United States v. State of Texas

Monitoring Team Report

Lufkin State Supported Living Center

Dates of Onsite Review: October 29 – November 2, 2012

Date of Report: December 28, 2012

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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 offsite review.

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

(c) **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. 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.

(d) **Interviews** – The Monitoring Team also interviewed a number of people. Throughout this report, the names and/or titles of staff interviewed are identified. In addition, the Monitoring Team interviewed a number of individuals served by the facility.

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 again acknowledge and thank the individuals, staff, clinicians, managers, and administrators at LSSLC for their openness and responsiveness to the many activities, requests, and schedule disruptions caused by the onsite monitoring review. The facility director, Gale Wasson, set the tone for the week and was supportive of the monitoring team's activities. She was readily available to the monitoring team. The Settlement Agreement Coordinator, Sherry Roark, again did an outstanding job, ensuring that the monitoring team was able to conduct its activities as needed. She was extremely organized and efficient.

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 services and supports at the facility.

- Department leadership: Staffing and supervision in leadership positions directly affected seven of the Settlement Agreement provisions: E, H, J, L, M, N, and Q:
  - Department leadership was absent in the medical, psychiatry, and dental departments.
  - Leadership was very new for quality assurance, nursing, pharmacy, and minimum common elements of clinical care departments.

- Appropriate peer review: Facility management should assure that when peer review is conducted, it is done so by peers with appropriate training, credentials, licenses, etc. This was an issue for medical and psychiatry services.

- Presentation: Facility management and Settlement Agreement provision leaders should be sure to thoroughly inform the monitoring team of special projects and initiatives. For example, the Key Performance Indicators were not thoroughly presented to the monitoring team at the beginning of the onsite review. Similarly, the pneumonia-related quarantine was not presented to the monitoring team in an organized manner.

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.

Restraint

- Overall, the facility had made very good progress towards meeting compliance with requirements for documenting and reviewing restraint incidents for crisis intervention. All requirements of the new restraint policy had not yet been implemented, particularly in that Protective Mechanical Restraint Plans had not been developed for individuals who were wearing protective restraints due to self-injurious behaviors.
- There were 213 restraints used for crisis intervention between 4/1/12 and 10/29/12 (seven months). This was a considerable increase compared to the 100 restraints for crisis intervention reported from 10/1/11 through 3/22/12 (six months). A new data collection system had been implemented by the facility in the last quarter. At least some of the increase may have been attributed to differences in the way data were being collected, though it was not possible to confirm this.
- There were 114 instances of dental/medical pretreatment sedation from 4/1/12 through 9/21/12. This was a decrease from the 130 reported during the last monitoring visit. Plans were in place to reduce or eliminate the need for medical/dental restraints for some, but not yet all individuals who required pretreatment sedation.

Abuse, Neglect, and Incident Management

- DFPS confirmed eight cases of physical abuse, two cases of verbal/emotional abuse, and seven cases of neglect. This was from a total of 77 allegations since April 2012 that included 34 allegations of physical abuse, 14 allegations of verbal/emotional abuse, two allegations of exploitation, and 27 allegations of neglect. An additional 46 other serious incidents were investigated by the facility.
- There were 1865 injuries reported between 4/1/12 and 9/3/12. These included 13 serious injuries resulting in fractures or sutures. As noted in the previous monitor's report, the facility was not adequately addressing injuries and trends of injuries. Many of the serious injuries were preceded by similar incidents, not adequately addressed. The facility needs to aggressively address trends in injuries and implement protections to reduce these incidents and injuries.
- Recommendations resulting from investigations, incidents, and injuries should include a focus on systemic issues that are identified and action steps should be developed to address those issues.

Quality Assurance

- Some progress was made in section E. Since the last review, a new QA director was appointed. The QA data list inventory was updated since the last review. A workgroup was going to be formed to get to a finalized, complete version by the time of the next onsite review. The QA plan narrative needed much work to be adequate and useful to the reader. The QA plan matrix was identical to what was submitted six months ago.
- The state-issued self-monitoring tools were being used, except for sections F, O, P, and S. The section leaders for these four provisions had created new/revised tools that better met their needs at LSSLC.
- The monitoring team identified 10 QA-type activities were occurring at LSSLC outside of the QA department. The QA director should incorporate these into her overall QA program, that is, include the data in the listing inventory, QA plan narrative, and QA matrix, as appropriate, and review data.
- The monitoring team recommends there be a monthly meeting of the QA director, SAC, and the lead person responsible for each provision of the Settlement Agreement. During these one-hour meetings, many QA- and Settlement Agreement-related activities could be accomplished.
- An adequate QA report did not exist. The minutes and the documents handed out at the QAQI Council meetings showed that interesting and relevant topics were on the agenda, but there was no indication of what was presented, reviewed, summarized, analyzed and/or discussed.
- There was good progress in beginning to organize the system of tracking of corrective action plans.

Integrated Protections, Services, Treatment, and Support

- DADS state office recognized that the previous ISPs did not meet the requirements of the Settlement Agreement. As a result, using a group of consultants as well as work groups that included state office and facility staff, the ISP planning and development processes had been revised and reflected in the draft policy. LSSLC QDDPs and many team members had been provided training on the new process by statewide consultants.
- There were some positive steps forward with the new ISP process.
    - A mentoring program was implemented using 12 department heads from various disciplines to attend ISP meetings and provide feedback to the IDTs on implementation of the new ISP process.
    - The mentoring team was collecting data with the Mentoring Tool and meeting to discuss findings.
    - The QDDPs, along with psychologists and habilitation therapist, were focusing on active treatment in the 510 day program.
- The monitoring team observed two annual ISP meetings in the new format. The IDT was following the format of the new ISP process and team members were holding a more integrated discussion.

Integrated Clinical Services

- The facility continued to make progress in this provision with improved integration noted in several areas. An integration policy was revised to include statements regarding integration for each clinical discipline. Several processes were revamped to further clinical integration including the pretreatment sedation process and the desensitization workgroup.
- The process of evaluating clinical problems was also taking a more integrated approach. This was seen in the hospitalization review workgroup (discussed in sections L and M) and in the management of the recent infectious outbreak.
- Progress was also seen in the consultation process. A new database was recently implemented. The timely documentation of consults improved although the quality of the documentation needs to be addressed.
- It was also evident that considerable work needed to be done to improve integration of clinical services. The successes and opportunities for improvement are presented in this report.

Minimum Common Elements of Clinical Care

- The facility's QA nurse assumed the lead role for this provision item. This was in itself a significant and positive change. This was the first review in which this provision was given serious and thoughtful consideration.
- The facility focused its efforts on H1 and H2. There was little progress noted in the other provisions, however, the facility drafted a policy on risk thresholds to ensure timely review occurred for those with a change in status.
- Each department was responsible for assessment tracking because there was no centralized tracking. Tracking completed by the facility in August 2012 showed significant problems with the timeliness of completion of assessments.
- Improvement was seen in the diagnostic formulation for psychiatric assessments and medical providers generally utilized ICD nomenclature.

At-Risk Individuals

- While progress had been made on this provision, through an initial attempt to ensure all individuals were accurately assessed and action plans were in place to address risks, adequate plans were not in place to address all risks identified. Risk action plans were not being consistently reviewed and monitored.
- Since the last review, there were revisions to the At-Risk Individuals policy, including regrouping the Risk Guidelines so that the risk factors that were clinically related were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form was revised to follow the same grouping sequence as the Risk Guidelines.
- Risk Action Plans were being replaced with Integrated Health Care Plans designed to provide a comprehensive plan that will be completed annually.

- Teams should be carefully identifying and monitoring indicators that would trigger a new assessment or revision in supports and services with enough frequency that risk areas are identified before a critical incident occurs. Teams were often waiting until a critical incident occurred before aggressively addressing the risk. Plans should be implemented immediately when individuals are at risk for harm.

Psychiatric Care and Services

- There was much improvement in many areas of section J. The facility had physicians and a physician's assistant providing care, however, there was limited availability of clinical resources with 1.1 total FTE available.
- The facility psychiatric staff made great strides with regard to the completion of comprehensive psychiatric assessments. 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.
- 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.

Psychological Care and Services

- There were many improvements, across almost every item in this provision, since the last onsite review. These improvements included three additional psychologists became certified applied behavior analysts. There was an expansion of the collection and graphing of replacement behaviors and of the collection of data collection reliability and inter-observer agreement (IOA). There were improvements in the quality of functional assessments, in the number and comprehensiveness of full psychological assessments, in the number of full psychological assessments that were current, and in the comprehensiveness of the annual psychological assessments. The psychology department established formalized counseling services and showed improvements in the quality of PBSPs and in the collection of treatment integrity data.
- LSSLC still needs to work on establishing minimal frequencies of data collection reliability and IOA collection per individual with a PBSP and minimal acceptable data collection reliability and IOA levels. In addition, they need to ensure that all data systems are providing the data necessary to encourage data based treatment decisions. The number of individuals with full psychological assessments needs to be increased and all annual psychological assessments need to contain a review of medical variables. Finally, there was a need to establish minimal frequencies

of treatment integrity collection per individual, establish minimal treatment integrity levels, and ensure that those levels are achieved.

Medical Care

- There was very little progress seen in the provision of medical services. LSSLC did not have the medical leadership necessary to develop, implement, drive, and oversee the provision of medical services and other healthcare related services. The facility director explained that the medical director maintained the title, but functioned in a limited role. The medical compliance nurse played a significant role in the operation of the medical department while also providing support for facility QA activities.
- The medical staff remained stable since the last compliance review. Caseloads were redistributed to become more manageable.
- Problems related to inadequate follow-up of medical problems and diagnostics persisted. There was continued use of older and non-evidence based medical practices. The timeliness of neurological care remained problematic and compliance with cancer screenings remained low.
- The external and internal medical reviews were conducted, but the external review was incomplete because the audit did not include all providers. The medical management audits were completed for the first time at LSSLC, but the data provided was not usable.
- Mortality reviews continued to be completed, but there was no evidence that a thorough review of the medical care was conducted. The QA department became more involved in the process by assimilating a list of all corrective actions in order to ensure that implementation occurred.
- No action occurred in the development of a medical quality program. The requirement to develop and implement policies and procedures to guide medical care received no attention.

Nursing Care

- There were some areas of improvement and some areas in which there was no improvement. The areas of immunization, employee health, and nurse education showed improvement, and positive achievements made six months ago were sustained in the oversight of hospitalized individuals.
- The infection prevention and control program failed to show improvement; violations of basic standards of infection control were often noted.
- Nursing assessments were not being performed and documented, in accordance with standards of practice. Plans of care were incomplete or absent from individuals' records. Health risks were not appropriately reviewed and revised, in accordance with changes in individuals' health status and needs. In addition, medications were not administered safely, hygienically, or in accordance with standards of practice.

- The new CNE was urged to work closely with facility administration and other department directors to regroup and reestablish management, direction, guidance, leadership, and accountability across the Nursing Department.

Pharmacy Services and Safe Medication Practices

- A new clinical pharmacist was hired on 8/1/12. Even so, she had become very familiar with the requirements of the Settlement Agreement, agency operations, and many of the issues requiring attention. The monitoring team, however, was concerned by the level of supervision and support provided to her by the pharmacy director.
- The pharmacists continued to document communication with staff, but most revolved around discussions with nursing staff. Physician order writing presented many challenges for the pharmacy department, but little effort was expended in assessing the contributing factors. The Intelligent Alerts continued to be used during prospective reviews, but the value of the module and its use at LSSLC were uncertain.
- The facility made some progress in resolving the problems related to the QDRRs. Overall, the reviews lacked substantive content and most were not reviewed by the psychiatry staff. The timelines for completion began to show improvement in August 2012.
- The MOSES and DISCUS evaluations were completed by nursing staff. Many of the evaluations were signed, but never completed by the medical staff. There was no compelling evidence that the medical staff utilized this information in clinical decision making.
- The ADR reporting and monitoring system remained unchanged and without full implementation. The clinical pharmacist recognized that under reporting was problematic and training for staff was needed.
- The facility continued to report medication variances, but there was evidence that some, particularly prescribing variances, were under-reported. The facility was not able to demonstrate that appropriate actions were implemented.

Physical and Nutritional Management

- Progress was made towards substantial compliance with provision O. The PNMT was fully staffed and each of the members was on the team since the previous review. They had completed a number of assessments reportedly in a timely manner. During the meeting that the monitoring team observed, the discussion was very good related to follow-up on individuals currently active. There appeared, however, to be a significant delay/absence of referrals of individuals who would benefit from PNMT evaluation.
- The PNMT did not appear to be routinely and proactively reviewing individuals with a high risk of key PNM indicators or with incidences of these concerns. They did not routinely track their status in an organized manner. Follow-up of individuals they provided assessment or review of was inconsistent and not well documented.
- Mealtimes and position and alignment were improved, though some issues related to diet texture and transfers were noted.

- Oral hygiene was an area of concern regarding positioning, alignment, and technique. There must be collaboration between the dental hygienists and therapy staff to identify strategies. This must be followed by staff training.
- Monitoring of staff compliance must be consistent and effective. If staff have demonstrated competency, there must be an expectation that the plan be implemented as written every time.

Physical and Occupational Therapy

- There was continued progress with provision P. That being said, therapists were not completing assessments and updates in a timely manner so that the IDTs could apply the information in the ISPs. The clinicians had difficulty routinely attending meetings and, in some cases, IDTs had to table discussions or send action referrals to request supports or further information.
- A system of assessment audits is needed to better shape the consistency of content in the assessments and updates completed by the therapists. Many individuals were identified for assessments, when an update was indicated because the individual was already provided supports and services.
- There was no routine effectiveness monitoring conducted by the clinicians. Staff compliance monitoring by the PNMPCs was deemed to be inaccurate and both should be implemented in a manner that is thoughtful, meaningful, and accurate.
- Some of the therapists had been spending more time in the day program areas to address integration. This needs to be expanded so they can model, coach, and support staff and individuals in the homes, day programs and work settings.
- Habilitation therapy staff have an important role in the provision of training and skill acquisition. The therapy clinicians have expertise in movement skill performance that should result in the identification of direct interventions and programs to promote improvement in this area as well as enhance the motor aspects of programs designed and implemented by other team members.

Dental Services

- The dental clinic made progress in the Oral Hygiene Maintenance program and it was good to see that resources were invested in the routine and preventive care that was provided in the homes.
- Basic services were provided onsite, and more advanced services were provided by a local oral surgeon. Most individuals referred to the oral surgeon required extensive restorations and/or multiple extractions.
- The clinic did not have a dental director or a full time dentist. A reduction in services and a relatively high failure rate resulted in only 68% compliance with the requirement to complete annual dental assessments within the anniversary month. A significant percentage of the failed appointments were due to a lack of staff in the dental clinic.
- Refusals continued and were addressed through a psychology driven desensitization program. The format for the plans was recently revised and some success was noted for those individuals.

Communication

- There was continued progress with this provision. The therapists implemented some very excellent programs and the completed assessments were improved. A system of audits should be implemented.
- Attendance at the ISPs was inconsistent. The current ratio for caseloads continued to be high.
- Use of AAC was appropriate, but more individuals required AAC. There was some direct therapy to some individuals. There were few SAPs for communication.
- NEO training was very limited related to communication and increasing the time allotted to this should be considered. Training should focus on teaching staff to be effective communication partners as well as to implement AAC.

Habilitation, Training, Education, and Skill Acquisition Programs

- Progress since the last review was seen in an increase in the number of SAPs that included an acceptable plan for maintenance and generalization, continuous progress in pretreatment sedation reduction, improved engagement as key performance indicator for the facility, and the percentage of SAPs reviewed that showed progress. A good relationship continued between LSSLC and the local public school district.
- Continued work was needed to ensure that each SAP contained a rationale for its selection that is specific enough for the reader to determine that it was practical and functional for that individual. The staff responsible for SAPs also need to track engagement across all treatment areas, review trends, establish acceptable levels of engagement in each treatment area; and document how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans. Finally, measures of skill training in the community need to be accurate. The facility should establish acceptable percentages of individuals participating in community activities and training on SAP objectives in the community, and demonstrate that these levels are achieved.

Most Integrated Setting Practices

- LSSLC continued to make progress across all of section T. The number of individuals placed was at an annual rate of less than 4% (7 placements in the last six months). Approximately 5% of the individuals at the facility were on the active referral list (18 individuals). The list of individuals not referred solely due to LAR preference contained 38 names (11% of the census).
- Of the 10 individuals who received post move monitoring, 7 (70%) ultimately transitioned very well and appeared to be having great lives. Of the remaining 3, 2 (20%) were still having transition problems and 1 (10%) was not doing well.
- Nine of the 18 individuals placed in the past year had experienced one or more untoward events. A simple review should be done for all of these cases to evaluate (e.g., root cause analysis type review) the placement and transition processes to see if anything might be done differently in the future. Note, however, that the problems for all 9 individuals were resolved successfully.

- The quality of the CLDPs had improved. Most of the improvement was seen in the two most recent of the CLDPs. IDT members continued to be actively involved in the placement process. The discharge assessments, however, need to focus more upon the individual moving to a new residential and day setting.
- There were some improvements in the identification of an adequate list of essential and nonessential (ENE) supports. Further improvement was needed. Some important supports might have been overlooked in some CLDPs.
- Twenty-two post move monitorings for 10 individuals were completed. This was 100% of the post move monitoring that was required. All 22 (100%) were documented in the proper format, in line with Appendix C. For the most part, the post move monitoring report forms were completed correctly and thoroughly.
- The new PMM conducted the post move monitoring in a very professional manner, proceeding through all of the items, asking questions, and asking for documentation. She needs to, however, conduct more thorough interviews of each staff, and she needs to raise concerns about what she observes whenever warranted.

Guardianship and Consent

- The facility appointed a new Human Rights Officer. The Consumer and Family Relations Director was now working closely with the HRO to develop a process to assess each individual's functional decision-making capacity and need for guardianship.
- The facility had still not developed a priority list of individuals needing an LAR based on an adequate assessment process. IDTs continue to need training to determine each individual's functional capacity to render informed decisions.
- Once a priority list of those in need of a guardian has been developed, then the facility can move forward with procuring guardianship for individuals with a prioritized need.

Recordkeeping Practices

- Good progress was made in all four of the items of provision V. The URCs conducted regular meetings and trainings with the record clerks to help ensure they were knowledgeable about filing and about criteria for their audits. The recordkeeping staff also maintained good relationships with the facility's many service disciplines and departments.
- The active records continued to be in good shape. The quality of entries in the observation notes, physician orders, and IPNs had improved. Gaps in the entries were addressed. There were, however, some missing, misfiled, and/or incorrectly filed documents. Individual notebooks continued to improve. Staff appeared comfortable and knowledgeable about the individual notebooks.
- The URCs continued to create appropriate master records. More than 60% were completed. Still to be resolved was what to do when non-optional documents could not be located or obtained.
- A detailed 18-page spreadsheet listed every policy. The facility must show that staff who should be trained on the policies have been trained on the policies.

- Continued progress was made in the quality and management of the monthly process for the review of five unified records, including addressing the recommendations and comments made in the previous monitoring report. The QA department was going to conduct inter-rater agreement checks, but this was not yet happening. Is was needed, especially given the finding that there were differences in average scoring across the set of record clerks who conducted these audits.
- The URCs re-initiated graphic summaries of data from their department's activities. The graphs were simple and easy to understand.
- The facility showed progress in V4 by taking first steps to assess, and possibly address, the six activities in this provision item.

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 8/1/12 o Restraint: Ordering, Assessing, and Evaluating Curriculum (RES0300) 08/12 o Restraint: Prevention and Rules for MR Facilities Curriculum o LSSLC Self-Assessment o LSSLC Provision Action Information Log o LSSLC Section C Presentation Book o Settlement Agreement Compliance Report 4/1/12-9/1/12 o FY12 Restraint Trend Analysis Report o Sample of Incident Management Team Minutes o List of all restraint by Individual 4/1/12 through 9/31/12 o List of all chemical restraints used for the past six months o List of all medical restraints used for the past six months o List of all restraints used for crisis intervention for the past six months o List of all mechanical restraints for the past six months o List of all restraint related injuries o LSSLC "Do Not Restrain" list o List of all individuals with a Crisis Intervention Plan (11) o List of individuals with desensitization plans or strategies to reduce the use of restraint o Desensitization plans for Individual #584, Individual #102, Individual #34, Individual #319, and Individual #144. o Medical Pretreatment sedation Restraint Documentation for: o Individual #34, Individual #504, Individual #52, Individual #33, Individual #308, Individual #317, Individual #62, and Individual #457. o Restraint Reduction Committee meeting minutes for past six months o Training transcripts for 24 LSSLC employees o ISPs, PBSPs, Crisis Intervention Plans (when applicable), and ISPAs for: • Individual #410, Individual #401, Individual #170, Individual #420, Individual #318, Individual #148, Individual #176, Individual #110, Individual #380

- A sample of restraint documentation for crisis intervention including:

Individual	Date	Type
#410	8/4/12	Physical
#410	8/6/12@ 4:36 pm	Physical
#410	8/6/12 @4:43 pm	Physical
#410	8/6/12@5:16 pm	Physical
#410	8/6/12@5:22 pm	Physical
#410	8/30/12	Physical
#410	9/12/12	Physical
#170	6/28/12	Physical
#170	9/2/12@2:41 pm	Physical
#170	9/2/12@10:29pm	Physical
#170	9/10/12@9:18pm	Physical
#170	9/10/12@9:37pm	Physical
#170	9/10/12@9:52pm	Physical
#170	9/23/12	Physical
#401	7/25/12	Physical
#401	7/26/12@4:48pm	Physical
#401	7/26/12@5:31pm	Physical/Chemical
#401	7/26/12@5:34pm	Physical
#401	9/1/12	Physical
#401	9/15/12	Physical
#420	9/18/12	Physical
#148	9/19/12	Physical
#318	9/7/12	Chemical
#176	8/23/12	Physical

<u>Interviews and Meetings Held</u>:

- 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

<u>Observations Conducted</u>:

- Observations at residences and day programs
- Incident Management Review Team Meeting 10/29/12 and 10/31/12
- ISPA regarding restraint for 10/29/12
- Oak Hill Morning Unit Meeting
- Annual IDT Meeting for Individual #465 and Individual #433

	o Human Rights Committee Meeting 10/31/12 o ISP preparation meeting for Individual #410 o Restraint Reduction Committee Meeting
	Facility Self-Assessment: LSSLC submitted its self-assessment. It was updated on 10/22/12. 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 gathered data from audits completed using the Section C audit tool developed by the state office to determine compliance with each provision. For C7, a sample of ISPAs addressing more than three restraints in a 30 day period was also reviewed. These activities were similar to the activities engaged in by the monitoring team to assess compliance. The facility self-assessment commented on the overall compliance rating for each provision item based on assessment findings, as well as commenting on processes in place to address compliance with each item. The facility self-assigned a rating of substantial compliance to C2 and C3. Findings from the facility self-assessment were the same as the findings of the monitoring team. Even so, there had been considerable progress made in developing an adequate self-assessment process.
	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 facility had reviewed the new policies and had begun implementing some of the requirements of the new policy, specifically, the new restraint checklists and monitoring guidelines. All requirements of the new policy had not yet been implemented, particularly in regards to protective mechanical restraints used for self-injurious behavior. Based on information provided by the facility, there were 213 restraints used for crisis intervention between 4/1/12 and 10/29/12 (seven months). This was a considerable increase compared to the 100 restraints for crisis intervention reported from 10/1/11 through 3/22/12 (six months). A new data collection system had been implemented by the facility in the last quarter. At least some of the increase may have been attributed to differences in the way data were being collected, though it was not possible to confirm this. There were still factors that were not adequately addressed that contributed to behavior leading to restraint at the facility. The facility needs to take a closer look at behavioral and restraint data collected and develop plans to address identified these factors, including: • Lack of individualized supports and treatment plans

	• Inadequate staffing patterns • Inadequately trained staff • Environmental issues. • Lack of attention to communication needs and supports. The facility had not yet begun to address protective mechanical restraints to comply with the new statewide restraint policy. Protective Mechanical Restraint Plans had not been developed for individuals who were wearing protective restraints due to self-injurious behaviors. There were 114 instances of dental/medical pretreatment sedation from 4/1/12 through 9/21/12. This was a decrease from the 130 reported during the last monitoring visit. Plans were not in place to reduce or eliminate the need for medical/dental restraints for all individuals who required pretreatment sedation for routine appointments. Overall, the facility had made very good progress towards meeting compliance with requirements for documenting and reviewing restraint incidents for crisis intervention. The facility was in substantial compliance with two of the eight provision items (C2, C3).

