechanisms already in place, such as an email/correspondence.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Notes the list of job categories to whom training should be provided. • Defines, for each policy o who will be responsible for certifying that staff who need to be trained have successfully completed the training, o what level of training is needed (e.g., classroom training, review of materials, competency demonstration), and o what documentation will be necessary to confirm that such training has occurred. Some of this responsibility may be with the Competency Training Department. • Includes timeframes 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., ISP annual refresher training). • Includes a system to track which staff completed which training.	
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.	As was being planned at the time of the last onsite review, record clerks were each conducting one unified record review each month (from one of the homes on another unit), and the URC was also conducting one. As a result, five to eight were conducted each month over the past six months. This was a nice improvement. The reviews were done in a consistent and thorough manner. The review consisted of five components: (1) the table of contents review of the active record and individual notebook, (2) a checklist review of the master record, (3) the statewide self-monitoring tool, (4) the V4 questionnaire, and (5) copies of emails showing that facility staff were notified of any needed corrections. Overall, the monitoring team was very satisfied with the audit procedures that were being implemented at LSSLC. The auditor reviewed all three components of the unified record and completed the table of contents tool and the statewide self-monitoring tool. She also completed the V4 questionnaire. The auditors had begun to use two documents created by the recordkeeping department to help make their reviews more consistent. One was a list of consulting physicians and their specialty area, and the other was a list common lab tests and common medical abbreviations. Then, the results of these reviews were written on the table of contents form and on the facility-wide Audit Tracker. Emails were sent out to the relevant staff, managers, and/or clinicians. The URC maintained a copy of every email and the response from the staff person (e.g., that it had now been corrected, that the document no longer applied to that individual).	Noncompliance

#	Provision	Assessment of Status	Compliance
		To achieve substantial compliance, the monitoring team recommends the following: • Some of the items on the statewide self-monitoring tool did not have a corresponding item on the table of contents tool and, therefore, if incorrect, did not make it onto the list of items that needed to be corrected (and thereby onto the Audit Tracker and into emails for follow-up). The URC should figure out a way to include any relevant information from the statewide tool. • There were two columns on the table of contents tool. One for presence and the other for guidelines followed. Almost always, both columns had the same rating. The URC, with assistance from the record clerks, should determine if having two columns was serving any meaningful purpose. If not, one could be deleted. • There was, appropriately, no expectation that the URC and record clerks should assess the quality of the content of documents for which they do not have sufficient training (e.g., content of a psychiatric assessment). If, however, a form is blank, it should be scored as an item in need of correction. For example, the Adult Preventive Care Flow Sheet was blank for one individual, but scored as acceptable. • Additional follow-up on items needing correction was needed. Most items were corrected, but others were not. They should not remain on the Audit Tracker forever, instead, there should be some cut-off period, such as two months. • Consider whether the monthly audit should include anything about the shared drive contents for the individuals being audited. More and more documents were being created and stored on the shared drive. It might make sense to include the shared drive in the audit process. • The recordkeeping staff had discontinued doing any graphing of important recordkeeping-related data. The URC reported that she had been seeing a lot of progress. Graphing recordkeeping outcomes would be a good way to show this. The monitoring team recommends that the URC create a set of graphs as follows, and that these graphs are included in the QA program: o Number of reviews done per month o Average score on the statewide self-monitoring tool o Average score on the statewide self-monitoring tool only including those items that have been problematic (i.e., the items regarding legibility, signatures, etc.). o The average number of errors per table of contents review o The average number of errors that were not corrected as of the cut off date (e.g., two months). o Data should be presented unit-by-unit (and perhaps by department/discipline) as well as for the facility as a whole.	