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C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable 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 facility provided a list of all restraints used for crisis intervention between 4/1/12 and 10/29/12: • 213 restraints occurred. • 21 individuals were the subject of restraints. • Three individuals accounted for 106 restraints (50%). • 206 were personal hold restraints, • Three were mechanical restraints (helmet and wristlets), and • Four were chemical restraints. This was an increase from the 100 crisis intervention restraints reported at the last monitoring visit. The facility had not begun to address protective mechanical restraints to comply with the new statewide restraint policy. Protective Mechanical Restraint Plans (PMRPs) had not yet been developed for individuals who were wearing protective mechanical restraints due to self-injurious behaviors. PMRPs will need to be developed to address level of supervision while in restraint, schedule of restraint use and release, application and maintenance of the restraint, and documentation. Further, the facility did not yet have an accurate listing of all individuals for whom a PMRP was needed.	Noncompliance

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		The monitoring team has expressed concern in the past regarding the monitoring of individuals wearing protective mechanical restraints. These issues remained unresolved. For example, it was noted during previous monitoring visits that Individual #192 was wearing a helmet to prevent self -injurious behavior. There was no plan in place to ensure time without her helmet on and monitoring of her skin integrity. A plan had been implemented for removal of her helmet every two hours, however, staff supporting her were not familiar with the plan and reported that she did not have a schedule for removing the helmet periodically. The facility needs to focus on protective mechanical restraints, including the development of strategies to reduce the amount of time in restraint, eliminate restraint when possible, and/or consider the use of the least restrictive restraint necessary. This includes looking at the use of gait belts, helmets, abdominal binders, and mittens. <u>Prone Restraint</u> Based on the state and 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 list provided by the facility of all restraints for the past six months, 0 (0%) showed use of prone restraint. 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 24 restraints for seven individuals, representing 11% of restraint records over the last six-month period and 33% of the individuals involved in restraints. The sample included 22 physical restraints and two chemical restraints. Three of the individuals in the sample had the greatest number of restraints. Four others represented some of the most recent restraints. The individuals in this sample were Individual #410, Individual #170, Individual #401, Individual #420, Individual #318, Individual #148, and Individual #176. • Individual #410 had 60 restraints. • Individual #170 had 28 restraints • Individual #401 had 18 restraints • These three individuals accounted for 50% of the 213 restraints for crisis intervention between 4/1/12 and 10/29/12. 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	

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		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. <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 22 restraints. The following are the results of this review: • In 24 of the 24 records (100%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. • In 15 of 24 (63%) restraints, staff documented events leading to the behavior that resulted in restraints. Exceptions included restraint checklists for: o Individual #410 dated 8/16/12 o Individual #170 dated 6/28/12, 9/2/12, and 9/10/12 (x3) o Individual #401 dated 7/25/12, 7/26/12, and 9/1/12. • Some examples where staff adequately described events leading to the behavior: o The restraint checklist for Individual #410 dated 9/12/12 noted he became upset when staff asked him to return a bike that he had stolen from another individual. o The restraint checklist for Individual #170 dated 9/2/12 indicated that he became aggressive towards staff when staff would not let him leave his home. o Staff documented that Individual #318 became physically aggressive on 9/7/12 when staff tried to get him to return to his home due to a quarantine for all individuals at his home. • Some examples where events leading to restraint were not adequately documented included: o The restraint checklist for Individual #170 did not describe events occurring that led to the restraint. Staff noted "aggression towards staff, flight from home."	

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		o The restraint checklist for Individual #401 dated 2/25/12 described his behavior prior to the restraint (fighting staff), but did not document what events led to the behavior. • In 23 of 24 records (96%), staff documented that restraint was used only after other interventions had been attempted. The exception was the restraint checklist for Individual #170 dated 9/23/12. State policies identified a list of approved restraints techniques. Based on the review of documentation for 24 restraints, 24 (100%) were documented as approved restraints techniques. <u>Dental/Medical Restraint</u> The facility reported 114 instances of dental/medical pretreatment sedation from 4/1/12 through 9/21/12. This was a decrease from the 130 reported during the last monitoring visit. A list of individuals with medical or dental desensitization plans was requested from the facility. The facility reported that there were 22 individuals with strategies to address dental/medical restraint and/or desensitization plans in place. The facility was not yet in compliance with provision C1. To do so: • The long-term use of protective mechanical restraints should be reviewed by the IDT as per the new state regulations and strategies should be developed to reduce the amount of time in restraint, and/or eliminate the restraint when possible. IDTs should consider the least restrictive type of restraint necessary to protect the individual from harm. • Include adequate documentation of events leading to the behavior resulting in restraint. • IDTs should focus on developing ISPs that support meaningful engagement throughout each individual's day. • The facility needs to examine systemic issues that result in behaviors leading to restraint including staffing patterns, staff training, environmental factors, and lack of individualized programming options. • The frequent use of medical and dental pretreatment sedation for routine care should be addressed with individualized strategies, including but not limited to formal desensitization plans.	

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C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The new statewide restraint policy required that any individual who is restrained as a result of a behavioral crisis must be released from restraint as soon as he or she no longer poses an imminent risk of physical harm to self or others. It further required that if a Crisis Intervention Plan is in place, the plan must describe the behaviors that signal there is no longer an imminent risk of physical harm to self or others. Crisis Intervention Plans (CIPs) had been developed to replace Safety Plans for Crisis Intervention and comply with requirements of the new policy. CIPs described behavioral indicators that would signal that the individual was no longer a danger to himself or others. CIPs developed in accordance with the new state policy were reviewed for Individual #410, Individual #401, and Individual #170. The new plans described what interventions to attempt prior to restraint, what behaviors would lead to restraint, and what behaviors indicated that the individual was no longer a risk of harm to himself or others. Instructions were presented in a clear, easy to follow format. The Sample #C.1 restraint documentation for 22 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. • 21 of 22 (95%) restraints reviewed indicated that the individual was released immediately when no longer a danger. The exception was the restraint for Individual #401 dated 7/26/12. Documentation indicated that the individual was released because staff could not maintain the proper hold. • The longest physical restraints in the sample were 15 minutes for Individual #410 on 9/12/12 and Individual #170 on 9/10/12. Five (21%) of the physical restraints in the sample lasted two minutes or less. The facility was in substantial compliance with C2	Substantial Compliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint	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 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 • 24 of 24 (100%) had current training in RES0105 Restraint Prevention and	Substantial Compliance

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	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.	Rules. • 17 of the 18 (94%) employees with current training who had been employed over one year completed the RES0105 refresher training within 12 months of the previous training. • 24 of 24 (100%) had completed PMAB training within the past 12 months. • 15 of the 18 (83%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. Training for all staff was not completed within the required timeframes based upon the sample of training records used to assess compliance. The facility should ensure that training is completed annually as required by state policy. Even so, given the high percentages, C3 remained in 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 24 restraint records (Sample #C.1), documentation in 24 (100%) indicated that restraint was used as a crisis intervention. Facility policy did not allow for the use of restraint for reasons other than crisis intervention, protection from self-injurious behaviors, or to complete medical/dental procedures. The facility reported 114 instances of dental/medical pretreatment sedation from 4/1/12 through 9/21/12. Twenty-two individuals had strategies to address desensitization. The facility had started a pilot program with one living unit to address oral healthcare needs and desensitization. Individuals were assessed by the psychology department and desensitization, support, and simulation plans were developed and implemented for individuals in the targeted unit. Treatments or strategies to reduce restraint use were not yet in place for all individuals who required the use of medical or dental restraints The facility had created a "Do Not Restrain" list. There were 66 individuals at the facility 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. As noted in C1, the facility had not begun to document or review the use protective mechanical restraints used for self- injurious behavior to comply with the new statewide restraint policy. A form to document the application of protective mechanical restraints had been developed in conjunction with the new policy. LSSLC had not implemented the new form. Protective Mechanical Restraint Plans had not been developed for individuals who were wearing protective restraints due to self-injurious behaviors. The facility	Noncompliance

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		should ensure that these protective restraints are documented, monitored, and reviewed. Teams should review all uses of protective mechanical restraints and document attempts at reducing the use of these restraints and ensuring that the least restrictive restraint necessary is being used. 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 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.	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 24 crisis intervention restraint records (Sample #C.1), a face-to-face assessment was conducted as follows: • In 24 out of 24 incidents of restraint (100%), there was assessment by a restraint monitor. The new restraint policy requires that the Face-to Face Assessment/Debriefing (FFAD) be used in all instances of restraint used for crisis intervention. The assessment began as soon as possible, but no later than 15 minutes from the start of the restraint in 22 (92%) out of 24 instances. The exceptions were: • The restraint monitor arrived 19 minutes after the initiation of a restraint for Individual #410 dated 8/30/12. • The restraint monitor arrived 25 minutes after the initiation of a restraint for Individual #410 dated 9/12/12. Based on a review of 22 physical and two 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 (for a minimum of two hours with the use of chemical restraint) in 19 (79%) of the instances of restraint. The exceptions were the following restraint checklists: o Individual #410 dated 8/6/12 (late x3) o Individual #170 dated 9/10/12 (noted refused, no time given x2) The facility remained out of compliance with this provision. Monitoring by a nurse should be conducted and documented as required by state policy.	Noncompliance

#	Provision	Assessment of Status	Compliance
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 24 Restraint Checklists for individuals in crisis restraint was selected for review for required elements in C6. The following compliance rates were identified for each of the required elements: • In 24 (100%), continuous one-to-one supervision was indicated as having been provided on the restraint checklist. • In 24 (100%), the date and time restraint was begun were indicated. • In 23 (96%), the location of the restraint was indicated. The exception was the restraint for Individual #170 dated 9/2/12. • In 15 of 24 (63%) restraints, staff documented events leading to the behavior that resulted in restraints (see C1). • In 24 (100%), the specific reasons for the use of the restraint were indicated. • In 24 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. • In 24 (100%), the names of staff who applied/administered the restraint was recorded. • In 23 (96%) of 24 observations of the individual and actions taken by staff while the individual was in restraint for physical restraints were recorded. The exception was the restraint for Individual #318. • In 22 (100%) of 22 physical restraint incidents, the date and time the individual was released from restraint were indicated. • In 23 (96%) of 24 restraints, the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects were recorded. The exception was for Individual #170 dated 9/2/12. • 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 15 minutes in duration. In a sample of 24 records (Sample C.1), FFADs had been completed for 24 (100%). These forms were generally complete in checking all the required boxes on the form, supplemented with appropriate narrative. The attention to detail required to complete this documentation accurately had improved since the last review. A sample of 10 individuals subject to medical restraint was reviewed, and in 10 (100%), there was evidence that the monitoring had been completed as required by the physician's order. A sample of two individuals who were the subject of a chemical restraint was reviewed, Individual #401 and Individual #318. In two (100%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional	Noncompliance

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		contacted the psychologist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. The facility had made significant progress in adequately documenting restraint incidents, however, remained out of compliance with the documentation requirements of C6. Events leading to the behavior resulting in restraint will need to be clearly documented to gain substantial compliance with C6.	
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 eight individuals were placed in restraint more than three times in a rolling 30-day period. This represented an increase from last two reviews when four and five individuals were placed in restraint more than three times in a rolling 30-day period. Four of these individuals (i.e., Individual #410, Individual #110, Individual #380, and Individual #401) were reviewed (50%) to determine if the requirements of the Settlement Agreement were met. PBSPs, crisis intervention plans, and individual support plan addendums (ISPAs) following more than three restraints in a rolling 30-day period for all four individuals were requested. There was no crisis intervention plan for Individual #380 (however, following the onsite review, the facility reported that a CIP was written on 8/28/12, but not submitted to the monitoring team). The results of this review are discussed below with regard to Sections C7a through C7g of the Settlement Agreement. This item was rated as being in noncompliance because the ISPAs did not consistently reflect a discussion of each individual's adaptive skills and biological, medical, and psychosocial factors and an action plan for modifying them to prevent the future probability of restraint. All four of the ISPA minutes reviewed reflected a discussion of the individuals' adaptive skills, biological/medical status, and psychosocial factors. Only one (Individual #110) of these (25%) discussions, however, reflected 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.	Noncompliance

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		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.	
	(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 #110) of the four ISPAs reviewed (25%) indicated that environmental conditions did not play a role in his restraints. The other three IPSAs identified potential contributing environmental conditions (e.g., a specific staff member not being on shift for Individual #401), 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. One of the ISPAs reviewed (i.e., Individual #110) indicated that the team identified no antecedents to restraint. The other three ISPAs reviewed identified potential antecedents, but no further discussion or no action to attempt to eliminate or reduce antecedents to dangerous behavior was evident in the ISPA minutes. In order to achieve compliance with this provision item, ISPA minutes need to reflect a discussion of the effects of these types of variables on the individual's restraint, and (if they are hypothesized to affect restraints) a discussion of an action plan to eliminate these antecedents or reduce their effects on the dangerous behavior that provokes restraint.	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 four of the ISPAs reviewed included a discussion indicating variables potentially maintaining the dangerous behavior that provokes restraint. For example Individual #110's ISPA hypothesized that his physical aggression was more likely to occur when he did not get his way. None of the ISPAs, however,	Noncompliance

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		reflected a discussion of potential action to address these hypothesized variables maintaining the individual's dangerous behavior that provokes restraint (e.g., provide alternative ways to get his way, teach him to better tolerate not getting his way). In order to achieve compliance with this provision item, the ISPA should reflect a discussion of the variables maintaining the dangerous behavior (e.g., staff attention) that provokes restraint. The ISPA minutes should also reflect an action (e.g., increase staff attention for appropriate behaviors) to address this potential source of motivation for the target behavior that provokes restraint. In the last review and report, this item was rated in substantial compliance. This was because all of the ISPAs at that time indicated that the IDT reviewed, but could not identify, any variables that likely maintained the behavior that provoked restraint. This time, however, for all four ISPAs, the IDTs identified variables potentially maintaining the behavior provoking restraint, but there was no plan in any of the ISPAs for how to address what was potentially reinforcing (i.e., maintaining) the dangerous behavior that provoked restraint, so a rating of noncompliance was given.	
	(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 four individuals reviewed (100%) had PBSPs to address the behaviors provoking restraint. The following was found: • Four (100%) were based on the individual's strengths, • Four (100%) of the PBSPs specified the objectively defined behavior to be treated that led to the use of the restraint, • Three of four (75%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint (Individual #110 was the exception), and • Four (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. Four of the four PBSPs (100%) included interventions to weaken or reduce the behaviors that provoked restraint, that were determined to be adequate (see K9). Crisis Intervention Plans were available for three of the four individuals (75%) reviewed (Individual #380 was the exception). • In all three of the Crisis Intervention Plans (100%), the type of restraint authorized was delineated, • In two of the three crisis intervention plans (66%), the maximum duration of restraint authorized was not specified (Individual #110 was the exception), • In all (100%) Crisis Intervention Plans, the designated approved restraint situation was specified, and	Noncompliance

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		• In all (100%) Crisis Intervention Plans, the criteria for terminating the use of the restraint were specified.	
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	For none of the individuals reviewed (0%) were integrity data available 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
	(g) as necessary, assess and revise the PBSP.	There was no evidence that the PBSPs for any of the individuals reviewed included a discussion of the effectiveness of the current PBSP (including possible modification when necessary) to decrease the future probability of requiring restraint. In order to achieve substantial compliance with this provision item, all individuals who were placed in restraint more than three times in a rolling 30-day period, should have evidence of a review, and revision when necessary, of the adequacy of the PBSP.	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 policy, the review of each incident of restraint began with a FFAD completed by a restraint monitor immediately following the restraint. The restraint was then reviewed at the daily Unit Meeting and the daily Incident Management Team meeting, within three business days. Additionally, the restraint was reviewed by the psychologist. During the onsite monitoring visit, Incident Management Team meetings were observed and, during this timeframe, discussion of restraint was evident on the day after the episode. A summary of the restraint episode was presented at the meeting and preliminary recommendations were made and referred to the IDTs for follow-up. For the 24 restraints in sample C1, • 22 of 24 (86%) were reviewed immediately by a restraint monitor (see C5). • 24 of 24 (100%) were signed by the unit director indicating review within three days. • 23 of 24 (96%) were signed by the IMT designee indicating review within three days. The exception was the restraint for Individual #176. • Two of two (100%) chemical restraints were reviewed by the psychologist within three days. The new statewide policy now required a review by the psychiatrist, as well. One had been reviewed by the psychiatrist a week after the restraint occurred.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The facility should ensure that the use of mechanical protective restraints are documented, monitored, and reviewed in accordance with the new state policy. Teams should review all uses of protective mechanical restraints and document attempts at reducing the use of these restraints and ensuring that the least restrictive restraint necessary is being used. The Restraint Review Committee (RRC) met regularly and reviewed restraint trends. The monitoring team observed an RRC meeting while onsite. Committee members analyzed data presented and discussed possible action to reduce any trends identified. Although there had been progress made in terms of ensuring that restraint reviews were documented, the facility was not yet in substantial compliance with this provision item. ISPs should document discussion regarding the use of protective mechanical restraints for self-injurious behavior to include a schedule for monitoring, release, and reduction or elimination when considered clinically justifiable.	

Recommendations:

1. Address trends that contributed to behavior leading to restraint at the facility (C1).
2. The long-term use of protective mechanical restraints should be reviewed by the IDT as per the new state regulations and strategies should be developed to reduce the amount of time in restraint, and/or eliminate the restraint when necessary. IDTs should consider the least restrictive type of restraint necessary to protect the individual from harm (C1, C2, C4, C8).
3. Ensure all staff receive training annually on the use of restraint and positive behavioral interventions (C3).
4. Develop treatments or strategies to reduce restraint use for all individuals who required the use of medical or dental restraints (C4).
5. Monitoring by a nurse should be conducted and documented as required by state policy (C5).
6. All restraints should be documented consistent with Appendix A (C6).
7. Each individual's ISPA meeting minutes following more than three restraints in 30 days 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) (C7).

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 Preventing Abuse, Neglect, Exploitation training curriculum dated April 2012 o Information used to educate individuals/LARs 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 Training transcripts for 24 randomly selected employees o Acknowledgement to report abuse for 24 randomly selected employees o Training and background checks for the last three employees hired o Training transcripts for DFPS investigators assigned to complete investigations at LSSLC (7) o Training transcripts for facility investigators o Abuse/Neglect/Exploitation Trend Reports FY12 o Injury Trend Reports FY12 o List of incidents for which the reporter was known to be the individual or their LAR 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 (0) o A sample of acknowledgement to self report criminal activity for 24 current employees o ISPs for: • Individual #401, Individual #288, Individual #245, Individual #310, Individual #43, and Individual #192 o ISPs, ISPAs, QDDP quarterly reviews, Risk Assessments, and Risk Action Plans for Individual #119, Individual #238, and Individual #542. o Injury reports for three most recent incidents of peer-to-peer aggression incidents o ISP, PBSP, and ISPA related to the last three incidents of peer-to-peer aggression o List of all serious injuries for the past six months o List of all injuries for the past six months o List of all ANE allegations since 4/1/12 including case disposition o List of all investigations completed by the facility since 4/1/12 o List of employees reassigned due to ANE allegations o Documentation of employee disciplinary action taken with regards to the last three incidents of

confirmed abuse or neglect.

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

Sample D.1	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#42371722	Neglect	Confirmed	7/11/12 7:50 am	7/11/12 2:45 pm	7/31/12
#42397007	Emotional/Verbal Abuse (2)	Inconclusive (1) Confirmed (1)	7/30/12 12:09 am	8/1/12 12:15 pm	8/8/12
#42404529	Physical Abuse	Inconclusive	8/4/12 2:32 am	8/4/12 7:10 pm	8/27/12
#42416832	Physical Abuse	Inconclusive	8/12/12 9:02 pm	8/16/12 1:45 pm	8/30/12
#42427558	Physical Abuse	Inconclusive	8/20/12 1:22 pm	8/20/12 2:15 pm	8/30/12
#42429659	Emotional/Verbal Abuse Physical Abuse	Unconfirmed Unconfirmed	8/21/12 4:26 am	8/23/12 11:20 am	8/29/12
#42435803	Neglect	Unconfirmed	8/23/12 7:10 pm	8/24/12 5:34 pm	9/12/12
#42438999	Neglect	Confirmed	8/25/12 2:14 am	8/27/12 2:00 pm	9/2/12
#42442698	Physical Abuse	Unconfirmed	8/29/12 9:49 am	8/31/12 10:30 am	9/7/12
#42452059	Neglect Physical Abuse	Confirmed Confirmed	9/5/12 8:31 am	9/7/12 5:30 pm	9/13/12
#42453725	Emotional Verbal Abuse	Unconfirmed	9/6/12 8:46 pm	9/7/12 3:55 pm	9/14/12
#42455886	Neglect (2)	Unconfirmed (2)	9/8/12 2:16 pm	9/11/12 1:55 pm	9/18/12
Sample D.2	**Type of Incident**	**DFPS Disposition**	**Date of DFPS Referral**	**DFPS Completed Investigation**	**Facility Completed Investigation**
#42371005	Neglect	Referred Back – Clinical Issue	7/10/12	7/10/12	7/11/12

Sample D.3	Type of Incident	Date/Time of Incident Reported	Director Notification		
#12-117	Serious Injury	4/1/12 4:30 pm	4/2/12 1:40 am		
#12-123	Sexual Incident	4/14/12 6:43 pm	4/14/12 8:30 pm		
#12-136	Death	4/27/12 8:20 am	4/27/12 8:40 am		
#12-181	Death	7/3/12 11:02 pm	7/3/12 9:50 pm		
#12-201	Serious Injury	8/9/12 9:40 AM	8/9/12 10:20 am		
#13-6	Serious Injury	9/13/12 7:00 am	9/13/12 8:05 am		
#13-7	Serious Injury	9/13/12 2:15 pm	9/14/12 11:05 am		

Interviews and Meetings Held:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs
- Mike Ramsey, Incident Management Coordinator
- Melissa Latham, Facility Investigator
- Sylvia Middlebrook, Director of Psychology
- Luz Carver, QDDP Coordinator
- Steven Webb, Human Rights Officer

Observations Conducted:

- Observations at residences and day programs
- Incident Management Review Team Meeting 10/29/12 and 10/31/12
- ISPA regarding restraint for 10/29/12
- Oakhill Morning Unit Meeting
- Annual IDT Meeting for Individual #465 and Individual #433
- Human Rights Committee Meeting 10/31/12
- ISP preparation meeting for Individual #410
- Restraint Reduction Committee Meeting

	Facility Self-Assessment: LSSLC submitted its self-assessment. Along with the self-assessment, the facility had two others documents that addressed progress towards meeting requirements of the Settlement Agreement. One listed all of the action plans for each provision of the Settlement Agreement and one 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 similar activities implemented by the monitoring team to assess compliance. For example, for D1, the facility reviewed the facility policy on abuse, neglect, and exploitations; reviewed staff training records; monitored residential and day sites for placement of posters regarding reporting requirements and rights; and reviewed a sample of staff acknowledgement forms to report suspected abuse and neglect. The facility was using the statewide section D audit tool, supplemented by additional activities for each provision item. The facility's review of its own performance found compliance with 17 of 22 provisions of section D. The monitoring team also found the facility to be in substantial compliance with 18 of the 22 provision items. Both the facility and the monitoring team did not find compliance with the requirements D2a, D2i, D3i, and D4. The facility self-assessment indicated that compliance had not been met with the requirement for timely investigations (D3e). Substantial compliance, however, was met for the sample reviewed by the monitoring team. It appeared that although extensions were requested in 25% of the cases in the sample, requests were reasonable, and investigation activities were not unreasonably delayed. Trend reports should be used to analyze whether or not compliance with section D requirements has an impact on the number of incidents and injuries at the facility. Ultimately, a reduction in these numbers should be a result of improvements in the incident management system.
	Summary of Monitor's Assessment: According to a list provided by LSSLC, DFPS conducted investigations of 77 allegations at the facility since April 2012, involving 34 allegations of physical abuse, 14 allegations of verbal/emotional abuse, two allegations of exploitation, and 27 allegations of neglect. Of the 77 allegations, there were eight confirmed cases of physical abuse, two confirmed cases of verbal/emotional abuse, and seven confirmed cases of neglect. An additional 46 other serious incidents were investigated by the facility. There were a total of 1865 injuries reported between 4/1/12 and 9/3/12. These 1865 injuries included 13 serious injuries resulting in fractures or sutures. As noted in the previous monitor's report, the facility was not adequately addressing injuries and trends of injuries. Many of the serious injuries were preceded by similar incidents, not adequately addressed. The facility needs to aggressively address trends in injuries

	and implement protections to reduce these incidents and injuries. The facility had made progress in addressing compliance with section D, but more importantly, had made little progress in addressing factors contributing to the large number of incidents and injuries at the facility. Recommendations resulting from investigations, incidents, and injuries should include a focus on systemic issues that are identified and action steps should be developed to address those issues. According to data gathered by the facility, some systemic issues that contributed to a large number of incidents and injuries at LSSLC included: • Behavioral issues, • Staffing patterns, • Lack of adequate supervision, • Failure to carry out support plans as written, • Failure to revise supports when supports are not effective for preventing incidents, and • Lack of adequate individualized planning and supports.

#	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. The criterion for substantial compliance for this provision is the presence and dissemination of appropriate state and facility policies. Implementation of these policies on a day to day basis is monitored throughout the remaining items of section D of this report.	Substantial Compliance
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		

#	Provision	Assessment of Status	Compliance
	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 • 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, investigations of 77 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility between 4/1/12 and 9/30/12. From these 77 allegations, there were: • 34 allegations of physical abuse, • 14 allegations of verbal/emotional abuse, • 27 allegations of neglect, and • 2 allegations of exploitation. • 17 allegations were confirmed, including eight physical abuse allegations, two emotional/verbal abuse allegations and seven neglect allegations. • 36 allegations were unconfirmed, and • 13 allegations were found inconclusive. There was not enough evidence to determine an outcome. • Additional outcomes were pending for 1	Noncompliance

#	Provision	Assessment of Status	Compliance
		The facility reported that there were 46 other investigations of serious incidents not involving abuse, neglect, or exploitation between 4/1/12 and 9/30/12. This included: • 12 serious injuries/determined cause • 1 serious injuries/peer-to-peer aggression, • 1 serious injuries/undetermined cause, • 2 deaths, • 3 sexual incidents, • 4 unauthorized departures, • 5 suicide threats, • 2 encounters with law enforcement, and • 16 other unclassified serious incidents. From all investigations since 4/1/12 reported by the facility, 20 investigations were selected for review. The 20 comprised three samples of investigations: • Sample #D.1 included a sample of DFPS investigations of abuse, neglect, and/or exploitation. See the list of documents reviewed for investigations included in this sample (12 cases). • Sample #D.2 included a facility investigation that had been referred to the facility by DFPS for further investigation (1 case). • Sample #D.3 included investigations the facility completed related to serious incidents not reportable to DFPS (7 cases). Based on a review of the 12 investigative reports included in Sample #D.1: • 10 of 12 reports in the sample (83%) indicated that DFPS was notified within one hour of the incident or discovery of the incident. DFPS case #42427558 was not reported until the day after the incident occurred. The employee reporter was retrained in reporting procedures. DFPS case #42438999 was not immediately reported. It was unclear when the neglect was discovered. • 12 of 12 (100%) indicated the facility director or designee was notified within one hour by DFPS. • 12 of 12 (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. • 12 of 12 (100%) documented that the state office was notified as required. In reviewing Sample D.3 (serious incidents), documentation indicated: • Five of seven (71%) were reported immediately (within one hour) to the facility director/designee. In UIR #12-117, the physician's orders indicated that Individual #574 returned to the facility at 11:00 pm with sutures to close a laceration to his head. The director was notified at 1:40 am. UIR #13-7 noted that the director was not notified until the following day when Individual #542	

#	Provision	Assessment of Status	Compliance
		sustained a serious injury. The IMC recommended retraining on reporting incidents for the nursing staff in the infirmary. • Documentation of state office notification, as required by state policy, was found in seven of seven (100%) UIRs. 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 that contained information about notifications was included in: • 12 out of 12 (100%) investigation files in Sample #D.1. • 8 of 8 (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 a random sample of 24 employees at the facility. All employees (100%) in the sample had signed this form. The facility was not yet in substantial compliance with the requirements of D2a. The facility needs to ensure DFPS (when appropriate) and the facility director are notified immediately when an unusual incident occurs.	
	(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 12 investigation reports included in Sample D.1, in 12 out of 12 cases (100%) where an alleged perpetrator (AP) was known, it was documented that the AP was placed in no contact status. The monitoring team was provided with a log of employees who had been reassigned since 4/1/12. The log included the applicable investigation case number and the date the employee was returned to work. All allegations were discussed in the daily IMRT meeting and protections were reviewed. In 12 out of 12 cases (100%), there was no evidence that the employee was returned to his or her previous position prior to the completion of the investigation or when the employee posed no risk to individuals.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The DADS UIR included a section for documenting immediate corrective action taken by the facility. Based on a review of the 12 investigation files in Sample D.1, 12 (100%) UIRs documented additional protections implemented following the incident. This typically consisted of placing the AP in a position of no client contact, an emotional assessment, a head-to-toe assessment by a nurse, and medical care when applicable. The facility was in substantial compliance with this provision.	
	(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 seven employees hired within the past year. • 24 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 17 (100%) of 17 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 (100%) of the 17 employees (employed over one year) with current training completed this training within 12 months of the date of previous training. Based on interviews with six direct support staff in various homes and day programs: • Five (83%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. One DSP stated that she would remove the person from harm and notify her supervisor. The facility was in substantial compliance with this provision.	Substantial Compliance
	(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	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 after completing ABU0100 training. A sample of this form was reviewed for a random sample of 24 employees at the facility. All employees (100%) in the sample had a current signed acknowledgement form. A review of training curriculum provided to all employees at orientation and annually	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	thereafter emphasized the employee's responsibility to report abuse, neglect, and exploitation. In one case in sample D1, an employee failed to report abuse, neglect, or exploitation within one hour. The employee was required to complete a refresher course in reporting requirements. The monitoring team assigned a substantial compliance rating to this provision.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	A review was conducted of the materials to be used to educate individuals, legally authorized representatives (LARs), or others significantly involved in the individual's life. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. It was a clear and easy to read guide to recognizing signs of abuse and neglect and included information on how to report suspected abuse and neglect. A sample of six ISPs developed after 4/1/12 was reviewed for compliance with this provision. The sample ISPs were for Individual #401, Individual #288, Individual #245, Individual #310, Individual #43, and Individual #192. • Six (100%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings. The new ISP format included a review of all incidents and allegations along with a summary of that review. This should be useful to teams in identifying trends and developing individual specific strategies to protect individuals from harm. In informal interviews with individuals during the review week, most individuals questioned were able to describe what they would do if someone abused them or they had a problem with staff. Individuals typically named a staff member that they were comfortable telling they had a problem. The facility was in substantial compliance with this item.	Substantial Compliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		showed that all of those reviewed, except one residential site, had postings of individuals' rights in an area to which individuals regularly had access. The facility safety officer reported that monthly rounds were made of each residential and day site to ensure ANE information and rights posters were in place in all buildings. There was a human rights officer at the facility. Information was posted around campus identifying the human rights officer with his name, picture, and contact information. The facility remained in substantial compliance with this provision item.	
	(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 12 allegation investigations completed by DFPS (Sample #D.1), DFPS notified law enforcement and OIG of the allegation in all (100%), as appropriate. OIG investigated eight cases in the sample and substantiated criminal activity in three cases (DFPS #42416832, DFPS #42427558, and DFPS #42452059). The allegations involving the AP were substantiated by OIG in two cases. In the third case, OIG substantiated criminal activity against an employee for false reporting, but not against the AP. The facility remained in substantial compliance with this provision item.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	The following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: • LSSLC Policy addressed this mandate 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. • 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 one case where fear of retaliation was reported. OIG investigated the case and found no evidence of retaliation. Based on a review of investigation records (Sample #D.1), there were no other concerns noted related to potential retaliation for reporting.	Substantial Compliance

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		The facility rated itself in substantial compliance with this item. The monitoring team agreed with that assessment.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Staff were required to notify the facility director and DFPS of injuries of unknown origin where probable cause cannot be determined and to DADS Regulatory if the injury was deemed serious. The facility: • Reviewed all injuries at the morning unit meetings and again at the daily IMRT meetings. • Quarterly data reports were used to identify trends in injuries. Sample #D3 included investigations completed on a sample of four serious injuries. All four investigations were completed by the facility. The facility reported that it did not yet have a formal system in place to ensure that all significant injuries are reported for investigation. Based on observations and the sample of documentation reviewed, the facility's audit system was not yet adequate for ensuring that injuries or trends of injuries were reported for investigation. The facility was not yet in substantial compliance with this provision item.	Noncompliance
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		

#	Provision	Assessment of Status	Compliance
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	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. The training records for DFPS investigators were reviewed 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 13 employees designated to complete investigations. All facility investigators were fully trained. 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 remained in substantial compliance with this item.	Substantial Compliance
	(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 staff did not cooperate with any outside agency conducting investigations.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect, and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS, the following was found: • Of the 12 investigations completed by DFPS (Sample #D.1), eight had been reported to law enforcement agencies. OIG investigated all eight of the incidents. In the investigations completed by both OIG and DFPS, it appeared	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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 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.	<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 with the alleged victim occurred within 24 hours in six of 12 (50%) investigations. It did not appear that a delay in contact with the alleged victim impacted the outcome of any of the cases in the sample. o Twelve (100%) investigations indicated that some type of investigative activity took place within the first 24 hours. This included gathering documentary evidence and making initial contact with the facility. • Eight of 12 (75%) were completed within 10 calendar days of the incident. Extensions were filed in three of three cases (100%) that were not completed within 10 calendar days. The lengthiest investigation in the sample was DFPS #42404529, which was completed in 23 days. A physical abuse allegation was inconclusive. Although the investigation noted that an extension had been filed on the 10th day, the extension was not included in the investigation packet, so reason for the extension was unknown to the monitoring team. • The facility incident management team continued to work closely with DFPS to facilitate timely completion of investigations. • All 12 (100%) resulted in a written report that included a summary of the	Substantial Compliance

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		investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below in section D3f. • In nine of the 13 (69%) DFPS investigations reviewed in Sample #D.1 and #D.2, concerns or recommendations for corrective action were included. One of those cases resulted in a referral 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: • The investigation began within 24 hours in seven of seven cases (100%). • Five of seven (71%) indicated that the investigator completed a report within 10 days of notification of the incident. Extensions were filed for UIR #12-136 and UIR #13-6. The extension filed for UIR #13-6, indicated that additional time was needed due to an unexpected leave for the facility investigator. It was not clear why another investigator did not complete the investigation in his absence. • All included recommendations for corrective action. Investigations commenced and were concluded in a timely manner.	
	(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	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 12 (100%), each serious incident or allegations of wrongdoing; o In 12 (100%), the name(s) of all witnesses; o In 12 (100%), the name(s) of all alleged victims and perpetrators (when known); o In 12 (100%), the names of all persons interviewed during the investigation; o In 12 (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;	Substantial Compliance

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	summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	o In 12 (100%), all documents reviewed during the investigation; o Facility UIRs included a review of all previous investigations involving the alleged victim. o In 12 (100%), the investigator's findings; and o In 12 (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of seven facility investigations included in sample #D.3 • The report utilized a standardized format that set forth explicitly and separately, the following: o In seven (100%), each serious incident or allegations of wrongdoing; o In seven (100%), the name(s) of all witnesses; o In seven (100%), the name(s) of all alleged victims and perpetrators when known; o In seven (100%), the names of all persons interviewed during the investigation; o In seven (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 seven (100%), all documents reviewed during the investigation; o In seven (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim known to the investigating agency. o In seven (100%), the investigator's findings; and o In seven (100%), the investigator's reasons for his/her conclusions. The facility was in substantial compliance with this item.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	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 12 DFPS investigations included in Sample #D.1: • In 12 (100%) investigative files reviewed from Sample #D.1, there was evidence that the DFPS investigator's supervisor had reviewed and approved the investigation report prior to submission.	Substantial Compliance

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		UIRs included a review/approval section to be signed by the Incident Management Coordinator (IMC) and director of facility. For UIRs completed for Sample #D.1, • 12 (100%) DFPS investigations were reviewed by both the facility director and IMC following completion. • 12 of 12 (100%) were reviewed by the facility director and/or the Incident Management Coordinator within five working days of receipt of the completed investigation. • In two investigations in the sample, OIG substantiated criminal activity while DFPS found evidence to be inconclusive. The facility requested further review by DFPS in both cases. 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. Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility. <u>Facility Investigations</u> • In seven of seven (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 within five working days of completion. • Seven of seven UIRs included recommendation for follow-up. o Adequate documentation of follow-up to serious incidents, however, was not found. Investigation files included ISPAs indicating that the team had met and made additional recommendations in most cases, but did not follow-up to ensure recommendations were adequate and/or implemented. See D3i for additional comments.	
	(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 20 out of 20 (100%) unusual incidents in the sample. A 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	Documentation was reviewed to show what follow-up had been completed to address the recommendations resulting from investigations in the sample. Four of 12 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 four of four cases where allegations were confirmed.	Noncompliance

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	promptly and thoroughly, and track and document such actions and the corresponding outcomes.	DFPS noted concerns or made recommendations in seven (58%) of the cases in sample #D.1. The facility maintained documentation of follow-up action taken to address concerns and recommendations. • Documentation of follow-up to all DFPS concerns was found in five (71%) of the investigation files in the sample. • In DFPS #4245886, the investigator expressed concern regarding inadequate staffing during the 6:00 am – 2:30 pm shift on home 559B. The facility director noted on the investigation review form that the facility investigator was to further investigate to determine if staff were working short and to report findings to the IMC. There was no documentation showing that the matter was further investigated by the facility. • DFPS expressed concern regarding staff transferring and individual in DFPS #42404529. The facility UIR indicated that Habilitation Therapy would provide training to staff. There was no evidence that the training had been completed. Sample #D.2 included an investigation (DFPS #42371005) that was referred back to the facility for further review as a clinical issue. The UIR noted that the case would be referred to the Nursing Department. No other concerns or recommendations were noted and no further follow-up action was recommended. There was documentation that the nurse involved resigned her position. Recommendations for programmatic actions were made in six of seven cases reviewed for facility investigations in Sample #D.3. The facility was not sufficiently following up on incidents to ensure that adequate protections were in place and remained in place. A number of serious injuries occurred following a string of similar incidents. For example, • Individual #119 fell on 11/1/12 sustaining a serious head injury when he attempted to leave the bathroom without supervision. His PNMP indicated that he should receive "stand by assistance with gait belt." Staff had left him in the bathroom alone while going to get him a change of clothing. He had four other falls during the previous quarter, two others resulted in serious injury including fractured ribs and a head injury. All occurred during similar incidents in the bathroom. His risk action plan had not been updated over the past quarter. His PNMP was updated on 10/14/12, but did not include any special instructions for toileting. The language regarding supports during transfers and mobility was not sufficient to clearly direct staff in providing support. DSPs, including the home manager, questioned following the incident were unable to describe supports needed to ensure safe mobility.	

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		• Individual #238 fell on 8/9/12 sustaining a serious head injury. He had 12 other injuries related to falls over the past year (three resulted in serious injuries). His profile sheet did not include any instructions for staff related to mobility other than a note stating "when traveling off the home, staff should remain close enough to ensure he does not walk through an ant bed." After a series of falls in March 2012, the team agreed to an "assessment in shoe clinic" and retraining staff to provide verbal prompts to him when walking. The quarterly review stated that, "his falls would be discussed more in-depth during the next quarterly review." His risk action plan was last updated 1/15/12. The investigator determined that the most recent incident occurred because he was wearing another individual's shoe that was too large. An orthotic evaluation was recommended and a helmet was ordered until new shoes were obtained. No additional staff supports were put into place. While a helmet could possibly prevent other head injuries, there were no other immediate supports put into place to minimize his risk of further falls and injuries (i.e., fractures). Outcome of recommendations was not tracked by the incident management department. • Individual #542 sustained a serious head injury requiring eight staples on 9/13/12 when he fell. He had 12 previous falls reported during the past year with one other serious head injury on 5/10/12. The UIR stated that the IDT met and recommended a habilitation therapy assessment following the incident. An ISPA dated 9/14/12 documented that the team met and requested the evaluation, but also noted that the team would reconvene to review recommendations following the assessment. There was no documentation that the assessment was completed, the team reconvened, or that additional protections had been put into place. His risk assessment was not reviewed following the incident. The facility was not yet following up on all recommendations, documenting all follow-up action, and monitoring outcomes of the action. See D4 for additional comments regarding follow-up on trends identified in regards to incidents at the facility. The facility was not in substantial compliance with this item.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	Files requested during the monitoring visit were readily available for review at the time of request. With regard to DFPS, DFPS investigations were provided by the facility and available as requested by the monitoring team.	Substantial Compliance

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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. The facility had initiated a new process of compiling data on a quarterly basis for allegations of abuse, neglect, mistreatment, and other unusual incidents and injuries. Trends were reviewed in QAQI Council meetings. Observation QAQI Council meeting confirmed that data regarding unusual incident trends were being presented at meetings, however, it was not apparent that presentation of data led to action to resolve issues. The committee held some discussion regarding putting protections in place to address the high number of scratches occurring which was the leading cause of injuries at the facility. The second greatest cause of injuries was slips, trips, and falls. Falls lead to the greatest number of serious injuries at the facility, however, the committee failed to address fall trends. The facility needs to address trends that have the potential for serious consequences (e.g., slips, trips, and falls versus minor scratches). The monitoring team rated D4 as being in substantial compliance in the last report since follow-up to trends and investigations was commented on in section D1. As noted in D1, the monitoring team is now commenting on policy rather than implementation in D1 and rating D4 in regards to implementation. The facility had made very little progress in addressing incident trends at the facility. Trend reports were up-to-date and included an analysis of the data gathered by the facility. Recommendations for action to address trends were not included in the trend reports. There was no evidence that the facility had developed a plan of correction to address systemic issues identified in trend reports. 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 data and frequently evaluate how data can best be used to evaluate progress and take action to reduce the significant number of incidents and injuries. The monitoring team expects to see the incident management department take a role in the facility's overall approach to addressing the frequency of occurrence of unusual incidents and injuries at LSSLC. They should help to determine and address factors that contributed to incidents and injuries at the facility.	Noncompliance

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D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: • Criminal background check through the Texas Department of Public Safety (for Texas offenses) • An FBI fingerprint check (for offenses outside of Texas) • Employee Misconduct Registry check • Nurse Aide Registry Check • Client Abuse and Neglect Reporting System • Drug Testing Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position, also had to undergo these background checks. In concert with the DADS state office, the facility 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 FY12, criminal background checks were submitted for all applicants. There were no 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 24 of 24 employees (100%). The facility remained in substantial compliance with this provision item. The facility needs to ensure that all employees have a signed acknowledgement to self- report	Substantial Compliance

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		criminal activities.	

Recommendations:

1. The facility needs to ensure DFPS (when appropriate) and the facility director are notified immediately when an unusual incident occurs (D2a).

2. The facility needs to develop an audit system that will identify problems that need to be addressed by the facility in reporting injuries for investigation (D2i).