#	Provision	Assessment of Status	Compliance
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.	Recently, the monitoring teams, DADS, and DOJ agreed that a proposed list of actions for the SSLCs to engage in to demonstrate substantial compliance with this provision item. The URC recently received this list and the monitoring team discussed it at length during the onsite review. It is likely that the DADS state office coordinator for recordkeeping will provide additional direction and guidance to the URC. The actions are below and LSSLC should now be able to more directly address the requirements for this provision item. <u>Records are accessible to staff, clinicians, and others</u> LSSLC was not yet self-assessing this. The monitoring team, however, observed that: • Records were usually available and accessible to staff, clinicians, and others when needed. • Records were accessible to clinicians once they were present in the home areas. • Individual notebooks were used and available. • Records were accessible to psychiatrists and the physician's assistant during clinic. • Many records contained odd notes from families related to various requests (e.g., to allow an individual to use age inappropriate toys). • Current ISPs were available to DSPs in individual notebooks in all residences. This was a significant improvement over the findings during the last onsite visit. The facility had recently added a tab to the front of individual notebooks for individual Risk Rating Forms and Risk Action Plans. These were also found to be in place in a sample of individual notebooks reviewed. <u>Data are filed in the record timely and accurately</u> LSSLC was assessing this during the monthly audits, that is, when the URC and record clerks indicated whether a document was in the record, up to date, and in the right place. The monitoring team found missing entries in several individuals' health status information, such as blood-glucose, intake, output, weekly weight, etc., which were supposed to be recorded on MARs and/or other tracking logs. The availability of documents in the shared drive, including assessments that are due 10 days prior to annual ISP meetings will be reviewed during the next onsite review. <u>Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)</u> LSSLC was not yet self-assessing this. The monitoring team, however, observed that: • Data were not always entered in a timely manner. Preventive care flow sheets were frequently not updated. Immunization data, eye exam data, and mammogram data were often not current and could result in unnecessary	Noncompliance

#	Provision	Assessment of Status	Compliance
		ordering of tests. • APLs were updated, but appeared to be infrequently re-typed so they became disorganized for the one or two providers who frequently added information. The APL should be included with packets to provide the updated diagnoses to consultants. Therefore, it should be relatively legible and clean. • The target behaviors sampled for five (in homes 557A, 563B, 549D, and 520A) of 14 data sheets reviewed (37%) were completed up to the previous recording interval. This represented an improvement over the last review when only 15% of the data sheets were completed up to the previous interval. • In another example, when the monitoring team looked at individual notebooks on the homes, the PNMP and PBSP data for Individual #261 were up to date, but the PBSP data for Individual #60 had only been completed through the end of the previous day. • There were missing entries in several individuals' health status information, such as blood-glucose, intake, output, weekly weight, etc., which were supposed to be recorded on MARs and/or other tracking logs. • Progress notes for direct therapies, wheelchair clinic, and some other limited actions taken by therapists were noted. These were often not completed with analysis and a plan that was related to the findings, but instead were notations of completion of assessment, or to document that an individual participated in a walking program. <u>IPNs indicate the use of the record in making these decisions (not only that there are entries made)</u> LSSLC was self-assessing this as part of the statewide self-monitoring tool. To do so, the URC and record clerks answered a question related to this item, however, there was no explanation as to how they arrived at their rating. In addition, the monitoring team observed that: • Physicians documented in the IPNs, some more than others. This can impact how IDTs can use these entries. • The APRN consistently provided excellent documentation. • There was little evidence that nurses' reviewed individuals' records to make care/treatment/training decisions. Usually, nurses' made these decisions based upon their assessment or evaluation of a particular situation. They usually did not incorporate a review of the individual's history and/or prior falls/injuries as part of their evaluation and/or when they made care, treatment, and training decisions. • There was a improvement in the use of clinical indicators to make decisions regarding risk ratings in the most current plans. However, it was found that not all assessments were completed in a timely manner, prior to the development of	