3. Recommendations resulting from investigations, incidents, and injuries should include a focus on systemic issues that are identified and action steps should be developed to address those issues. Documentation of adequate protections implemented to reduce the likelihood of similar incidents occurring should be included in investigation files (D3g).

4. 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 (D3i).

5. 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 are accurate and how data can best be used to evaluate that progress (D4).

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS policy #003.1: Quality Enhancement, new policy revision, dated 1/26/12 o LSSLC facility-specific policies: • Quality Assurance, Adm-14, 10/15/12 • QAQI Council, C&C-02, 10/15/12 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, revised draft July 2012 o LSSLC organizational chart, 10/9/12 o LSSLC policy lists, October 2012 o List of typical meetings that occurred at LSSLC, undated, likely October 2012 o LSSLC Self-Assessment, 10/22/12 o LSSLC Action Plans, 10/17/12 o LSSLC Provision Action Information, most recent entries 10/19/12 o LSSLC Quality Assurance Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 10/29/12 o LSSLC DADS regulatory review reports, 8/23/12 through 9/25/12, no annual survey o QA department organizational charts, undated o List of all QA department staff and their assigned responsibilities, 10/1/12 o LSSLC QA department meeting notes, monthly, 9/5/12 through 10/31/12 (3 meetings) o Book club information, documents, and presentation materials o LSSLC data listing/inventory, hard copy, after 9/27/12 o LSSLC QA plan narrative, October 2012 o LSSLC QA plan matrix, 1/25/12 o Set of blank tools used by QA department staff • Statewide self monitoring tools, and those modified by LSSLC • Tools developed in response to DADS ICF regulatory reviews o Trend analysis report, for full three years, September 2009 through October 2012, all four components o Various packets of data and/or reports • Death information • Psychiatry peer review example (one) o LSSLC QA Reports, June 2012 (one) o QAQI Council minutes, 5/30/12 to 10/30/12, including meeting attended by monitoring team (11 meetings o LSSLC Corrective Action Plan, tracking, 5 pages, 10/23/12 o Work group reports/information: PIT (1), KPI (6), and other (1)

	o DADS SSLC family satisfaction survey online summary, 5/12 through 9/12, 61 respondents o Staff employee survey (within QAQI Council minutes) o Blank, new community partner survey o List of self-advocacy leadership 2012 o Self-advocacy monthly meeting minutes/notes, monthly May 2012 to September 2012, 3 meetings o Self-advocacy meeting handouts for meeting 11/1/12 o Home meeting agenda and notes, (none) o Facility newsletters, Pine Bark, Summer 2012, Winter 2012 <u>Interviews and Meetings Held</u>: o Paula McHenry, Director of Quality Assurance o Sherry Roark, Settlement Agreement Coordinator o QA staff: Elizabeth Carnley, Robert Cheshire, Shela Gibson, Paul Vann, Melinda Morgan o Gale Wasson, Facility Director o Residential Director and Unit Directors: Keith Bailey, Rotley Tankersley, Kenneth Self, Todd Miller, Mary Stovall o Stephen Webb, Human Rights Officer <u>Observations Conducted</u>: o QAQI Council meeting, 10/30/12 o QA staff meeting, 10/31/12 o Self-advocacy meeting, 11/1/12 o Death review data review, 10/30/12
	Facility Self-Assessment The QA director improved upon the previous self-assessment by including additional activities and outcomes. Further, she took steps to include in her self-assessment many of the processes and outcomes that the monitoring team looks at and includes in the monitoring report. For example, in E1, she self-assessed and commented upon the data listing inventory, QA plan narrative and matrix, and monitoring tools. In E2, she self-assessed and commented upon the QA report, and the way that the facility reviewed and acted upon data. In E2 through E5, she self-assessed and commented upon the corrective action plan process. Overall, this was an excellent first step towards an adequate self-assessment for section E. The QA director's comments in the Results of the self-assessment sections were thoughtful and informative. As the facility and state office work towards a somewhat standardized self-assessment tool that is based upon the content and topics of the monitoring team's report, it is likely that the self-assessment will become a very good indicator of the status of each of the provision items of section E. The QA director should ensure, however, that her self-assessment does not merely assess the presence of

	the required item or activity, but that it also looks at the quality of those items and activities. The action plans for section E also looked reasonable. They will need to be updated based upon the content of this monitoring report as well as the discussions the monitoring team had with the QA director while onsite. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts of the QA director and believes that the facility was continuing to proceed in the right direction. The facility self-rated itself as being in noncompliance with all five provision items of section E. The monitoring team agreed with these self-ratings.
	Summary of Monitor's Assessment: Some progress was made in section E. Since the last onsite review, a new QA director was appointed. Further, all QA department staff were all new (except for one program monitors). The new QA director included professional development content for her staff and established (with the support and participation of the facility director) a quality assurance book club that met monthly. The unit directors appeared to be engaging in a variety of QA-related activities. This should continue to be fostered. The QA data list inventory was updated since the last review. A workgroup was going to be formed to get to a finalized, complete version by the time of the next onsite review. The QA plan narrative had 11 sections and was nine pages long. Although a good first attempt, it needed much work to be adequate and useful to the reader. The QA plan matrix was identical to what was submitted six months ago for the previous monitoring review. According to the QA director, the state-issued self-monitoring tools were being used, except for sections F, O, P, and S. The section leaders for these four provisions had created new/revised tools that better met their needs at LSSLC. The family/LAR satisfaction survey continued. The creation of a new self-advocacy committee and the appointment of a new HRO may set the occasion for self-advocacy group to be one way that individual satisfaction may be obtained. A statewide DADS staff survey was conducted in February 2012 and three topics from the survey became one of the key performance indicator areas. A short survey for local businesses was created by the QA director, but had not yet been implemented. The monitoring team identified 10 QA-type activities were occurring at LSSLC outside of the QA department. The QA director should incorporate these into her overall QA program, that is, include the data in the listing inventory, QA plan narrative, and QA matrix, as appropriate, and review data. The monitoring team recommends there be a monthly meeting of the QA director, SAC, and the lead person responsible for each provision of the Settlement Agreement. During these one-hour meetings, many QA-

	and Settlement Agreement-related activities could be accomplished. An adequate QA report did not exist. The minutes and the documents handed out at the QAQI Council meetings showed that interesting and relevant topics were on the agenda, but there was no indication of what was presented, reviewed, summarized, analyzed and/or discussed. There was good progress in beginning to organize the system of tracking of corrective action plans. Based on the limited number of departments that had CAPs, and the inconsistency in the breadth and depth of what was required by the CAP (e.g., 21 for one individual), however, it was evident that much more work needed to be done to have a system of generating and managing corrective actions and CAPs that would meet the requirements of E2, E3, E4, and E5.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	Since the last onsite review, a new QA director, Paula McHenry, was appointed. She was functioning in this new position only for a few months at the time of this review. Even so, she had made some progress in some areas of section E. More importantly, she demonstrated that she will be an active member of the senior management team at LSSLC, understood what the Settlement Agreement required for section E, and was likely to bring the facility forward towards substantial compliance. The monitoring team makes this statement based upon discussions with Ms. McHenry, observations of her participation in facility meetings and meetings with her staff, and in documents she prepared for this review. Ms. McHenry is the fourth person to be leading the QA department in the two and a half years of visits by the monitoring team. The monitoring team hopes and expects that she will provide stability and consistent direction to the QA program. In general, the QA program should help guide and manage data systems so that important information is made available to senior management for decision-making and intervention. Thus, the LSSLC QA staff should (along with department leads) be coming up with a mix of important indicators (both process and outcome) for each provision of the Settlement Agreement (i.e., the QA plan matrix). Problems should be identified and reviews conducted thoroughly and appropriately (e.g., intense case analysis, route cause analysis). <u>Policies</u> 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 two facility-specific policies that were related to quality assurance. Both were	Noncompliance

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		revised since the last review. The first, Quality Assurance, contained many items from the most recent state policy. The second, QAQI Council, was only slightly revised since the last review. The QA director reported that she wanted to make progress with developing and implementing other aspects of the QA program and then she would engage in updating/rewriting the facility specific policies. This seemed to make sense and to be a good way to proceed. Training and orientation of both the state and facility policies and their requirements should be provided to QA staff and to senior management, including but not limited to QAQI Council. Any training should be relevant and practical. Merely walking through the policies, as written, will not be of much interest or use to most managers and clinicians. This training should occur a few months from now, once the QA director has updated/rewritten the facility-specific policies. The new state policy also called for a statewide QAQI Council, and for statewide discipline QAQI committees. Neither appeared to be in place at this time. Also, given that the statewide policy was in development for more than a year and was disseminated almost a year ago, edits may already be needed. State office should consider this. <u>QA Department</u> Ms. McHenry was new in her position, but was already on the right track to move the LSSLC QA program forward. She had experience in managing QA programs and had a plan to develop and implement the many components of a comprehensive QA program at LSSLC. The monitoring team also agreed with two of her broad goals for the program: wanting to be proactive and wanting to be knowledgeable about any problems at the facility so that outside entities would not be identifying issues before the facility did so itself. A productive working relationship between the QA director and the Settlement Agreement Coordinator (SAC) is another important aspect to a successful QA program. The LSSLC SAC, Sherry Roark, was organized and hard working. She was very knowledgeable about the Settlement Agreement and the workings of the facility. At LSSLC, the SAC and QA director each had roles regarding the Settlement Agreement, data collection, and data management. The monitoring team recommends that the QA director and SAC collaborate regularly. Holding QAD-SAC-Discipline meetings might be one way that this can occur (see below). The QA department staff were all new, except for one of the program monitors. The previous staff had either taken new positions at the facility or had moved on. The new	

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		QA staff transferred from other LSSLC departments or from other DADS facilities. The monitoring team found the group to be vibrant, energetic, and very interested in doing meaningful work for the facility, staff, and individuals. It may be that the combination of a new QA director and a new QA staff team will result in there being much progress by the time of the next onsite review. The QA director was in the process of assessing what should be each staff member's responsibilities. She had re-written job descriptions and created a QA department organizational chart. She re-started monthly QA department staff meetings and kept thorough minutes. She included professional development content, so that staff could learn about the profession of quality assurance. Further, the QA director established (with the support and participation of the facility director) a book club that met monthly. Participants were all of the staff who were responsible for sections of the Settlement Agreement (i.e., section leaders). The QA director chose a book about quality assurance. She prepared a formal presentation and fostered discussion. This was a great idea and likely will play a positive role in the QA program becoming more integrated (and known) across the facility. The unit directors appeared to be engaging in a variety of QA-related activities. The monitoring team noted three ways in which this was occurring. First, the unit directors were on a number of the KPI workgroups. Second, they implemented a process to increase staff's checking of email notifications. Third, they were part of the implementation of tracking the completion of quality residential assessments for the annual ISP. The QA director should consider ways of formally including the unit director's input into the QA program. <u>Quality Assurance Data List/Inventory</u> The QA data list inventory was updated since the last review. The QA director reported that she was planning to form a workgroup to get to a finalized, complete version by the time of the next onsite review. As she does so, the monitoring team repeats some comments from previous reports. • Ensure that the list is comprehensive and as complete as possible. Once complete, it will likely only need updating once per year or so. • Consider putting the list/inventory into an electronic spreadsheet format that contains a worksheet for each department and discipline, and an additional worksheet for 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	

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		responsibilities, sample size, and so forth. The goal is to have a simple listing that can be easily read by QAQI Council members as well as any other interested parties. The monitoring team also recommends that the facility consider the possible benefit to there being a system put in place for communication with other SSLCs to share relevant data listing inventory related information. • The actual data listing inventory electronic spreadsheets might be shared, so that QA directors can see how their colleagues were meeting this requirement. • Whenever there is a serious problem identified related to an important set of data, each facility might be updated and asked to ensure the data are being collected, managed, and reviewed correctly. <u>Quality Assurance Plan Narrative and Matrix</u> The QA Plan should consist of a QA narrative and a QA matrix. LSSLC made some progress by drafting an initial QA plan narrative. The QA plan narrative had 11 sections and was nine pages long. Although a good first attempt, it needed much work to be adequate and useful to the reader. For example, four and half pages of job descriptions was not a good way to describe what the QA department did (or engage the reader). The monitoring team recommends the QA director write a narrative with the following suggested headings/sections. Each should be no more than one or two descriptive paragraphs. Remember, the purpose of the QA plan narrative is to give the reader an understanding of the QA program at LSSLC. • Comprehensive data listing inventory • QA matrix o Key important indicators ▪ Process indicators ▪ Outcome indicators o Self-monitoring tools • How data are summarized and analyzed • QAD-SAC-Discipline meetings • Workgroups, PITs, KPI • QA report • QAQI Council • Corrective Actions o CAPs o Route cause analysis, intensive case analysis, fishbone diagram	

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		The QA plan matrix was identical to what was submitted six months ago for the previous monitoring review. All the comments regarding the QA matrix in the previous monitoring report, therefore, continued to be relevant and applicable to LSSLC and will not be repeated here. To reiterate, the QA plan matrix should include all key important indicators (i.e., measures, data), that is, a mix of process and outcome indicators for each section of the Settlement Agreement (i.e., each discipline department). It is insufficient to only include data from the self-monitoring tools. The QA department and the QAQI Council are more likely to take action when they are presented with, and understand, data that represent actual occurrences of processes and outcomes. QA Activities • QA Staff Activities: LSSLC had a very good group of new QA staff members and the monitoring team enjoyed meeting with them during the onsite review. They were engaging, committed, knowledgeable about their tasks, and completely interested in doing their jobs at a quality level. QA staff spent their time collecting data regarding nine DADS ICF plans of correction, completed statewide self-assessment tools primarily to assess interobserver agreement, and participated on various committees and in meetings. At this time, there were no other tools being used solely by the QA department. There may or may not be a need for additional tools. The QA director should make an explicit determination regarding this. The QA director was not yet regularly assisting the discipline departments in creating data collection tools, graphs, and databases. The QAD-SAC-Department meetings described below may help set the occasion for this to occur more regularly. • Self-Monitoring Activities: Since the last review, the DADS state office gave 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. According to the QA director, the state-issued self-monitoring tools were being used, except for sections F, O, P, and S. The section leaders for these four provisions had created new/revised tools that better met their needs at LSSLC. 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	

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		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 provision at the beginning of each section of this report. The QA department may be able to help section leaders to develop valid, reliable tools. Additionally, and to reiterate, it is insufficient for the only measures to be the self-monitoring tools. Instead, what is needed is a mix of important process and outcome key indicators (with data collected, summarized, and reviewed) for each provision of the Settlement Agreement. • Satisfaction Measures: As discussed in previous reviews, a variety of satisfaction measures are important indicators to include in a comprehensive QA program. The family/LAR satisfaction survey continued. Since the last review, there were 61 additional respondents. For the most part, their comments and ratings were very positive. The data from these surveys should become part of the QA program (even if managed by the family relations department). Further, the facility should consider the three suggestions that were in the previous monitoring report because they continued to be relevant. Similarly, the comments made in the previous report about ways to assess individual satisfaction also remained relevant. The creation of a new self-advocacy committee and the appointment of a new HRO may set the occasion for self-advocacy group to be one way that individual satisfaction may be obtained. Another way, via home meetings, might also be done, however, it did not appear that LSSLC homes held any regular meetings with the individuals who lived in the home. A statewide DADS staff survey was conducted in February 2012 and the results had become available to LSSLC managers since the time of the last onsite review. Data were being reviewed by QAQI Council and three topics from the survey became one of the key performance indicator topics (see below). This was good to see. A more localized assessment of staff satisfaction, and staff suggestions, might be good for the facility, too. A short survey for local businesses was created by the QA director. It had not yet been implemented. The monitoring team suggests that the form be one page long, and focus upon the community partner's experience and observation of the individuals, the staff, their care and interaction, and their appearance. Some facilities have had very positive interactions with community businesses by setting up a brief (5-10 minute) meeting at	

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		their business. <u>Other QA Activities at LSSLC</u> A number of QA-type activities were occurring at LSSLC. The QA director should incorporate these into her overall QA program, that is, include the data in the listing inventory, QA plan narrative, and QA matrix, as appropriate, and review data and reports, as appropriate. • Statewide trend analysis o This was a standard four component quarterly report with data for the past few years. The monitoring team requested the entire report for the past two quarters, but instead received one report for a three year period, September 2009 through October 2012, for only three of the four components. It was wonderful to have such a longitudinal data set, but decisions should be made on the data trends, not on totals for the entire three-year period (see sections C and D). • Key Performance Indicator (KPI) Teams o The facility leadership chose six areas to focus upon (risks, environments, attendance at day program, integrated ISPs, active engagement, and communication with staff). They called these their six key performance indicators. Work teams were created. An eight-item structured form and some action plans/steps were made. Data were reported at QAQI Council (see below). o The KPI groups functioned separate from the QA department. Even if under the direction of the facility director and/or QAQI Council, there should be some tie-in with the QA department and QA program. • Performance Improvement Teams (PIT) o There was one PIT, regarding training staff on the needs of individuals who were rated to be at high risk via the facility's risk identification process. o It was not clear how this PIT differed from a KPI group, and/or how the activities of this PIT related to the KPI group that focused on risks. • Workgroups o There was one workgroup. Its purpose was to review hospital admissions and re-admissions. o It was not clear how this workgroup differed from a PIT or from a KPI group. It was also not clear if this group had completed its work and had disbanded or if it was continuing. o Comments on the activities of the hospitalization workgroup are in section M1 of this report.	

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		• Death data o For the first time, the facility had some data on the deaths of individuals over the past two years or so. A meeting was held during the week of the onsite review, led by the facility director. o These were data from the Quantros reviews, however, they seemed to be data that facility staff already had, but had not yet put together themselves. • Active Treatment Quality Rating Tool (in QAQI Council minutes 7/11/12): o This was a new tool used by those who observed and measured active engagement. This may have been part of the KPI on active engagement, but it was not clear if that was the case. • Quality Improvement Risk Thresholds (in QAQI Council minutes 9/12/12): o This was a new tool and a new process, the goal of which was to give teams guidance on taking action when certain criteria were met regarding risk-related behaviors, conditions, and outcomes. This may have been part of the KPI on risk, but it was not clear if that was so. • Nursing o The nursing department and the QA nurse collected a lot of data regarding the performance and activities of the nursing department. See section M. • Areas requiring a quality assurance process by the Settlement Agreement o Medical: external and internal audits of medical care, as required by section L. o QDDPs: a quality program regarding ISPs was needed as required by section F2g. o Admissions and placement: a quality assurance system was needed as required by section T1f. o Recordkeeping: section V3 required an audit of the unified record. • FSPI	
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	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, QA-related meetings, the QAQI Council, the use of performance/quality improvement activities, and the management of corrective actions and corrective action plans. Some 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	Noncompliance

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	action step; the person(s) responsible; and the time frame in which each action step must occur.	to be summarized. This was not yet occurring for all of the items in the QA matrix (as noted in E1, however, the QA matrix was not yet adequately completed). The importance of QA department review of data plays a very important role in the QA process. The facility should set an expectation for the provision leaders/service departments to submit data and graphic summaries each month of their self-monitoring and their key process and outcome indicator data. Some of this might be accomplished during QAD-SAC-Department meetings, which are discussed below. Many of these graphs can be inserted into the QA report and be presented to QAQI Council. But again, 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. LSSLC should be able to show that each of their data sets were reviewed, summarized, and analyzed. The monitoring team had hoped to comment on how this was done for each of the bulleted items above that are listed in E1 under "Other QA Activities at LSSLC." Unfortunately, there was no evidence that this occurred. Documentation that some of these were presented at the QAQI Council was in the QAQI Council minutes. <u>Monthly QAD-SAC meeting with discipline departments</u> The monitoring team recommends there be a monthly meeting of the QA director, SAC, and the lead person responsible for each provision of the Settlement Agreement. During these one-hour meetings, the following could be accomplished: • Review QA-related actions, including review the data listing inventory, discuss/determine key indicators and outcomes, review conduct of the self-monitoring tools, create corrective action plans, and review previous corrective action plans. A set of graphs can portray the discipline's performance on the metrics that are part of the meeting agenda. The monitoring team believes these meetings, although time consuming for the QA director and SAC, can be an excellent part of the QA program. The monitoring team and the QA director discussed this at length during the onsite review. The QA director said she would consider this. <u>QA Report</u> Only one QA report was submitted. It was for June 2012, before the new QA director began her appointment. Further, the QA director reported that she was going to re-work the QA report, some time over the next six months. The monitoring team, therefore, did not review this sole QA report and instead will provide a review in the next monitoring report of the next iteration of the LSSLC QA report.	

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		In the last report, the monitoring team provided many comments on the facility's QA report. As the QA director develops a new QA report, the monitoring team recommends that the QA director review these comments because they may be helpful to her. Some additional guidance is also presented below. Organization: • The report should be divided into sections and should have a table of contents. One possible way to organize the report is as follows: o Settlement Agreement provisions that are in that month's report (this will be the largest section of the QA report) and will include: ▪ the statewide (or facility-made) self-monitoring tools ▪ other key process and outcome indicators (see below) o KPI, PIT, Workgroup updates ▪ When appropriate, these should be either cross-referenced or subsumed under the appropriate Settlement Agreement provision or provisions. o DADS regulatory ICF information o FSPI information o Other important indicators (if any) o CAPs update/summary • A short explanatory paragraph should be included in each Settlement Agreement section. The narrative paragraph should <u>not</u> be primarily about the mechanics of the data collection or a description of the scores. Instead, it should be an analysis paragraph. It might read, for example, "The three most important things to know about this month's data are…" • Some CAP information should be in the report. The monitoring team recommends a simple piece of data, such as the number of CAPs that are active at this time. Individual CAPs should not be included in the QA report. Important key process and outcome indicators/data: • The provision leaders should present key, important, relevant data (process and outcome) in addition to the statewide (or facility-made) self-monitoring tool data. The purpose of the QA report is to present the status of progress in each provision, therefore, data in addition to self-monitoring tools is required. • QAQI Council could help the department head determine what else to present. One way would be for the QAQI Council to refer to the data listing inventory to see what other types of data were being collected in the department. • Determining what other key indicator data to present could also be a topic during the monthly QAD-SAC-department meetings, if those are implemented.	

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		• Consider key indicators/data related to what is reviewed by the monitoring team. • Consider the major issues raised in the previous monitoring review. Formatting: • Start each provision on a new page. • If there were no observations (i.e., no data available), the graph should have no data point for that month. The absence of data should not be graphed as a zero. • Do not put individual practitioner or clinician names in the report, especially not associated with specific data findings. QAQI Council: This meeting plays an important role in the QA program and is to be led by the facility director. The monitoring team attended a meeting during the onsite review and read the minutes of all QAQI Council meetings back to 5/30/12. The QAQI Council meeting observed by the monitoring team was held at an atypical time of the day, in a different room than where it was usually held, and for a shorter amount of time. As a result, the monitoring team believes it did not observe a true representation of a QAQI Council meeting. Therefore, the monitoring team requests that a more typical QAQI Council meeting be held during the next onsite review. In addition, the monitoring team is amenable to receiving an audio recording of the QAQI Council meeting held immediately prior to the onsite review so that this example can be also be "observed" by the monitoring team. The minutes and the documents handed out at the meeting were reviewed by the monitoring team. The minutes showed that interesting and relevant topics were on the agenda, but there was no indication of what was presented, reviewed, summarized, analyzed and/or discussed. The agenda listed Settlement Agreement provisions with the words "POI data," but no data or analysis were attached or described in the minutes. Therefore, the reader could not tell what occurred, if anything, during these presentations. The minutes up until 7/25/12 included information in the style of the old QA report, but there were problems with the way these data were presented (as noted in the previous report) and it was discontinued after this date. Thus, after 7/25/12 there was no information about the statewide and facility-made self-monitoring tools data, or about any other key process and outcome data and/or indicators. Further, it was not clear if the statewide trend analysis data were included with sections C and D. The KPI, PIT, and workgroups were not aligned with their corresponding provision sections and no data were presented, only descriptions of what was being implemented. Data from the death	

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		reviews, active treatment quality rating tools, and quality improvement risk threshold process were not presented. It was unknown if the four provision items that were specifically required by the Settlement Agreement were included with their corresponding section presentations. FSPI and satisfaction data were not presented. It is likely that the content of the QAQI Council meetings will improve as the overall QA program improves, including the development of a useful QA report. Below are the Settlement Agreement topics that were presented since the last onsite review, according to the QAQI Council meeting minutes. FSPI presentations are also listed. Some sections appeared more than others. 10/30/12: D-S-V-FSPI 10/10/12: G-J-M 9/26/12: C-F-R-U 9/12/12: E-I-L-P 8/22/12: E-K-T 8/15/12: N-O-Q 7/25/12: D-S-V-FSPI 7/11/12: G-J-M 6/27/12: C-F-R-U 6/13/12: I-L-P-O 5/30/12: none <u>Corrective Actions</u> The QA director made good progress in beginning to organize the system of tracking of corrective action plans. To that end, she created a well-organized and well-designed five-page spreadsheet that listed each CAP, the responsible person, type of evidence required, due dates, and comments. In her spreadsheet, there were 54 CAPs. The QA director was tracking how many were not yet started (40), the number that were on schedule (4), and the number that were completed (3). This type of tracking summary was good to see (even though it did not add up to 54). Of the 54 CAPs, 21 were related to a single individual as part of the follow-up to his care needs (Individual #447), 14 were from mortality reviews, 10 were nursing related, and 9 were the result of DADS ICF regulatory reviews or investigations. Some CAPs were very specific (e.g., order two medical alert bracelets indicating placement of the pump) and some were more complicated (e.g., implement an S-Bar report for nurses to utilize when reporting individuals' status to physicians). Others	

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		were very lengthy (e.g., the DADS ICF regulatory-related CAPs). Thus, based on the limited number of departments that had CAPs, and the inconsistency in the breadth and depth of what was required by the CAP (e.g., 21 for one individual), it was evident that much more work needed to be done to have a system of generating and managing corrective actions and CAPs that would meet the requirements of E2, E3, E4, and E5. Comments provided at the end of section E2 in the previous monitoring report may be helpful to the QA director (e.g., how to determine what should be a CAP). In addition, she will need to determine how KPI, PIT, and workgroups fit into the system of CAPs (e.g., is a PIT a part of a CAP, always, sometimes?). Further, the QA director might work with the facility director to determine what role the QA department can play in a facility where there are the kinds of systemic implementation issues that were observed at LSSLC, especially in the medical-healthcare area. The monthly QAD-SAC-Department meetings can also present an opportunity for the review and documentation of the status of every 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. When the facility-specific QA policies are re-written, provide training and orientation of both the state and facility policies and their requirements to QA staff and to senior management, including but not limited to QAQI Council. (E1).

2. Implement the statewide discipline QAQI committees, as per the new state policy (E1).

3. Consider ways of formally including the unit director's input into the QA program (E1).

4. Make a comprehensive listing/inventory of all data collected at LSSLC (E1).

5. Edit the QA plan narrative as suggested in E1 (E1).

6. Follow the suggestions regarding the QA matrix presented in E1 (E1).

7. Develop key indicators/data (process and outcome) for each of the Settlement Agreement provisions. See guidance provided in E1 and E2. Include in the data listing inventory, QA plan matrix, and QA report (E1, E2).

8. Determine if there need to be any tools solely implemented by the QA department staff, other than tools made in response to DADS ICF reviews (E1).

9. Determine how to best use the statewide self-monitoring tools. Consider the suggestions made in E1 regarding development of facility-specific self-monitoring tools (E1).

10. Use data from the family survey and begin to address satisfaction measures for staff, individuals, and community businesses (E1).

11. The monitoring team identified 10 QA-type activities were occurring at LSSLC outside of the QA department. The QA director should incorporate these into her overall QA program, that is, include the data in the listing inventory, QA plan narrative, and QA matrix, as appropriate, and review data (E1).

12. Consider holding monthly QAD-SAC-Department meetings. Structure them and document the meeting (E2).

13. Consider the suggestions provided in E2 regarding the QA report regarding format, indicators/data, and editorial (E2).

14. Demonstrate that discussion and decision making occurred at QAQI Council (E2).

15. Create a system to meet the CAPs requirements (E2-E5).

16. Keep simple data on CAPs (E2).

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Supported Visions: Personal Support Planning Curriculum o DADS Policy #004: Personal Support Plan Process o Supporting Visions: Person Centered Training Curriculum o LSSLC Section F Presentation Book o LSSLC Self-Assessment o Q Construction Facilitation Monitoring Form o A sample of completed Section F audits done by LSSLC o Data summary report on assessments submitted o Data summary report on team member participation at annual meetings. o A list of all ISP dates o ISP mentoring schedule o ISP Draft for Individual #465 and Individual #433 o ISP, ISP Addendums, Assessments, PFAs, SAPs, Risk Rating Forms with Action Plans, QDDP quarterly reviews: • Individual #412, Individual #310, Individual #43, Individual #192, Individual #245, Individual #97, and Individual #288. <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Mike Ramsey, Incident Management Coordinator o Sylvia Middlebrook, Director of Psychology o Luz Carver, QDDP Coordinator o Royce Garrett, Director of Consumer and Family Relations o Steven Webb, Human Rights Officer <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 10/29/12 and 10/31/12 o ISPA regarding restraint for 10/29/12 o Oak Hill Morning Unit Meeting o Annual IDT Meeting for Individual #465 and Individual #433 o Human Rights Committee Meeting 10/31/12 o ISP preparation meeting for Individual #410 o Restraint Reduction Committee Meeting

	Facility Self-Assessment: LSSLC continued to use the self-assessment format it developed for the last review. It had been updated on 10/22/12 with recent activities and assessment outcomes. The QDDP Coordinator was responsible for the section F self-assessment. The facility had added a number of activities to the self-assessment efforts in regards to section F. The self-assessment commented on findings from a monthly sample of Settlement Agreement Monitoring Tools (SAMTs) completed by the QDDP Coordinator, as well as other activities for each provision. A newly formed mentoring team was responsible for attending two ISP meetings monthly and commenting on the ISP development process. The facility was using information gathered from the mentoring team focus areas for training. The QDDP Coordinator was also observing ISP meetings and monitoring QDDP facilitation skills, informally tracking attendance at team meetings, and tracking completion and submission of assessments prior to the annual ISP meeting. The facility had just begun tracking data sufficiently enough in regards to the ISP process to allow trends to be identified and addressed. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts to develop an accurate audit system and believes that the facility was continuing to proceed in the right direction. The QDDPs were recently trained on the new ISP process that was designed to meet the requirements of the Settlement Agreement. Moving forward, the facility can begin to assess the impact of that training. The facility self-rated itself as being out of compliance with all provision items in section F. The monitoring team agreed.
	Summary of Monitor's Assessment DADS state office recognized that the previous ISPs did not meet the requirements of the Settlement Agreement. As a result, using a group of consultants as well as work groups that included state office and facility staff, the ISP planning and development processes had been revised and reflected in the draft policy. LSSLC QDDPs and many team members had been provided training on the new process by statewide consultants. In consultation with the parties, it was agreed that beginning in August 2012, the monitoring teams would only review and comment on the ISP documents that utilized the newest process and format. LSSLC had recently received training on the new process from state office consultants. The first IDT meeting held in the new format was during the week of the monitoring visit. Thus, the new ISP process had not yet been completed for any individuals at LSSLC. The intention of limiting the monitoring teams' review to newer plans is to provide the state and facilities with more specific information about the revised process. Compliance will then be contingent on both the new plans meeting the requirements, and a sufficient number of individuals having plans that meet the Settlement Agreement requirements. Since there was only one written ISP available that was representative of the new ISP process, this review was limited to

	data gathered through the facility's self-assessment process and limited observation of the new process. There had, however, been some positive steps forward with the new ISP process. • A mentoring program was implemented using 12 department heads from various disciplines to attend ISP meetings and provide feedback to the IDTs on implementation of the new ISP process. • The mentoring team was collecting data with the Mentoring Tool and meeting to discuss findings. • The QDDPs, along with psychologists and habilitation therapist, were focusing on active treatment in the 510 day program. The monitoring team observed two annual ISP meetings in the new format. The IDT was not yet competent at developing an integrated plan that included all needed supports and services based on preferences and needs of each individual. The IDT was following the format of the new ISP process and team members were holding a more integrated discussion. The facility was moving in a positive direction, though little progress was evident.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	During the week of the review, the monitoring team observed two ISP meetings in the new format. One written plan was completed after the onsite review, but submitted for review by the monitoring team prior to the completion of this report. The QDDP facilitated both meetings. Progress definitely continued to occur and was evident, with regard to the facilitation of meetings. • Efforts were made to include the individuals, and focus the discussion on them. • More efforts were made than in the past to elicit information from all team members. • Although not consistent, there was an increase in the use of specific clinical data to support risk ratings. • The teams had a more comprehensive discussion than in the past about a wider variety of the protections, supports, and services. • Limited brainstorming took place regarding developing new supports and outcomes for the upcoming year with a greater focus on integration. • Teams were discussing action plans in more detail than in the past, particularly some of the strategies and supports that were in place or would be put in place.	Noncompliance

#	Provision	Assessment of Status	Compliance
		QDDPs had undergone additional training with a state office consultant on the new ISP format. A revised ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was introduced to assist the QDDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. Using assessment and other information, the QDDP used this template to draft portions of the ISP prior to the meeting. The QDDP came to the meeting prepared with a draft Integrated Risk Rating Form and a draft ISP format. These documents provided team members with some relevant information and assisted the team to remain focused. Both QDDPs kept the meeting moving and encouraged discussion among team members. The facility had a 43% turnover rate in QDDP positions. All positions except one had been filled at the time of this review. The facility recognized that there were lapses in ISPs due to larger caseloads distributed among QDDPs. There were 186 ISPs completed between 4/1/12 and 9/28/12. Of the 186 ISPs, 103 (55%) were filed more than 30 days after the annual ISP was held. The facility needs to ensure that plans are distributed and available to staff implementing the plan. While progress had been made towards meeting substantial compliance, it will be important for the QDDPs to continue to develop facilitation skills that will allow them to ensure that meetings result in comprehensive support plans that focus on the individual's strengths and preferences. The plan should then be monitored and revised as needed. 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 supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	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 Preferences and Strengths Inventory (PSI) was the document that should contribute to the identification of the team composition based on the individual's preferences, strengths, and needs. The QDDP Coordinator had begun to track data on attendance at IDT meetings by residential unit. Attendance data collected over the past six months showed an increase in attendance by individuals from 39% during the previous monitoring period to 60% over the past six months. Presence and participation by other relevant team members averaged 75% over the past six months. There were challenges with the integration of psychiatry into the IDT process. Psychiatric physicians were not currently participating or attending IDT meetings. SLPs	Noncompliance

#	Provision	Assessment of Status	Compliance
		attended only 9% of the ISPs reviewed in section R. Approximately one-third of the ISPs reviewed for section P had no representation by either OT or PT and another one-third had signatures for OT or PT but not both. Although it is understandable that all disciplines will not be able to have a representative available for all IDT meetings, when input is critical from a particular discipline, the team needs to ensure that discipline is available for discussion with the IDT. At the IDT meeting for Individual #433, for example, there was a significant amount of discussion regarding her PNMP and sensory assessment. A habilitation therapy assessment was not completed prior to the ISP meeting and the COTA in attendance at the meeting could not answer questions regarding her support needs. The state recently developed a new tool to assess personal preference and support needs. The Preferences and Strength Inventory (PSI) was similar to the PFA and should serve the same purpose in identifying the individual's preferences, strengths, and support needs. The facility had just begun using the PSI process to plan for the annual IDT meeting. A sample was not available for this review. An ISP preparation meeting was observed for Individual #410. • The team completed the PSI form regarding his preferences and any assessments that he would need prior to his annual meeting. Progress towards outcomes was briefly reviewed. Core team members were in attendance at the meeting and gave input. This process should be beneficial in ensuring that the IDT comes to the annual ISP meeting with adequate information. A small sample of the most recent ISPs (in the previous format) provided to the monitoring team was reviewed for attendance at team meetings by key team members. Signature sheets were only provided for two ISPs in the sample. This included ISPs for Individual #412 and Individual #192. A fully constituted team was not present for either individual. • At the annual IDT for Individual #412, neither she nor her guardian was at her annual IDT meeting. Other team members not present included her LA, direct support staff, and her dietician. • For Individual #192, her OT, PT, dietician, and day habilitation staff did not attend her meeting. The facility was not yet in compliance with requirements for the IDT to accurately identify key team members.	

#	Provision	Assessment of Status	Compliance
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. The facility had begun to gather data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. Data gathered regarding the submission of assessments from 4/1/12 through 9/30/12 indicated: • 86% of the assessments were submitted on time, • 10% of the assessments were submitted late, but still prior to the ISP meeting, • 4% of the assessments were submitted after the ISP meeting or never completed. 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 state had recently developed a new tool to assess personal preference and support needs (and to replace the PFA). The facility had just begun using the Preferences and Strength Inventory (PSI). The PSI was similar to the PFA, but was designed to be a rolling document that could be updated throughout the year as new preferences were identified or as preferences changed. At the one ISP preparation meeting observed (for Individual #410), the IDT met to identify preferences, assessments needed, and topics to be discussed at the annual ISP meeting. Functional assessments were still not adequately addressing individual's preferences related to work, relationships, and community integration. The facility needs to expand opportunities for individual's to experience new activities and record responses to those activities in order to identify a broader range of preferences. 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 yet in compliance with this item based on data available.	Noncompliance

#	Provision	Assessment of Status	Compliance
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	As described in F1c, assessments required to develop an appropriate ISP meeting were not consistently done in time for IDT members to review each other's assessments prior to the ISP meeting. 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. Recommendations resulting from these assessments need to be addressed in the ISPs either by incorporation, or by evidence that the IDT considered the recommendation and justified not incorporating it. Most of the ISPs failed to adequately incorporate the individuals' health problems, needs, and risks into their plan for daily living and participation in work, leisure, community activities, etc. For example, although Individual #310 was at risk for weight gain, he had a money management SAP to make purchases at the canteen or vending machine. His nutrition recommendations were not included in the teaching strategies. Further, there were no planned interventions to address Individual #475's physician's recommendation to promote his maximum independence with his ADLs and encourage him to participate in a toilet training program. The ISPs contained very limited descriptions of how an individual communicated. Usually, any information was in the assessment section, rather than within a description of the individual and his or her strengths, potentials, and preferences. There were generally no strategies for staff use as communication partners.	Noncompliance
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 Support 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. The ADA and Olmstead Act require that individuals receive services in the most integrated setting to meet their specific needs. Training provided to the facility by DADS consultants included facilitating the living options discussion to include input from all team members. The facility had begun gathering data on obstacles to community placement. In 75% of ISPs developed between 6/1/12 and 8/1/12, barriers to community placement were adequately addressed according to data gathered by the facility. QDDPs reported that individual reluctance was most often cited as the greatest obstacle to community placement. LAR reluctance was the second most frequently noted obstacle. In both ISP meeting observed by the monitoring team, LAR reluctance was the only noted obstacle to community placement. Both IDTs developed strategies to provide additional education	Noncompliance

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		to family members regarding community placement. This was a very positive step. The facility continued to struggle with developing ISPs that encourage training in the community. For the most part, community based outcomes consisted of generic opportunities to visit in the community. When outing are planned specifically for greater exposure to the community, documentation should include a means to capture individual's preferences and interests. Those preferences and interest should be used to develop additional action steps that would encourage greater independence and integration into the community. Outcomes should be developed to address communication skills, decision making skills, and increased exposure to life outside of the facility The facility self-assessment determined that this item was not yet in substantial compliance. The monitoring team agreed with this self-rating. Also see section T of this report.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	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 IDT "will clearly document these priorities; document their rationale for the prioritization, and how the service will support the individual." 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. As noted in F1, additional opportunities to try new things should lead to the identification of additional preferences.	Noncompliance

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		Observation across the LSSLC campus by the monitoring team did not support that individuals were spending a majority of their day engaged in activities based on their preferences. Opportunities to explore new interests and develop new skills were limited. Engagement levels varied in homes observed. There was minimal improvement in some of the homes in offering active treatment opportunities based on preferences, while in other homes good interaction and engagement was observed. Day habilitation programming was not consistently offering opportunities for meaningful engagement. For example, the monitoring team observed both good and poor examples of programming based on preferences in the Woodland Crossing program area during the week of our visit. During one observation, very few individuals were actively engaged in programming. A staff person was painting at a table with five individuals. Three were watching the staff person and two were sleeping. At another table, a staff person was assisting two individuals in participating in an activity while three other individuals were sleeping. During another observation the following day, there were additional staff present and, this time, were doing a good job engaging individuals in a variety of more meaningful activities. The IDT for Individual #465 developed a fairly comprehensive list of her preferences and interests. The team stopped short of brainstorming new ways to incorporate her preferences into training opportunities. She expressed a desire to live and work in the community. The team noted barriers to her living and working in the community, but did not develop sufficient strategies to overcome those barriers. The IDT developed action steps to give her additional opportunities to visit in the community, but stopped short of offering opportunities for true integration, such as attending church in the community, banking in the community, joining community groups focused on her interests, or exploring volunteer opportunities. 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	Examples of where measurable outcomes were not developed to meet specific health, behavioral, and therapy needs can be found throughout this report. Adequate data were not available for the monitoring team to determine compliance with this provision. The one new style written ISP available for review did not include SAPs. As noted in past reviews, there was not a focus on identifying and addressing barriers to living in the most integrated setting. The facility had made little progress in developing measurable, meaningful training in the community. All individuals were offered opportunities to take trips in the community, but this still was not resulting in opportunities to integrate into the community. Work opportunities were limited to a few options based on contracts that the facility had for work in the onsite sheltered	Noncompliance

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	appropriate to his/her needs;	workshop. The facility will need to assess whether or not IDTs are adequately identifying each individual's preferences, support needs, and barriers to living in a more integrated setting prior to assessing compliance with the requirements of F2a2.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	The outcome of the new ISP process should be a plan that integrates all protections, services and supports, treatment plans, and clinical care plans. The new ISP template included prompts to guide the IDT discussion and ensure that important information would not be omitted during the planning process. The development of action plans that integrate all services and supports was still an area that the facility was struggling with. State office had established a workgroup to provide more guidance regarding action plan development. At both ISP meetings observed, the team spent more time trying to identify areas where measurable outcomes were needed. The team engaged in more integrated discussion regarding support needs and preferences. This was a much better discussion than was observed during the last monitoring visit, though still an area where additional training is needed. 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, so that information could be integrated among disciplines. Assessment recommendations need to be available when teams are developing action plans for training and interventions. Habilitation therapists had developed treatment interventions and programs, but very few of these appeared to actually be a part of the ISP. The documentation for these was on a separate form with limited information provided and filed in the Habilitation Therapy tab of the individual record, so were not readily available to other team members. For example, Individual #310 had a PNMP that was referred to in the ISP without specific interventions noted. The PNMP was not integrated into his SAP teaching strategies or included as part of the ISP. 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.	Noncompliance

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	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Teams will need to develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. Community based outcomes were still not specific enough in identifying what information should be gathered and how successful completion of outcomes would be measured. For example, many individuals had outcomes to eat out or shop in the community, but there were no specific directions for staff implementing training to follow to ensure that functional training would occur. There was not a sample of new ISPs with SAPs to review for this provision item.	Noncompliance
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	Very little functional learning was observed during the week of the monitoring visit. Although, many individuals were engaged in activities at times, it appeared that training was provided to keep individuals busy rather than teach new skills. Individuals were often sitting around a table listening to a trainer talk about a topic rather than engaged in hands-on learning in a more appropriate setting. For example, groups were sitting at a table in the day area discussing food choices with pictures of food. This type of training would be more functional if at a grocery store selecting items for purchase, at a restaurant ordering food, or in the kitchen helping to prepare food. Overall, however, the facility was doing a better job of developing specific functional objectives to be implemented at both the facility and in the community, but implementation was not consistent. There was little evidence that functional work skills that might lead to community employment were considered when developing employment outcomes. Minimal focus on job training opportunities was observed at the sheltered workshop. The primary focus of a sheltered workshop should be job training that might lead to competitive employment. Interventions, strategies and supports will need to adequately address individual's needs and be both practical and functional at the facility and/or in community settings.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the	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. ISPs in the new format will be reviewed for compliance during the next monitoring review. Also 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	Noncompliance

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	person(s) responsible for the data review.	nursing indicators, and, sections P and O for data collection relevant to physical and nutritional indicators.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	This provision item will 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 G1 regarding the coordination and integration of clinical services. As noted in F1b and F1c, adequate assessments were often 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
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 11 out of 12 (92%) records reviewed. There were 186 ISPs completed between 4/1/12 and 9/28/12. Of the 186 ISPs, 103 (55%) were filed more than 30 days after the annual ISP was held. The facility needs to ensure that plans are distributed and available to staff implementing the plan. There had been positive improvements made in developing a more comprehensive ISP that provided a clear guide to carrying out supports. The latest ISPs developed contained much less clinical jargon. 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	QDDPs were completing a quarterly review of services, supports, and outcomes for each individual. IDTs were no longer routinely holding quarterly review team meetings. Teams met to review any incidents, significant injuries, or changes in status immediately when determined necessary. The quarterly review format had been revised to include prompts for the QDDPs to review all supports, services, appointments, injuries, family contact, community integration, and any changes in health, behavioral or functional status. Data were being gathered on the implementation of SAPs and graphed to show progress or regression. This should be a positive step towards ensuring that QDDPs are monitoring the efficacy of supports and interventions. It was not evident, however, that teams were using the quarterly review process to	Noncompliance

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	expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	ensure that all services and supports were in place or supports were modified immediately when changes in status occurred. For example: • The 2nd quarter review for Individual #412 indicated that data were not collected for two of three months on four of nine SAPs. There was no indication that the QDDP addressed the lack of implementation. Her risk action plan noted that she was at high risk for weight gain. The IDT was to follow-up on weight loss goals monthly to ensure that she was exercising and following her diet. It was noted in April 2012 that she refused to complete exercises and she gained weight in May 2012. There was no evidence that the team had met to discuss the efficacy of interventions. • The 2nd quarter review (May 2012) for Individual #310 noted 51 documented seizures for the quarter. There was no evidence that the team addressed his seizure activity. It appeared that his seizure activity was not reviewed again until his risk assessment was completed in August 2012. • On the quarterly review dated 2/23/12 for Individual #97, the QDDP noted that she observed a "couple of occasions, he appeared to be upset and crying." There were no further notes indicating that she followed up on this concern. He had met completion criteria for his SAPs for keeping his shoes on and waiting for change after making a purchase. The QDDP noted "progress shown over the past quarter" and marked "N" for met criteria. 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 require such staff to successfully complete related competency-based training, commensurate with	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 7 employees hired within the past year indicated that 7 (100%) had completed the new training on ISP process entitled Supporting Visions. All staff were required to attend an initial course on the ISP process. The facility was still waiting for additional training to be provided by the state office on developing and implementing the ISP. QDDPs were still learning to use the new statewide ISP format.	Noncompliance

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	their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised	As noted throughout this report, staff were not consistently carrying out supports included in the ISP. This resulted in untoward outcomes for some individuals. For example, Individual #119 fell sustaining a serious head injury during the week of the monitoring team's visit. Staff on duty at the time were not able to accurately describe supports included in his ISP to minimize his risk of falls. 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.	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 11 of 12 individual notebooks in the sample. Informal interviews with staff, however, indicated that not all staff were adequately trained on the requirements of individual ISPs. Familiarity with plans varied widely from home to home. Some staff interviewed were able to summarize outcomes, PBSP, therapy plans, and health risks for individuals whom they were assigned to support (this was good to see), while other staff interviewed were not able to describe interventions for even the most significant health risks for individuals that they were assigned supervision (this was concerning). Of the 186 ISPs completed between 4/1/12 and 9/28/12 data collected by the facility indicated that 103 (55%) were filed more than 30 days after the annual ISP was held. The facility needs to ensure that plans are distributed and available to staff implementing the plan. 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 ISPs are developed and implemented consistent with the provisions of this section.	The facility was using the 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 just begun to analyze findings and develop corrective action plans based on self-assessment findings.	Noncompliance

Recommendations:

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

2. It will be important for the QDDPs to develop facilitation skills that will allow them to ensure that meetings result in comprehensive support plans that focus on the individual's strengths and preferences. The plan should then be monitored and revised as needed (F1a).