#	Provision	Assessment of Status	Compliance
		ISPs and Risk Action Plans. • A review of a sample of quarterly reviews did not confirm that adequate data were available for teams to consider when determining if a plan was adequate. Although data were now being graphed, there was not sufficient detail to determine if the data collected was consistent and accurate. • The record was clearly used for extensive chart review in the completion of OT/PT/SLP and PNMT assessments. <u>Staff surveyed/asked indicate how the unified record is used as per this provision item</u> • The URC or record clerk conducted a brief, but informative, interview with one or more IDT members each month for the individuals whom she audited. The results of these interviews were given to the monitoring team. o Some of the comments were interesting, but the results were not used in any way by the facility, other than perhaps to assist the auditor in scoring the statewide self-monitoring tool question for V4. The reviewers and/or URC should summarize and bring forward any interesting comments or suggestions to the QA department for consideration by QAQI Council. • The URC also reported that they were attempting to complete the questionnaire with one of the community physician specialists. This was not helpful, was confusing to the community physician, and should be discontinued. • Psychiatry clinic staff were noted to utilize other information with regard to making treatment decisions (e.g., psychology evaluations, data graphs, MOSES, DISCUS, nursing information). <u>Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item, and data are reported rather than only clinical impressions</u> LSSLC was not yet assessing this, however, the monitoring team found the following: • At annual IDT meetings and quarterly meetings observed onsite, teams were using unified records to provide information in regards to the efficacy of supports. This finding, however, was not confirmed on review of a sample of quarterly review forms. • The individual's record was used during his ISP meeting to help IDT members recall/remember certain events, data, information, etc. pertinent to the subject matter of the meeting. • The PNMT meeting, however, was conducted without the availability of the record to check current status or for other reference during the meeting. • Multiple versions of many forms existed (e.g., PCFS). • The quarterly review form included a section to note progress or regression on all service and training objectives. It was not evident that this process was	

#	Provision	Assessment of Status	Compliance
		thorough enough to adequately assess the progress and efficacy of the related interventions. Quarterly reviews indicated that IDTs were continuing outcomes regardless lack of progress or when regression was apparent.	

Recommendations:

1. Continue to work on reducing the number of gaps in entries, and ensuring proper filing in the active record (though there had been much improvement since the last review) (V1).
2. Add asterisks to the table of contents for consents that don't apply to all individuals (V1).
3. Consider initiating a facility-wide practice of putting a date on every form used at the facility (V1).
4. Ensure individual notebooks not contain any excess unnecessary documents (V1).
5. Ensure individual notebook data entries are timely (V1, V4).
6. Put all of the master records into the new format following the new table of contents (V1).
7. In the master record, document efforts of the URC and record clerks when a document that is not optional could not be obtained (V1).
8. Expand the spreadsheet to include relevant information from the assistant commissioner's email on 2/15/12 (V2).
9. Create a process for the implementation and training of relevant staff on state and facility-specific policies (V2).
10. Consider whether/how to include items from the statewide self-monitoring tool in the list of items that need correction (V3).
11. Follow-up on all needed corrections until corrected, or until a standard cut-off time, such as two months (V3).
12. Determine if two columns are needed for the table of contents tool (V3).
13. Score blank forms as needing correction (V3).
14. Determine how to include the shared drive in the audits of the unified records.
15. Graph important recordkeeping outcomes and include in the facility's QA program (V3).
16. Implement and monitor all of the aspects of assessing the use of records to make care, treatment, and training decisions, that is, the six areas highlighted with underlined headings in section V4 (V4).