3. Efforts need to be made to ensure all team members are in attendance at IDT members in order to ensure adequate integration occurs during planning (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 will need to identify each person's preferences and address supports needed to assure those preferences are integrated into each individual's day (F2a1).

9. 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).

10. 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).

11. 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).

12. 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).

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

14. 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).

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

16. 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).

17. 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 scheduled monthly reviews. 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).

18. 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, 10/1/12 o LSSLC Facility Operational Procedures Manual Committee and Councils -12, Clinical Services Morning Meeting, 1/24/12 o LSSSLC Section G Self-Assessment o LSSLC Section G Action Plan o LSSSLC Sections G and 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 Frances Mason, RN, Medical Compliance Nurse o Tammy Nelson, LVN, Medical Administrative Assistant 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 clinical services meeting
	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. The activities engaged in included a review of documents and data such as the number of PNMT referrals, evaluation of SAPs, review of dental recommendations, and audits of consultation responses. It appeared that the facility director reviewed many of the items included in the most recent monitoring report. This was a good approach to the self-assessment.

	For future self-assessments, the facility director should consider adding information on the activities that departments considered to be important in integration of clinical services as well as any additional items that are included in the forthcoming state policy on integration. The recommendations and comments included in this report should, likewise, be taken into consideration when conducting the self-assessment. The results of the assessment should assist the facility in determining the next course of action in moving towards substantial compliance. 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 with improved integration noted in several areas. An integration policy was revised to include statements regarding integration for each clinical discipline. Several processes were revamped to further clinical integration including the pretreatment sedation process and the desensitization workgroup. The process of evaluating clinical problems was also taking a more integrated approach. This was seen in the hospitalization review workgroup (discussed in sections L and M) and in the management of the recent infectious outbreak. Progress was also seen in the consultation process. A new database was recently implemented. The timely documentation of consults improved although the quality of the documentation needs to be addressed. The monitoring team had the opportunity to meet with the facility director and medical compliance nurse to discuss integration activities at the facility. The facility director outlined a series of activities that she believed provided good examples of integration. The monitoring team noted that integration was indeed occurring in many areas and facility staff were aware of the benefits of providing clinical services in an integrated manner. It was also evident that considerable work needed to be done to improve integration of clinical services. The successes and opportunities for improvement are presented in this report.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals	The facility director, as lead for this provision, revised the Integrated Clinical Services Policy. It essentially continued to describe the duties of each discipline. The policy now included an attachment in which each department iterated its philosophy on integration. Some departments provided little information on specific integration activities, while others, such as habilitation services, did an excellent job in stating how the various departments worked with other disciplines to achieve integration of clinical services including: • Interactions with nursing, such as gathering pertinent information about the current health status, such as vital signs and recent changes in heath status and medications. Other interactions included head of bed evaluations and assisting	Noncompliance

#	Provision	Assessment of Status	Compliance
	receive the clinical services they need.	with wound care. • Interactions with dieticians to gather information about an individual's diet, nutrition needs, and preferences in order to create and carry out plans for safe and proper nutritional intake • Interactions with dental clinic to assist in providing safe positioning and to discuss oral hygiene and treatment options The monitoring team reviewed local procedures, conducted interviews, completed observations of activities, attended meetings 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 daily 8:00 am clinical services meeting continued. The medical director facilitated these meetings, which were attended by representatives from all clinical disciplines. Information regarding the past 24 hours was discussed. During this meeting, the medical director reviewed various individuals' consultation reports and diagnostic tests and 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. This was a very helpful process in achieving integration of clinical services. Minutes were taken during this meeting and were available to staff. The minutes reviewed by the monitoring team, however, did not adequately reflect closure of all issues that surfaced. • Pharmacy, Medical, and Psychiatry – The clinical pharmacist attended the daily clinical services meeting. The facility recently developed a new process for pretreatment sedation. Recommendations for pretreatment sedation were brought to the meeting and given to the pharmacist for review. The recommendations were then reviewed by psychiatry. The completed form was reviewed the following day in the morning meeting. Recommendations were then submitted to the IDT for further action such as obtaining consent. • Medical and Dental Desensitization Workgroup – Collaborative efforts between medical, dental, psychology, residential, and other disciplines continued. Meetings occurred regularly and the minutes reviewed indicated that there were good discussions and exchange of ideas on how to overcome barriers to treatment. • Dental – Habilitation – The habilitation department continued to collaborate with the dental department on positioning individuals for clinic. • Since the prior review, two of the facility's IDTs were trained on how to conduct integrated risk assessment and planning meetings to address their health needs	

#	Provision	Assessment of Status	Compliance
		and risks. Notwithstanding these positive findings, the review of 22 sample individuals' records revealed that more than three-fourths had a pattern of problems ensuring that individuals received integrated clinical services to meet their needs. • Given psychiatric resources, integration was a challenge for psychiatry. Psychiatrists were not able to attend the morning clinical services meeting. In their stead, the psychiatric nurse or psychiatry assistant attended and shared information with the physicians. Overall, integration between psychiatry and primary care was limited. • Psychiatry was participating in the newly developed consultative process for pretreatment sedation, but was otherwise uninvolved in the desensitization planning process. The psychiatric nurse did attend planning and workgroup meetings in the psychiatrist's stead. • Integration of psychology and psychiatry was good. Psychologists and psychiatrists appeared to have meaningful interactions during psychiatric clinic meetings observed. Integration of psychology and medical (around medical and dental desensitization) was also improved, as evidenced by the initiation of interdisciplinary dental/medical desensitization meetings. • The PNMT met consistently with the IDTs to review their findings and to participate in the risk assessments for individuals they had reviewed or assessed. An SLP attended the Behavior Support Committee meetings to ensure that communication strategies were to be accurately integrated into the BSPs. As there were very few communication assessments completed, the discussion of the BSPs and the relationship of behavior and communication by the SLPs was not consistent at this time. • Infection Control – In response to an infectious outbreak that occurred in the facility during the months of August and September 2012, the facility brought together numerous clinical disciplines to discuss the events that were occurring and actions that needed to occur. The assessment resulted in the implementation of a quarantine of the affected areas in an effort to prevent further spread. The collaborative efforts also brought to the attention of the facility director that improvements were needed in the processes related to infectious outbreaks. Several areas offered great opportunities for improvement: • Medical participation in the annual planning for individuals was an important component of providing integration of clinical services. The facility reported that during the months of April 2012 through September 2012, there was no participation by the medical staff in annual ISPs. While the accuracy of the reported zero attendance was questioned by the medical staff, there was little	

#	Provision	Assessment of Status	Compliance
		doubt that attendance was not adequate. The primary providers should present information regarding medical issues, such as treatment and medication plans to the IDT in a manner relevant to the health and well being, goal setting, opportunities, and barriers for the individual. Ideally, this should occur for every individual. When situations arise due to scheduling and other conflicts, the QDDP should be notified. Additionally, there should be a process in place to ensure that the IDT receives the appropriate information. A discussion between the case manager and primary provider may be helpful in achieving this. • Pharmacy and Psychiatry – A review of QDRRs submitted showed that less than 10% of the evaluations were reviewed by psychiatry. This may have been the result of scheduling issues. Nonetheless, it was noted that for the few evaluations that were reviewed, significant delays occurred. • Psychiatry and Neurology – The facility conducted a weeklong series of neurology clinics in July 2012 utilizing the services of a contract epileptologist. Members of the IDTs and all but one psychiatrist participated in the various clinics. Apart from this, there was no means of ensuring the continued integration of psychiatric and neurological services. • During the onsite review, the facility administration reported to the monitoring team that two individuals – Individual #433 and Individual #465 – had undergone application of the revised version of integrated risk rating assessment and integrated health care planning process. Neither of the individuals' records yet had a complete, current IRRF, IHCP, and 2012 ISP. • Integration with psychiatry and nursing was limited to contacts necessitated via psychiatry clinic. Outside of this interaction, there was limited integration. • There were noted challenges in the integration between psychiatry and rehabilitative therapies. Psychiatrists documented interest in obtaining consultations, however, in many cases noted either no response, or a significant delay in response. This may have been due to challenges with the consultation process (i.e., therapist's were not receiving the consult) or due to resource issues in other departments.	
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	The facility implemented a system to electronically track all outside appointments. The medical compliance nurse reported implementation occurred on 10/1/12 and the new system was easier to update and monitor. The database submitted to the monitoring team allowed for sorting by specialty, date ordered, status, and home. It should serve as an effective method of tracking consultations. It was noted that several consults ordered over the past four months did not have scheduled dates. The urgency of the consultation was not clear from the information reviewed. The consults and IPNs for eight individuals were requested. A total of 63 consults	Noncompliance

#	Provision	Assessment of Status	Compliance
	refer the recommendations to the IDT for integration with existing supports and services.	completed after March 2012 (including those from the record sample) were reviewed: • 41 of 63 (65%) consultations were summarized by the medical providers in the IPN within five working days. Overall, the documentation of the recommendations of the consultants was brief and did not convey the recommendations of the consultants in a manner that was appropriate for the IDTs. Many of the entries provided summaries of a few words and stated "see consult." None of the entries explicitly stated agreement or disagreement with the recommendations and none documented a decision to refer or not refer the recommendations to the IDT. Referral to the IDT was, for the most part managed through the daily clinical services meeting. During this meeting, the medical director briefly reviewed the consults and a determination regarding IDT referral was made at that time. The QDDP coordinator took note of this and provided information, via email, for the QDDP. While this review had value, the decision was based on a cursory review and not the primary provider's review of the consult within the context of overall individual case management. The primary provider, in some instances, would likely need to review information in the record to make a final determination about the plan of care. The monitoring team also noted that recent clinical services meeting minutes did not consistently provide a synopsis of the consult. Most minutes reviewed simply stated that the consults were reviewed by the medical director and forwarded to the administrative assistant for tracking. The monitoring team suggests that IPN documentation of consultations include a brief summary of recommendations of the consultants, contain a statement regarding agreement or disagreement, and include a decision about referral to the IDT. The primary providers should also indicate the specific consult that is being addressed.	

Recommendations:

1. Consideration should be given to re-formatting the minutes of the daily clinical services meeting. Minutes should document discussions, actions that need to occur, responsible parties responsible, and the outcomes (G1).

2. The facility should develop a process for implementation during infectious outbreaks that includes daily morning briefings with key staff. During those daily meetings, comments and updates for facility staff should be drafted. The facility director must also work with state office in developing status updates for families and the local community.

3. The facility director must address the attendance of medical providers at annual ISPs. Guidelines for attendance based on prioritization should be implemented (G1).

4. The review of QDRRs by psychiatry must occur in accordance with state issued guidelines (G1).

5. Efforts to achieve integration of neurology and psychiatry through a joint neurology-psychiatry clinic must continue (G1).

6. 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).

7. The facility should ensure that consults are obtained in a timely manner. Adding a priority level (within seven days, 21 days, etc.) to the database may be helpful in achieving this regard (G2).

8. 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 LSSSLC Section H Self-Assessment o LSSLC Section H Action Plan o LSSSLC Sections H and 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 Frances Mason, RN, Medical Compliance Nurse o Tammy Nelson, LVN, Medical Administrative Assistant o Paula McHenry, QA Director o Paul Vann, RN, QA 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, actions completed to conduct the self -assessment, the results of the self-assessment, and a self-rating. For provision H1, a series of audits and activities were completed to assess compliance. The results were reported and discussed in detail. The activities reviewed many of the items reported in previous compliance reports. The results of these activities appeared to help the facility understand what areas

	needed additional work. This was discussed in also in the self-assessment. For the other provision items, one or two activities were listed along with the results. These assessments were briefer, but each attempted to assess the area and provided information on future actions for assessment. The facility will need to develop a policy with guidance from state office to move further along in these areas. The facility found itself in noncompliance with all seven provision items. The monitoring team agreed 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 compliance nurse, QA director, and QA nurse. The facility's QA nurse assumed the lead role for this provision item. Assigning this responsibility to the QA Nurse was in itself a significant and positive change. This was the first review at LSSLC in which this provision was given serious and thoughtful consideration. Each department was responsible for assessment tracking as there was no centralized tracking. Tracking completed by the facility in August 2012 showed significant problems with the timeliness of completion of assessments in several areas. There was no process in place to measure the timeliness of interval assessments. The monitoring team found significant improvements in the timeliness of completion of scheduled assessments. This finding did not extend to the adequacy of interval assessments. Improvement was seen in the diagnostic formulation for psychiatric assessments and medical providers generally utilized ICD nomenclature. The facility focused its efforts on Provisions H1 and H2. There was little progress noted in the other provisions, however, the facility drafted a policy on risk thresholds to ensure timely review occurred for those with a change in status. There was for every provision item, an assessment of the current status and consideration given to the next actions that needed to occur. This was not seen in previous reviews. To that end, there was some progress. Further progress will likely be seen as the new center lead becomes more familiar with the requirements and additional guidance is received from state office in the form of a finalized policy.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	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 a local policy for this provision. There was no centralized tracking of assessments. Rather, each department was responsible for tracking compliance with the requirements for completion. Future plans included implementation of a centralized tracking system. The facility had yet to address the requirement to assess the timeliness of interval assessments. The facility director shared a draft policy related to risk thresholds. This policy set specific thresholds, which once reached, required the individual's team to meet and discuss possible changes in treatment and support. The expectation was that this process would assist in ensuring that significant changes would trigger a team review and assessments of exiting supports and services. Some, but not all, disciplines were utilizing tools to assess the quality of assessments. The facility will need to evaluate those tools and determine if they are measuring the appropriate aspects of the assessments. 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, and reviewed assessments and facility data. The results of those activities is summarized here: • For this review, the compliance for timely completion of Annual Medical Assessments was 100%. This was a significant improvement from the last review. The need to conduct and document interval assessments was more problematic. As discussed in section L, follow-up assessments were not always completed in a timely manner. Medical assessments are discussed in detail in section L1. • Quarterly Medical Assessments were found in very few records included in the record sample. The self-assessment documented that two of the four medical providers had began completing these required assessments. • The completion of Quarterly Drug Regimen Reviews improved compared to the previous compliance review. Evaluations were found in all records, although many were completed several months late. • Annual Dental Assessments – Compliance with timely completion for the review period was 68%. • Regularly scheduled quarterly and annual nursing assessments were present in	Noncompliance

#	Provision	Assessment of Status	Compliance
		all but one of the 22 sample individuals' records. This was an improvement from the findings of prior reviews. Nonetheless, a review of the individuals' nursing assessments revealed that although there were some improvement in some areas of the nursing assessments, 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 to achieve desired health outcomes. • Psychiatry did a remarkable job of completing comprehensive psychiatric assessments for 185 of 186 individuals participating in psychiatry clinic. There were concerns with regard to delinquencies in completing quarterly psychiatric clinic assessments. There may be challenges with psychiatry responding to crises, or scheduling evaluations in response to behavioral changes due to a deficit in clinical resources. • The communication assessments were not consistently provided. There was a Master Plan to prioritize these, but the progress with this was slow. The OT/PT assessments were not consistently provided 10 days or more prior to the ISP. A number of the individuals reviewed for section P had current comprehensive OT/PT assessments. The intent was to provide an update for individuals who received some type of service, though this was inconsistently noted. In fact it was noted that the recommendations for many individuals who received services included that subsequent evaluations would be completed on an as needed basis or upon referral and there was no mention of an annual update. The therapists generally did not routinely and proactively conduct reviews or assessments for individuals with a change in status unless an action referral was sent by the IDT. The PNMT had begun to review individuals with changes in status during their weekly meetings and the PNMT nurse conducted post-hospitalization assessments to determine if there was a need for PNMT supports. These assessments should generate the identification of need for the IDT OT, PT, or SLP to conduct an assessment as well. • Psychological assessments were not completed for all individuals. Functional assessments were completed for all individuals with PBSPs, however, some were not current. Annual psychological assessments were completed for all individuals. The facility reported data based on audits completed for August 2012. Those data showed compliance rates less than 80% for medical, nursing, habilitation therapy, and nutrition services. The facility director instructed all disciplines to develop tracking systems to ensure that timely completion occurred. Development of systems was occurring at the time of the review.	

#	Provision	Assessment of Status	Compliance
		The monitoring team needs to emphasize 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.	During the May 2012 review, the facility identified records with grossly inaccurate diagnoses. The self-assessment indicated continued problems in this area. There was no system in place for ensuing the accuracy and consistency of diagnoses based on assessments. The monitoring team assessed compliance with this provision item by reviewing many documents including medical, psychiatric, and nursing assessments. • Generally, the IPN documentation revealed that the medical diagnoses were consistent with ICD nomenclature. The diagnoses, for the most part, fit the signs and symptoms documented. One significant problem was that the IPNs frequently failed to document the appropriate positive and negative findings related to signs and symptoms. This documentation varied significantly among providers. • The medication profiles submitted with the QDRRs showed the use of indications that were not consistent with ICD nomenclature. The indications included with the drug profiles should be those written by the prescriber. • The psychiatry review demonstrated marked improvement in this area. Psychiatric physicians improved their diagnostic formulation. The quality of documentation was largely physician dependent and there was notable variability in the documentation reviewed. This was an area where quality assurance monitoring including peer review, corrective action, and physician education may be necessary. • The review of nursing documentation showed across the majority 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 and failed to result in complete lists of nursing diagnoses. o For example, Individual #229 was a 60-year-old man with many health problems. Although his comprehensive nursing assessment listed his nursing diagnoses related to his responses to his seizure disorder, urinary retention, hyponatremia, and ear infection, his assessment failed to reference his responses to his vision impairment, lower extremity edema, stasis dermatitis, chronic sinusitis, obesity, constipation, poor oral hygiene, and left leg and foot cellulitis.	Noncompliance

#	Provision	Assessment of Status	Compliance
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 level of implementation of the state issued protocols at LSSLC was not clear. The facility director indicated that primary medical providers were given this information, but most reported only vague knowledge of the various protocols. Many protocols were multidisciplinary and it was reported that the protocols were implemented within the nursing department. In fact, nursing was responsible for the initial training of direct care professionals. However, the use of these protocols within the nursing and medical departments was not measured. Assessing compliance with a given protocol will require that a measurable standard or metric – clinical indicators be developed. This had not occurred. Furthermore, LSSLC had complete only one round of medical management audits. The monitoring team could not use that information because graphs and data were not adequately identified. In order for the monitoring team to assess compliance with this provision item, the usual activities of interview and document reviews were completed. • Record reviews indicated that generally, physicians responded to the changes in health status, however, the responses were not always adequate or timely. Diagnostics were not always obtained or reviewed in a timely manner and individuals did not always receive adequate follow-up for acute medical issues. Examples are found in section L. • As noted in all prior reports, 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. • Of note, the process of health care planning was slated to change. At the time of the review, LSSLC had just begun its implementation of the state's integrated health care planning process.	Noncompliance
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	The level of implementation of the state issued protocols at LSSLC was not clear. The facility director indicated that primary medical providers were given this information, but most reported only vague knowledge of the various protocols. Many protocols were multidisciplinary and it was reported that the protocols were implemented within the nursing department. In fact, nursing was responsible for the initial training of direct care professionals. However, the use of these protocols within the nursing and medical departments was not measured. Assessing compliance with a given protocol will require that a measurable standard or metric – clinical indicators be developed. This had not occurred. Furthermore, LSSLC had complete only one round of medical management audits. The monitoring team could not use that information because graphs and data were not adequately identified. In order for the monitoring team to assess compliance with this provision item, the usual	Noncompliance

#	Provision	Assessment of Status	Compliance
		activities of interview and document reviews were completed. • Record reviews indicated that generally, physicians responded to the changes in health status, however, the responses were not always adequate or timely. Diagnostics were not always obtained or reviewed in a timely manner and individuals did not always receive adequate follow-up for acute medical issues. Examples are found in section L. • As noted in all prior reports, 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. • Of note, the process of health care planning was slated to change. At the time of the review, LSSLC had just begun its implementation of the state's integrated health care planning process.	
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 remained without a global plan to address this provision item. There was no functional medical director hence there was no member of the medical staff to review the data generated by the various databases. Other than the review of hospitalizations in October 2012, there was no ongoing review of medical data. 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 assurance, 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 – clinical indicators. The proposed risk management policy will likely address this issue to some degree by requiring that teams review individuals who showed a change in status based on crossing a risk threshold. However, a number of processes, reviews, and evaluations are needed to monitor health status. The facility had the capability of monitoring health status in many ways through: • Sick call evaluations/interval assessments • Quarterly medical reviews • Quarterly Drug Regimen Reviews • Daily clinical meetings • Medical databases Many of these processes were not completed as required. Follow-up of acute problems was problematic. Most providers did not complete quarterly medical reviews and psychiatry was not reviewing QDRRs in a timely manner. Interval assessments, such as quarterly drug and medical reviews, are particularly important because completion of such reviews provides an opportunity to identify concerns prior to the onset of clinical problems.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The daily clinical meetings surfaced many health concerns through the review of recent events. Physicians should follow-up on issues and the minutes should reflect that follow-up. Finally, data included in medical databases, such as hospitalizations and pneumonia were not reviewed regularly and used to monitor status and quality of care. This will require development of a medical quality program. As of the review, there were no nursing systems for effectively monitoring the health status of individuals that were being consistently implemented. Although the nursing assessment process vis a vis implementation of the assessment and reporting protocols and conduct of acute, quarterly, and annual assessments, would/could serve as such, there was no evidence that it was implemented, partially or otherwise. Thus, health plans (acute and chronic), which were in place for days, weeks, months, and even years, were not adequately reviewed/revised and modified to meet the individuals' needs and the changes in their health status and risks.	
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 should be based on clinical guidelines developed and should be used to set triggers for the risk threshold policy. Indicators not found in the clinical guidelines could include the rate of hospitalizations, readmission rates, the incidence of pressure ulcers, and the prevalence of undesired weight loss. Follow-up through the risk process will provide one means of tracking changes that occur in response to therapy. However, this process captures only those individuals who have experienced <u>significant</u> untoward events and have therefore crossed a defined threshold. The monitoring team found 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 risk for alteration in skin integrity were not modified in response to episodes of skin breakdown, individuals with plans to address their risk for injury related to falls were not modified despite falls with injuries, individuals with plans to address an acute head injury were not modified to address repetitive head injuries, and individuals with plans to address the risk of side effects of their medications, especially psychotropic medications, were not modified in response to episodes of adverse reaction(s) to medication(s). 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	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. The appropriate tools should be developed for all clinical disciplines (H1).

2. The facility must address the problem of inappropriate indications noted in the QDRRs. Audit tools should address this issue (H2).

3. The facility director should ensure that clinical protocols and guidelines are fully implemented (H3).

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-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 DADS SSLC Risk Guidelines dated 4/17/12 o List of individuals seen in the ER in the past year o List of individuals hospitalized in the past year o List of all choking incidents o List of individual at risk for aspiration o List of individuals with pneumonia incidents in the past 12 months o List of individuals at risk for respiratory issues o List of individual with contractures o List of individual with GERD o List of individuals at risk for choking o Individuals with a diagnosis of dysphagia o List of individuals at risk for falls o List of individuals at risk for weight issues o List of individuals at risk for skin breakdown o List of individuals at risk for harm to self or others o List of individuals at risk for constipation o List of individuals with a pica diagnosis 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 dehydration o List of individuals who are non-ambulatory o List of individual who need mealtime assistance o List of individuals at risk for dental issues o List of individual receiving enteral feedings. o List of individuals with chronic pain. 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 ISPs, Risk Rating Forms, Risk Action Plans for: • Individual #245, Individual #97, Individual #192, Individual #288, Individual #43, Individual #412, and Individual #310.

	Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Mike Ramsey, Incident Management Coordinator o Sylvia Middlebrook, Director of Psychology o Luz Carver, QDDP Coordinator o Gail Husband, Assistant Director of Programs Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 10/29/12 and 10/31/12 o ISPA regarding restraint for 10/29/12 o Oak Hill Morning Unit Meeting o Annual IDT Meeting for Individual #465 and Individual #433 o Human Rights Committee Meeting 10/31/12 o ISP preparation meeting for Individual #410 o Restraint Reduction Committee Meeting
	Facility Self-Assessment: LSSLC submitted its self-assessment. It was updated on 10/1/12. Along with the self-assessment, the facility had two others documents that addressed progress towards meeting requirements of the Settlement Agreement. One listed all of the action plans for each provision of the Settlement Agreement and one 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 similar activities implemented by the monitoring team to assess compliance. • For I1, the facility looked at assessment tracking data collected by the QDDP coordinator. Data collected regarding DSPs overall understanding of individual specific risk information and reviewed two completed ISPs including the Integrated Risk Rating Form. • For I2, the facility reviewed clinical morning meeting minutes, ISP Mentor monitoring findings, and Key Performance Indicator Worksheets. • For I3, the facility looked at risk action plans for ISPs completed with the newest format. Findings from the facility self-assessment were similar to findings by the monitoring team. The facility self-rated each of the three provision items in section I in noncompliance. The monitoring team agreed. As the facility gains a better understanding of the risk process, it will be important for the audit process to

	evaluate quality and efficacy of risk assessments and plans.
	Summary of Monitor's Assessment: 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. Adequate plans were not in place to address all risks identified. Risk action plans were not being consistently reviewed and monitored. Since the last review, the state office had made revisions to the At-Risk Individuals policy. Some of the changes included regrouping the Risk Guidelines so that the risk factors that were clinically related were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form was revised to follow the same grouping sequence as the Risk Guidelines. Some additional revisions included replacing the Risk Action Plans for the identified high and medium risk indicators with Integrated Health Care Plans designed to provide a comprehensive plan that will be completed annually. Consultants from the state office recently provided training to select department heads and IDTs. 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. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual. Teams should be carefully identifying and monitoring indicators that would trigger a new assessment or revision in supports and services with enough frequency that risk areas are identified before a critical incident occurs. Teams were often waiting until a critical incident occurred before aggressively addressing the risk. Plans should be implemented immediately when individuals are at risk for harm.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	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 an integrated health care 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. Since the last review, the state office had made revisions to the At-Risk Individuals policy. Changes included regrouping the Risk Guidelines so that the risk factors that were clinically related (regarding outcomes or provision of services and supports) were listed	Noncompliance

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		together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form (IRRF) was revised to follow the same grouping sequence as the Risk Guidelines. Seven groupings of risk categories were identified. The template of the draft Integrated Risk Rating Form included bulleted items to be addressed for each risk factor, including: data, supports, baseline, discussion and analysis/need for new supports, rationale/risk rating, triggers, and criteria for IDT review. Updates in status were to be noted on the form, making it easier to track status and determine when the team had met to discuss changes in status. The Risk Action Plans for the identified high and medium risk indicators were to be replaced with Integrated Health Care Plans (IHCP) designed to provide a comprehensive plan that will be completed annually and updated as needed. The state office 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 risk identification process had undergone several revisions in the past year. The consultants had recently provided training and technical assistance to two IDTs at LSSLC on the latest revisions in the risk process. The monitoring team was able to observe two IDT meetings using the new style ISP format and new risk rating forms. Progress towards developing an effective process to identify risks was observed in both meetings. Both IDTs followed the newly created IRRF. At the ISP meeting observed for Individual #465, the nurse case manager led the risk discussion. She read each of the risk categories, summarized her health assessment for each area, and then offered a recommended rating of high, low, or medium risk. She asked for agreement from other team members before moving to the next category. The team relied heavily on the state guidelines for risk ratings but these do not take into account the many integrated factors that can raise an individual's level of risk. For example, the team considered her cardiac risk without discussing her medications or hyperlipidemia diagnosis. As the meeting moved on, team members became more comfortable offering input and were less hesitant to disagree with the nurse's suggested risk level. The risk discussion took place as if a separate part of the meeting and there was little consideration of Individual #465's preferences or lifestyle when discussing risks. QDDPs need to gain facilitation skills that will allow them to encourage more interdisciplinary discussion among team members regarding risks. At the annual ISP meeting for Individual #433, the risk discussion was held at the end of the meeting, thus, after a discussion of her preferences and living options. This kept the	

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		focus on the individual's preferences and support needs. By the time the IRRF was reviewed, many of the risk areas had been discussed in relation to her daily supports. Much less time was needed to go through the IRRF and rate her risks in each area. The team had a good discussion regarding her risk rating for aspiration. The IDT deliberated and listened to rationale from several team members before finally agreeing on a rating and action steps to address her risks. Her OT/PT assessment was not completed prior to her annual ISP meeting which meant important information that should have been available in regards to her risk status was not available for discussion. A review of a sample of risk rating forms indicated that although the risk process had undergone significant improvements, all risks still were not accurately being identified. For example, • Individual #192 was rated as low risk for falls. She had seven falls in the quarter prior to her risk assessment. Similarly, she was rated at low risk for fractures with the justification of no history of fractures. She was rated at medium risk for choking and aspiration, though she had a diagnosis of dysphagia, was on a modified diet and required mealtime assistance. She was rated at low risk for skin integrity, though had a lengthy history of SIB. She wore a helmet through most of the day to protect against SIB. Staff were not monitoring her skin integrity under her helmet. • Individual #97 was rated as medium risk for urinary tract infections. He had a diagnosis of chronic urinary tract infections. He was catheterized three times daily. He should have been considered high risk for UTIs. • Individual #43 was rated as medium risk for falls and low risk for fractures even though she had 10 recorded falls over the past year and was visually impaired requiring sighted guidance when she ambulates. Each home was attempting to ensure that DSPs were trained on identifying risk and recognizing clinical indicators to evaluate risk for individuals whom they supported. There was not yet a formal system in place to provide individualized risk training. Each home manager was responsible for training DSPs on risk factors for individuals. The state policy required that all relevant assessments were submitted at least 10 days prior to the annual ISP meeting and accessible to all team members for review. As noted in section F, all disciplines were not routinely completing assessments prior to annual ISP meetings or attending ISP meetings. The facility had begun to track submission of assessments by discipline and attendance at IDT meetings. These databases will be useful when the facility begins consistently collecting and analyzing data. As noted in section F, the submission of assessments and attendance at IDT meetings was a barrier to accurately identifying risks and support needs for individuals.	

#	Provision	Assessment of Status	Compliance
		Additionally, the facility had developed a Key Performance Indicator workgroup to focus on risks. Action steps were developed to ensure that changes in health status were identified prior to a critical event occurring. Action steps included collecting data on hospitalizations and ER visits and developing training on identifying and reporting changes in health status. 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). • Ensure that assessments are updated and submitted prior to annual ISP meetings and all relevant disciplines attend meetings and participate in discussions regarding risks. • 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. • Ensure that data collected regarding incidents and injuries are frequently analyzed for indication that supports may not be adequate for safeguarding individuals. A noncompliance rating was assigned to I1 in the facility self-assessment. The monitoring team agreed with this assessment.	
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	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. A sample of records was reviewed to determine if changes in circumstance should have resulted in an assessment of current services and support, risk ratings, and/or plan revisions. Although it appeared that teams were usually meeting immediately following a critical incident, it was difficult to determine if assessments were obtained and discussed by the team in a reasonable amount of time. For example,	Noncompliance

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	assessment process as soon as possible but within five working days of the individual being identified as at risk.	• Individual #542's IDT met to reassess his risk ratings 5/16/12 following a serious head injury resulting from a fall. The team did not request reassessment by habilitation therapist at that time. He had another serious head injury resulting from a fall on 9/14/12. The team met again and requested a therapy assessment. There was no documentation that the team reconvened to discuss recommendations following the assessment. His PNMT was not updated until 10/23/12. • Individual #310's IDT noted at his quarterly review on 5/25/12 and at his annual ISP meeting on 8/1/12 that he had increased seizure activity (according to his risk assessment, 156 seizures over the past year). The team agreed to continue monitoring his seizure activity. There was no documentation that a neurological assessment had been recommended. The facility self- assessment indicated the process to ensure timely completion and implementation of action plans needs to be refined to meet substantial compliance with I2. The facility was not yet in compliance with this provision item.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the 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 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, plans were in place to address all risks for those individuals designated as high risk or medium risk in specific areas. The ADOP reported that individuals would be assessed and action plans developed using the IRRF and IHCPs as annual ISP meetings were held. As noted throughout this report, it was not evident that risks were being appropriately identified and action plans developed to support all risks. Only the most recent ISPs developed integrated risk action plans into the ISP. None of the ISPs and risk action plans in the sample reviewed included specific risk indicators to be monitored for all areas of risk. The ISP and risk action plans often referred to an HMP in place. HMPs were not integrated into the ISP, so staff did not have a comprehensive plan to monitor all supports. For example, • Individual #288 was at high or medium risk in a number of areas, including respiratory compromise, oral hygiene, constipation, osteoporosis, fractures, and polypharmacy. Her risk action plan did not include clinical indicators that	Noncompliance

#	Provision	Assessment of Status	Compliance
		should be monitored by DSPs in any area. It was not evident that consistent monitoring of those risk indicators was occurring. ISPAs were used to document initial discussion when a change in status was identified. There was not always documentation of follow-up when recommendations were made by the IDT. QDDPs completed quarterly review of all supports and services. This review included a review of risk factors. QDDPs generally just listed risk areas that were designated as medium or high in this area, but did not comment on clinical indicators for the quarter. It was not evident that clinical data were gathered and reviewed at least monthly for all risk areas. Furthermore, data gathered on distribution of ISPs indicated that ISPs were not routinely filed in individual notebooks within 30 days of development. Therefore, DSPs did not have access to current risk action plans. 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 agreed 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. Ensure attendance or at least input by all relevant team members in the risk process (U1).
4. 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).
5. Ensure IDTs are monitoring progress on health and behavioral outcomes and plans are revised when necessary (12).
6. Ensure that plans to address risks are individualized to address specific supports needed by each individual identified as at risk (I2).
7. 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 Ten 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 Four dental skills acquisition plans and two 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 Thirteen examples of MOSES and DISCUS examination for 13 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; MOSES/DISCUS examinations for the previous six months; Pharmacy Quarterly Drug Regimen Review for the previous six months; Consult section; Physician's orders for the previous six months; Integrated progress notes for the previous six months; Comprehensive Nursing Assessment; Dental Section including desensitization plan if available o A list of all meetings and rounds that are typically attended by the psychiatrist, and which categories of staff always attend or might attend, including any information that is routinely collected concerning the Psychiatrists' attendance at the 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 months, 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 three individuals requiring chemical restraint, a copy of the following: Doctor's order; Nurses Notes associated with the incident; Psychiatry notes associated with the incident; Documentation of any 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 quality assurance monitoring of the Comprehensive Psychiatric Assessment from each evaluator. o List of all individuals seen by the consulting epileptologist. o All information presented, doctor's notes and documentation regarding Dr. Vyas' clinic 10/31/12 regarding Individual #119 and Individual #423. o Five examples of epileptology consultation documentation. o IDT documentation regarding meeting 10/30/12 regarding Individual #465. o Copy of peer review documentation completed by physician from SASSLC. o Tracking spreadsheet for completion of informed consent. o All information presented, doctor's notes and documentation regarding Dr. Buckingham's clinic on 11/1/12 regarding Individual #305. o All information presented, doctor's notes and documentation regarding Dr. Middlebrook's clinic 10/29/12 regarding Individual #587 and Individual #170. o All information presented, doctor's notes and documentation regarding Dr. Buckingham's clinic 10/30/12 regarding Individual #466 and Individual #67. o Medical record of Individual #176 o These documents: • Identifying Data Sheet • Consents for psychoactive medication • Personal Support Plan with addendums and signature sheets

	• Psychological Evaluations • Reiss screen • 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, gynecology, urology, endocrinology, orthopedics, dermatology, nephrology • Physician's orders for the previous six months. • Integrated progress notes for the previous six months. • Comprehensive Nursing Assessment • Vital signs record • Annual weight graph form o For the following individuals: • Individual #363, Individual #305, Individual #365, Individual #60, Individual #574, Individual #420, Individual #582, Individual #562, Individual #226, Individual #410, Individual #170, Individual #318, Individual #34, and Individual #163 <u>Individual Interviews and Meetings Held</u>: o JoAnne Lancaster, R.D.H. 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 Michelle Richard, Pharm D., clinical pharmacist o Brian Carlin, M.D., Medical Director and Tammy Nelson, L.V.N. administrative assistant o Sylvia Middlebrook, Ph.D., Director of Psychology o Tom Middlebrook, M.D., facility psychiatrist o Belinda Byron, M.S.N., R.N., Chief Nursing Executive o Gale Wasson, M.Ed., facility director <u>Observations Conducted</u>: o Dr. Vyas' clinic 10/31/12 regarding Individual #119 and Individual #423. o IDT meeting 10/30/12 regarding Individual #465. o Dr. Buckingham's clinic on 11/1/12 regarding Individual #305. o Dr. Middlebrook's clinic 10/29/12 regarding Individual #587 and Individual #170.

	o Dr. Buckingham's clinic 10/30/12 regarding Individual #466 and Individual #67 o Quarantine Meeting o Polypharmacy Committee Meeting o Medical/Dental Desensitization (DERST) workgroup meeting 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. 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. 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 was one monitoring tool provided for review during this monitoring visit. This was a quality assurance review document geared toward review of the comprehensive psychiatric assessment. At the time of this review, a peer review of one comprehensive assessment had been completed. 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. The facility self-assessment indicated a substantial compliance rating for J2. This was based on the rationale that all individuals had received a comprehensive psychiatric assessment by a qualified psychiatric professional. In addition, the self-assessment reported that a sample of evaluations reviewed contained documentation of clinical justification. A review of documentation performed for this report revealed marked variability in the quality of the case formulations or descriptions of what led the psychiatrist to make a specific diagnosis. Given this, it was difficult to determine the adequacy of the evaluation and diagnosis of the individuals and, therefore, this provision item was found in noncompliance by the monitoring team. In order to address this, the facility will need to begin formal quality assurance monitoring of a percentage (e.g., 10%) of each psychiatrist or physician's assistants documentation via peer review with resultant corrective action and staff training if necessary. The monitoring team would be happy to review case formulations with facility providers with regard to requirements necessary to reach

	substantial compliance. The facility self-assessment indicated a substantial compliance rating for J3. This was based on a review of individual's active records to ensure that each individual who was prescribed psychotropic medication had a current PBSP. In review of this provision item, the facility will need to ensure psychiatric participation in the development of the PBSP, as well as improve these documents with regard to the identification of non-pharmacological interventions. Psychiatric participation in the development of the PBSP can be achieved by a review of this document in psychiatry clinic where the IDT is in attendance. In addition, psychiatric documentation regarding the use of emergency chemical restraints must improve. As such, this provision remained in noncompliance. These are items that can be addressed via quality assurance monitoring with resultant staff training. The facility self-assessment indicated a substantial compliance rating for J5. This was based on a review of the current psychiatric resources available at the facility, calculating for the number of hours needed to complete annual assessment updates and quarterly reviews, and annual reviews. The 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, ISP attendance, emergency ISP attendance, discussions with nursing staff, call responsibility, 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. At the time of this review, psychiatry time was consumed with direct clinical care. Psychiatric physicians were not able to attend any ISP or other team meetings due to the lack of clinical resources. In addition, the facility did not have a lead psychiatrist designated, and as such, the current providers were not organized as a group, but rather functioned as individual service providers. Given these challenges, this provision remained in noncompliance. The facility self-rated itself as being in substantial compliance with six provision items: J1, J2, J3, J5, J12, and J15. The monitoring team agreed with two substantial compliance ratings, for provision items J1 and J12. 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. The three 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 integration 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, analysis of data, collaboration regarding case formulation, behavioral support planning, and identification of non-pharmacological interventions). It was apparent staff from both disciplines were aware of the need for increased 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. 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.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Qualifications LSSLC had a total of 1.1 FTE (full-time equivalent) psychiatrists/physician's assistant. All three physicians who were responsible for providing psychiatric treatment were board certified in adult psychiatry. One physician was also board certified in child and adolescent psychiatry and another was board eligible in child and adolescent psychiatry. The physician's assistant had significant experience in the treatment of psychiatric disorders, and had experience in the treatment of individuals with developmental disabilities. As such, the staff were qualified. There was, however, no lead psychiatrist identified. In the intervening period since the last monitoring report, the facility had terminated the contract of one of the part time psychiatrists, however, as this physician only provided four hours of service on a monthly basis, the loss of this resource did not significantly affect the total FTE available. Experience Of the three part-time physicians, one had been providing care at the facility for over three years. A second part-time physician had joined the psychiatry department approximately 18 months prior to this monitoring review. The third part-time psychiatrist had begun providing services at the facility approximately six months 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 at the facility approximately nine months ago. 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. 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. Monitoring Team's Compliance Rating Based on the qualifications of the psychiatrists and the physician's assistant at LSSLC, this item was rated as being in substantial compliance.	Substantial Compliance

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J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	Number of Individuals Evaluated The psychiatrists had continued to perform comprehensive psychiatric assessments per Appendix B. At the time of this visit, 185 out of 186 assessments had been completed (99.5%). Evaluation and Diagnosis Procedures Overall, evaluation and diagnostic 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. Clinical Justification While all individuals prescribed psychotropic medication had a five-axis diagnosis documented, there was marked variability in the quality of the case formulations or descriptions of what led the psychiatrist to make a specific diagnosis. A review of 14 records of individuals at LSSLC revealed varying quality of the documentation in the quarterly medication reviews. Although there was marked variability, the quality of the justification for the use of specific psychopharmacological agents had improved since the previous review, in. Given that the improvement was not seen in all 14 records, that is, for some records, it was difficult to determine the adequacy of the evaluation and diagnosis of the individuals. 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 was only one quality assurance monitoring performed via peer review. In addition, beginning two weeks prior to this visit, the psychiatric nurse and psychiatric assistant had begun quality assurance monitoring. For further discussion regarding this practice, please see J8. Tracking Diagnoses and Updates LSSLC was at the beginning stages of keeping a database of diagnoses, medications, and tracking of dates when psychiatric quarterly clinics were due in order to ensure timely services. While there were some data were available, it was not yet comprehensive or complete. Challenges 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 had now managed to complete almost all 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	Noncompliance

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		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 14 records, all had diagnoses noted in the record. Individuals prescribed psychotropic medication must have an active positive behavior support plan (PBSP). In 10 of the 14 records reviewed, there was a PBSP on file. One record was for an individual admitted in September 2012, and it was understood that the PBSP was pending. It was notable, however, that none of the PBSP documents reviewed included 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 (also please see section K). Staff interviews performed during the previous visit revealed plans to add the psychiatrist as a signer on the PBSP and to review the document with the psychiatrist via psychiatry clinic 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. At the time of this review, the PBSP revision to add the psychiatrist's signature indicating review and input remained pending. All individuals prescribed medication had diagnoses noted in the record. As noted above in J2, psychiatric practitioners were justifying diagnoses and describing appropriate pharmacological interventions, however, as discussed in the ensuing provisions, there was need for improvement due to variability in quality. See J8 and J13 for additional information. Given the team approach to psychiatry clinic that was piloted and expanded throughout the facility, psychology representatives and other staff disciplines were present at clinic. Per the documentation reviewed and observations of psychiatry clinic during this review, there were collaborative efforts with regard to the justification of diagnosis and pharmacological interventions. An expansion to include a review of non-pharmacological interventions,	Noncompliance

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		both occurring or proposed for a specific individual, would be a natural outgrowth of this process, and was noted in some of the clinic observations. Review of psychiatric documentation revealed some excellent examples of non-pharmacological interventions (see the example in J10), however, this tended to be physician dependent in that some psychiatrists authored consistently good recommendations for non-pharmacological interventions while others were rudimentary. This was an area where quality assurance and staff training would be beneficial. 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 remained low. During the prior monitoring period, there was one incident, during this monitoring period, there were four incidents. Of these, data indicated that three incidents resulted in intramuscular medications authorized by the primary care physician. In one incident, the psychiatric physician's assistant authorized the medication. Documentation was received for three of the four incidents. A review of the documentation revealed that in two of the three incidents, the physician completed the "Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint." The third document was blank. No additional physician documentation (i.e., physician's progress notes, quarterly clinical documentation) was provided for review with regard to these incidents.	