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
AACAP	American Academy of Child and Adolescent Psychiatry
AAUD	Administrative Assistant Unit Director
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ABX	Antibiotics
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
ADD	Attention Deficit Disorder
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
AMS	Annual Medical Summary
ANC	Absolute Neutrophil Count
ANE	Abuse, Neglect, Exploitation
AOD	Administrator On Duty
AP	Alleged Perpetrator
APC	Admissions and Placement Coordinator
APL	Active Problem List
APEN	Aspiration Pneumonia Enteral Nutrition
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
AV	Alleged Victim
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
BPD	Borderline Personality Disorder
BPM	Beats Per Minute
BS	Bachelor of Science
BSC	Behavior Support Committee
BSD	Basic Skills Development
BSP	Behavior Support Plan
BPRS	Brief Psychiatric Rating Scale
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
CEA	Carcinoembryonic antigen
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
CMA	Certified Medication Aide
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
CPT	Certified Pharmacy Technician
CPT	Certified Psychiatric Technician
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	Development Center
DC	Discontinue
DCP	Direct Care Professional
DCS	Direct Care Staff
DD	Developmental Disabilities
DDS	Doctor of Dental Surgery
DERST	Dental Education Rehearsal Simulation Training
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
DRM	Daily Review Meeting
DRR	Drug Regimen Review
DSHS	Texas Department of State Health Services
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)
EC	Enteric Coated
ECG	Electrocardiogram
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
FLACC	Face, Legs, Activity, Cry, Console-ability
FNP	Family Nurse Practitioner
FNP-BC	Family Nurse Practitioner-Board Certified
FOB	Fecal Occult Blood
FSA	Functional Skills Assessment
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
GB	Gall Bladder
GED	Graduate Equivalent Degree
GERD	Gastroesophageal reflux disease
GFR	Glomerular filtration rate
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
HMO	Health Maintenance Organization
HMP	Health Maintenance Plan
HOB	Head of Bed
HOBE	Head of Bed Evaluation
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
ICA	Intense Care Analysis
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
ICN	Infection Control Nurse
ID	Intellectually Disabled
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
ISPA	Individual Support Plan Addendum
IT	Information Technology
IV	Intravenous
JD	Juris Doctor
K	Potassium
KCL	Potassium Chloride
KG	Kilogram

KUB	Kidney, Ureter, Bladder
L	Left
L	Liter
LA	Local Authority
LAR	Legally Authorized Representative
LD	Licensed Dietitian
LDL	Low Density Lipoprotein
LFT	Liver Function Test
LISD	Lufkin Independent School District
LOC	Level of Consciousness
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 Plan
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
MHA	Masters, Healthcare Administration
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
MOT	Masters, Occupational Therapy
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
MPT	Masters, Physical Therapy
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
NMES	Neuromuscular Electrical Stimulation
NMS	Neuroleptic Malignant Syndrome
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NOS	Not Otherwise Specified
NPO	Nil Per Os (nothing by mouth)
NPR	Nursing Peer Review
O2SAT	Oxygen Saturation
OBS	Occupational Therapy, Behavior, Speech
OC	Obsessive Compulsive
OCD	Obsessive Compulsive Disorder
OCP	Oral Contraceptive Pill

ODD	Oppositional Defiant Disorder
ODRN	On Duty Registered Nurse
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
PAD	Peripheral Artery Disease
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
Pharm.D.	Doctorate, Pharmacy
Ph.D.	Doctor, Philosophy
PHE	Elevated levels of phenylalanine
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
QMS	Quarterly Medical Summary
QPMR	Quarterly Psychiatric Medication Review
QTR	Quarter
R	Respirations
R	Right
RA	Room Air
RD	Registered Dietician
RDH	Registered Dental Hygienist
RN	Registered Nurse
RNCM	Registered Nurse Case Manager
RNP	Registered Nurse Practitioner
RO	Rule out
ROM	Range of Motion
RPH	Registered Pharmacist
RPO	Review of Physician Orders

RR	Respiratory Rate
RT	Respiration Therapist
RTA	Rehabilitation Therapy Assessment
RTC	Return to clinic
RX	Prescription
SAC	Settlement Agreement Coordinator
SAISD	San Antonio Independent School District
SAM	Self-Administration of Medication
SAMT	Settlement Agreement Monitoring Tools
SAP	Skill Acquisition Plan
SASH	San Antonio State Hospital
SASSLC	San Antonio State Supported Living Center
SATP	Substance Abuse Treatment Program
SDP	Systematic Desensitization 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
SIDT	Special Interdisciplinary Team
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
TAC	Texas Administrative Code
TAR	Treatment Administration Record
TB	Tuberculosis
TCHOL	Total Cholesterol
TCID	Texas Center for Infectious Diseases
TCN	Tetracycline
TD	Tardive Dyskinesia
TDAP	Tetanus, Diphtheria, and Pertussis
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
TX	Treatment
UA	Urinalysis
UD	Unauthorized Departure
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
VRE	Vancomycin Resistant Enterococci
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