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		Monitoring Team's Compliance Rating As discussed above, there was 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. In addition, psychiatric documentation regarding the use of emergency chemical restraints must improve. 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.	Extent of Pretreatment Sedation The facility reported a total of 123 instances of pretreatment sedation between 4/3/12 and 9/27/12. Of these, 81 were reported as medical pretreatment sedation and 42 were dental pretreatment sedation. TIVA (general anesthesia) accounted for 22 of the 42 instances of dental pretreatment sedation. Interestingly, of the total of 123 instances of pretreatment sedation, 74 (or 60%) were for individuals participating in psychiatry clinic who were prescribed psychotropic medications. Interdisciplinary Coordination During the month of September 2012, the facility had instituted a pretreatment sedation consultation process. This system, not yet formalized in policy and procedure, required documented input from dental, primary care, psychiatry, and clinical pharmacology prior to the use of pretreatment sedation. Ten examples of this consultation were provided for review. The document allowed for review and commentary by pharmacy, psychiatry, and primary care prior to the consensus review, which occurred in the morning clinical meeting. Of 10 examples available for review, two (20%) did not indicate the consensus recommendation, yet were signed by the medical director. The primary care provider signed all examples, but there was no documentation included with regard to his or her opinion of the proposed treatment. Psychiatry signed all 10 examples. In the majority, the psychiatrist noted agreement with information and concerns documented by pharmacy. In three examples, psychiatry included other information for consideration. 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 continue.	Noncompliance

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		Monitoring After Pretreatment Sedation A review of documentation for 10 individuals 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. In nine examples, this information was included, it was missing from the example included regarding Individual #162. It was acknowledged that this might have been an error in document production. 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. The DERST group had triaged all individuals from one particular home (N=37). They reported for these individuals, the majority required a SAP, however, a total of seven individuals required additional support services. Three individuals required desensitization for medical procedures, and four required dental simulation. The DERST group indicated planned to expand the triage process, ultimately assessing all individuals on campus. A review of current plans, formulated following the formation of DERST revealed four examples of dental desensitization plans and two example of a medical desensitization plan. Of the desensitization examples, all were individualized. 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.	

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		Monitoring Team's Compliance Rating In agreement with the facility self-assessment, this item will remain in noncompliance because continuing effort must be made with respect to interdisciplinary coordination for those individuals requiring pretreatment sedation. As noted above, the facility had made great efforts with regard to developing a process to review individuals who require pretreatment sedation. The had 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 52% of the census (186 individuals) received psychopharmacologic intervention requiring psychiatric services at LSSLC as of 10/29/12. There were three part-time psychiatrists and one physician's assistant providing services totaling 1.1 FTE. 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 in general psychiatry, with one psychiatrist board certified in child and adolescent psychiatry. One psychiatrist was board eligible in child and adolescent psychiatry. There was currently no lead psychiatrist designated. 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 rated this item in substantial compliance and documented their review of the current psychiatric resources in the self-assessment, indicating that there were enough hours for each individual to have a minimum of one hour of consultation with psychiatry monthly (n=186 hours). The calculation then indicated allowances for annual psychiatric assessment updates, IDT meetings, and quarterly psychiatric reviews totaling 112 hours per month. The total psychiatric resources were 197 hours per month, which indicated that these two calculations, resulting in total resource requirements of 298 hours, was impossible to address with the current resources.	Noncompliance

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		The 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, ISP attendance, emergency ISP attendance, discussions with nursing staff, call responsibility, 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. At the time of this review, psychiatry time was consumed with direct clinical care. Psychiatric physicians were not able to attend any ISP or other team meetings due to the lack of clinical resources. During the previous 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 9/25/12. 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 185 individuals. As there were a total of 186 individuals receiving treatment via the psychiatry clinic, the facility psychiatric practitioners had completed 99.5% of the evaluations on the individuals currently assigned to clinic. There had been a laudable effort by the psychiatry clinic staff to complete the annual comprehensive psychiatric evaluations. A review of the data revealed that the vast majority, 147 evaluations or 80% of all comprehensive psychiatric evaluations had been completed in 2012. <u>Review of Completed Evaluations</u> A review of 10 completed comprehensive evaluations revealed that these evaluations were completed between 8/10/12 and 8/31/12. There were sample evaluations provided from	Noncompliance

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		all facility practitioners. Specific challenges noted with the reviewed evaluations included: • variability in the quality of the collaborative case formulation, • variability in the quality of documentation with regard to the justification for both the psychiatric diagnoses and the particular psychotropic medication regimen, • variability in the quality of the generation and documentation of the behavioral-pharmacological hypothesis, and • variability in the quality of identification of non-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 evaluations, 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 must be included. 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. There had been one peer review activity completed wherein a psychiatric provider from another SSLC reviewed one comprehensive psychiatric evaluation. Interviews with facility staff revealed consideration of obtaining outside psychiatric consultants to perform peer review. In addition, the psychiatric nurse and psychiatric assistant were performing quality	

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		assurance monitoring of the psychiatrist's documentation. This was not appropriate. For additional discussion regarding this issue, please see J8. <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 self-assessment, 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	
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 four individuals admitted to the facility since 4/4/12. All newly admitted individuals received a Reiss Screen upon admission. A review of the dates of admission versus the dates the Reiss Screen was completed that the screen was performed an average of 10 days after admission (range 4-15 days). There was no delay in completion of the Reiss Screen following facility admission. <u>Reiss Screen for Each Individual (excluding those with current psychiatric assessment)</u> The total facility census was 359, with 185 individuals enrolled in psychiatry clinic. Therefore, 174 individuals were eligible for baseline Reiss screening. Information received for this visit revealed that from January 2011 through August 2012 a total of 58 individuals were screened, with 11 of these screens occurring in 2012. This indicated that 116 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. These data results differed from the facility self-assessment where it was noted that	Noncompliance

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		"progress has been made – there are approximately 24 individuals that are not followed by psychiatry that need to receive a Reiss screening." Data provided for review indicated the number of individuals requiring screening numbered 116. This is a substantial discrepancy, and it is acknowledged that data provided for review in preparation for the monitoring report may have been incomplete. <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. Interviews indicated that there was one individual (Individual #574) who had received a Reiss screen due to a change in status over the monitoring period. <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, the "Psychiatry Services Procedure Manual" dated 9/25/12 had been revised to include the need for the referral of individuals with a positive Reiss screen for a psychiatric evaluation, "a psychiatrist/PA/ANP will complete a comprehensive psychiatric assessment for…any individual identified as needed a comprehensive psychiatric assessment based on a Reiss screen…any newly admitted individual who has a psychiatric diagnosis or is receiving psychotropic medication, even if the individuals Reiss screen does not identify a need for a comprehensive psychiatric assessment." Of those who were screened in 2012 (N=11), it was documented that three individuals ultimately received a comprehensive psychiatric evaluation. One of these evaluations was performed seven days prior to the Reiss screen and another was preformed 28 days prior to the Reiss screen. The third individual had a Reiss screen dated 3/21/12 and data indicated that the comprehensive psychiatric evaluation was still pending as of October 2012. Review of the "Psychiatry Services Procedure Manual" dated 9/25/12 did not reveal designations of timelines within which psychiatric evaluations should be completed following a referral. <u>Monitoring Team's Compliance Rating</u> 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 implementation of a Reiss screen if there is a change in status, this provision will remain in noncompliance.	

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J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	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 documentation in seven of 10 examples that these were performed collaboratively, and 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. 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. 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), but 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). As data presentation was improved, the next step is for psychology to analyze the data and present hypotheses for improved clinical utility. Data collection practices are also discussed in section K. Collaborative Diagnostic Formulations	Noncompliance

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		A review of the comprehensive psychiatric evaluations of 10 individuals revealed that all contained a case formulation. In 80% of the examples, there was documentation of input by psychology staff or other IDT members 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. • Individual #440: Per the comprehensive psychiatric evaluation dated 8/28/12, documented as completed in collaboration with the IDT, "Schizophrenia, Undifferentiated Type…meets criteria for this by having a history of apparent hallucinations…manifest by trying to rip things out of her throat…seeing and conversing with nonexistent dogs and delusions where she seems to have this belief that there is something evil in her throat…illness…has…with her Mental Retardation… led to social and occupational dysfunction…has previously had a diagnosis of generalized anxiety disorder…further reflection…do not believe she meets criteria for this…has physical problems which can…contribute to her psychological presentation…some chronic pain…difficulty in ambulating…genetically would be predisposed towards Schizophrenia given her mother's history…has during this year, had spikes of behavior which can in part be attributed to an unsettled home situation…individuals acting out more than usual…staff turnover…when staff is more stable, they are better able to work with her, pay proper attention and she is less likely to act out…new staff…would have less familiarity with her and she is more likely to try to gain their attention through inappropriate ways such as screaming…part of her…attention seeking behavior also could be learned…apparently that seemed to work well for her as she was grouping up…basically having a tantrum resulted in being rewarded…will need ongoing attention which hopefully will help her lean ways to seek attention appropriately." The document included specific pharmacological and non-pharmacological interventions for this individual. o This was a good example of a collaborative case formulation. The individual diagnoses were justified, and hypothesis regarding the behavioral challenges were discussed. In addition, specific interventions and suggestions for working with this individual were reviewed. • Individual #166: Per the comprehensive psychiatric evaluation dated 8/31/12 that did not include documentation of collaboration with the IDT, "diagnostic impression: Impulse Control Disorder, NOS; Bipolar Disorder, NOS; Moderate Mental Retardation; Down Syndrome…currently on Depakote and Abilify…has	

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		borderline personality behaviors in the past…has had self injurious behaviors…attention seeking behaviors in the past…history of physical aggression and inappropriate sexual behaviors…a change in residence in June 2012…residing in a transitional home…she has adjusted well to this home…has had some worsening of aggression in the last month, possibly because of the move." The pharmacological interventions revealed plans to continue Depakote, but to increase Abilify due to worsening of aggression in the last month. Non-pharmacological interventions included explanations regarding the potential of increased behavioral challenges following relocation, and "she is in encouraged to participate in activities on the dorm and workshop." o This example did not include specific symptomatology that led the physician to make the diagnosis. It was not possible to determine the physician's thought processes with regard to the current medication regimen, other that medications were to be increased due to behavioral challenges associated with a specific situation. There was a paucity of non-pharmacological interventions recommended. Given the marked variability in documentation, the development of a quality assurance process for document review was recommended. There was one evaluation reviewed by an external peer reviewer, a psychiatrist from a different SSLC. The psychiatric nurse and psychiatric assistant were performing other quality assurance monitoring of the comprehensive psychiatric evaluations. While the psychiatric nurse and assistant can review the documents to ensure that they were performed in a timely manner, that they were signed, and that the information was present on the document, it was inappropriate to have them responsible for quality assurance and the provision of feedback to the physician's with regard to the quality of the evaluations. This should consist of a peer review process performed by a psychiatric physician with staff training followed by corrective action, as needed. <u>Monitoring Team's Compliance Rating</u> Due to the need to improve the quality of the collaborative case formulations, to ensure that the case formulations were collaborative, and to ensure that the psychiatrists were integrated into the overall treatment program inclusive of behavioral support planning and IDT meetings, this provision item remained in noncompliance, which was in agreement with the rating provided via the facility self-assessment.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving	<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	Noncompliance

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	psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	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. 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. 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 #170 – the IDT requested a meeting with this individual's psychiatrist. The monitoring team observed this meeting. The IDT was concerned with regard to this individual experiencing increased restraint episodes, but indicated that some of the increases may have been related to changes in the data reporting requirements for restraint episodes. It was reported that this individual had refused medication on occasion, but it was not possible to determine if medication refusals correlated with increased behavioral challenges and resulting restraint episodes. While the data provided were difficult to interpret, it was notable that there were increased behavioral challenges and restraint episodes occurring on the weekends, when this individual was not engaged in activities. The psychiatrist asked questions regarding behavioral antecedents, the intensity of the behavioral challenges, and the individual's behavior during and following a restraint episode. The IDT was initially focused on medication as the issue, but following the discussion, it was evident that this individual's behavior exacerbations were multifactorial. The psychiatrist solicited input from all members of the IDT, and did a good job of describing the current treatment plan and what benefits would and	

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		would not be observed. This example was illustrative of the need for the psychiatrist to have input into the BSP and the need for psychology to perform an analysis of available data. Per a review of the PBSP documentation provided in the records of 14 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 <u>some</u> 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. This revision to the document was pending at the time of this monitoring visit. <u>ISP Specification of Non-Pharmacological Treatment, Interventions, or Supports</u> Non-pharmacological interventions were discussed during some of the psychiatric clinic encounters observed during the monitoring visit. These included references to related services (i.e., occupational therapy), 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, 30% of these indicated a need to "continue behavioral support plan." There were some excellent non-pharmacological interventions documented in other evaluations (please see the example in J10 below). Overall, both observation and document review revealed that while the focus was primarily on medication management and diagnostic clarification, there was increasing attention to non-pharmacological interventions, which was good to see. 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. <u>Monitoring Team's Compliance Rating</u> 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	

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		appropriate treatment interventions, both pharmacological and non-pharmacological. Therefore, this provision item was rated as being in noncompliance in agreement with the facility self-assessment.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	<u>Policy and Procedure</u> 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." Facility-specific policy "Psychiatry Services Procedure Manual," dated 9/25/12, stated, "before the non-emergency administration of psychotropic medication, the IDT including the psychiatrist, PCP, and nurse, will determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications." 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 14 individuals at the facility who were prescribed various psychotropic medications revealed variable quality in the documentation by the psychiatric physician of an individualized specific risk/benefit analysis with regard to treatment with medication as required by this provision item. In eight of the records, a section entitled "Risk v. Risk analysis" was included in the psychological evaluation. This section did include some elements required by this provision, but did not document collaboration with the psychiatrist. In two records, there was no specific psychiatric documentation and the psychological evaluation was not included. In the remaining four records, the psychological evaluations did not include the "Risk v. Risk" section and information was not specifically included in the psychiatric documentation. For example:	Noncompliance

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		• Individual #562: Per the annual psychiatric evaluation dated 7/13/11, diagnoses included Bipolar Mood Disorder, Type 1; Obsessive Compulsive Disorder; and Intermittent Explosive Disorder. A risk vs. benefit discussion was not included in this documentation, nor was it included in subsequent quarterly psychiatric reviews. At the most recent quarterly psychiatric review dated 9/5/12, non-pharmacological interventions included, "encourage participation in activities on dorm and classroom if possible." At the time of this quarterly review, this individual was prescribed medications including: Benadryl, Prozac, Lithium, Seroquel, and Diazepam. A review of informed consent documentation for this individual documented specific risk associated with the medications and included medication information sheets for the LAR. The documentation of alternatives to treatment included only alternate psychopharmacological agents. o This description did not include a risk vs. benefit analysis per se. • Individual #170: Per the annual psychiatric evaluation dated 2/10/12, diagnoses included Attention Deficit Hyperactivity Disorder, not otherwise specified; Intermittent Explosive Disorder; and Pervasive Developmental Disorder, not otherwise specified. While this document did not specifically address risk vs. benefit of treatment with psychotropic medication, this information was included in the totality of the document. There was a review of this individual's challenging behaviors, the need for the use of physical restraint due to "highly disruptive behaviors" and documentation of attention and concentration deficits. The document also reviewed the use of specific psychotropic medications to address the target behaviors. Medications included Depakote, Seroquel, Adderall XR, Lorazepam, and Inderal. Non-pharmacological interventions were not included in the annual psychiatric evaluation, but were documented in the quarterly psychiatric review dated 4/2/12, "sensory evaluation to determine if…suitable for a weighted vest…placement of pictures of a train in his room to see if he can tolerate additional items…encourage his interest in airplanes, trucks, and trains…continue visits to the zoo and the airport on a monthly basis…continue interventions related to his positive behavior support plan in regards to his targeted behaviors…discuss with dietician his current weight and diet." A review of the subsequent quarterly psychiatric review dated 7/11/12 did not reveal documentation of non-pharmacological interventions. A review of informed consent documentation dated January 2012 did not reveal documentation of non-pharmacological interventions or specific risk vs. benefit information. o While this documentation did not include a risk vs. benefit analysis per se, information was included in the totality of the document. Non-pharmacological interventions were well elucidated.	

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		Additional issues with consent documentation are reviewed below in J14. Even though improvements were 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 for 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 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 <u>during</u> 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, a reasonable estimate of the probability of success, and also compares the former	

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		to likely outcomes and/or risks associated with reasonable alternative strategies. <u>Human Rights Committee Activities</u> 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). <u>Monitoring Team's Compliance Rating</u> 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. The facility self-assessment also gave a noncompliance rating for this provision.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	<u>Facility-Level Polypharmacy Review</u> The facility had their initial monthly polypharmacy review committee 11/1/12. The facility had adopted the correct definition of polypharmacy and had determined, given this definition, which individual's medication regimen met criteria for polypharmacy. At the inaugural meeting, which was observed during the onsite visit, the facility staff reviewed data regarding polypharmacy facility wide, via the individual's psychiatric treatment provider, and via the individual's home. The staff indicated plans to review data trends over time. At this initial meeting, individual medication regimens were not reviewed. Facility staff indicated plans to include the review of individual regimens in the upcoming agenda. <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." In response to the document request, polypharmacy justifications were provided for 39 individuals, these justifications were collated from the document referenced above. There was variability in the quality of the documentation. For example: • Individual #194- documentation indicated, "Polypharmacy is in effect, because she is on Latuda, Ativan, and Trazodone." o This documentation did not include a rationale for polypharmacy and was unacceptable as a justification for treatment with these medications. • Individual #505 – documentation indicated, "is on three different psychotropic	Noncompliance

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		medications…Lithium and Zyprexa are…both mood stabilizers and target…mania…did not really respond to treatment with Lithium primarily and Zyprexa was necessary to get his manic behavior, which had reached an extreme degree, to be controlled. He does not appear overly sedated from the medication…the Lithium is in the therapeutic range. BuSpar was added for agitation and restlessness and seems to make a difference for him and of course this targets anxiety type symptoms. Accordingly it is felt given the degree of mania on lesser amounts of medication that polypharmacy is warranted and that the benefit outweighs the risk. He did have weight gain on Zyprexa and Lithium can contribute to that; however, this again is now controlled well with caloric restrictions." o This was an example of a well articulated justification for polypharmacy that indicated the physician's thought process and rationale for 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 meets 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. <u>Review of Polypharmacy Data</u> A review of the current data available regarding polypharmacy revealed 43 individuals who met criteria for polypharmacy. Per interviews with the facility clinical pharmacist, the facility had just begun to review polypharmacy data, with the initial data review performed by the facility psychiatric nurse. This should be the responsibility of the facility clinical pharmacist. The initial data review was completed during this monitoring visit, thus, the facility had not begun the review of 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. If the individual meets criteria for polypharmacy, there must be justification for this (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. <u>Monitoring Team's Compliance Rating</u> Given the ongoing challenges noted above with regard to the need for a review of the	

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		medication regimens for the individuals as well as the need for a facility level review of polypharmacy justifications, this provision was rated in noncompliance, which was the same self-rating by the facility in the self assessment.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	<u>Completion Rates of the Standard Assessment Tools (i.e., MOSES and DISCUS)</u> 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 July 2012. Tracking data for other months were not provided. This may have been an error in the generation of the document request because, in previous monitoring reviews, tracking data were provided for the period under review. Review of the tracking information provided revealed timely completion of both evaluations for July 2012. Review of 14 records and 10 examples of MOSES and DISCUS documentation provided revealed timely completion of the assessments. 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. <u>Training</u> A review of information regarding training for nursing staff revealed that a one hour 15minute block of time during pre-service orientation was assigned to MOSES and DISCUS training. Training 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. The information provided included sign-in sheets for four nurses who attended new employee orientation in June 2012. Per the facility self assessment, four registered nurses were promoted to nurse case manager during this time period and all four received MOSES and DISCUS training. Sign-in sheets regarding the latter group's attendance were not provided for review. <u>Quality of Completion of Side Effect Rating Scales</u> In regard to the quality of the completion of the assessments, it appeared that for the set of scales provided (13 examples of each assessment tool), five were completed appropriately and all included the signature of the psychiatrist. In three cases, clinical correlation was documented on the evaluation form. For example, in the case of Individual #392, documentation included on the completed MOSES dated 7/26/12 per the nurse examiner stated, "has experienced an increase in agitation, psychotic thoughts, insomnia, and aggression." Psychiatric documentation indicated, "When psychiatric agitation improves,	Substantial Compliance

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		her MOSES will improve." This individual was seen in psychiatry clinic 8/7/12 where MOSES and DISCUS scores were reviewed and discussed with regard to elevations in scores related to irritability and agitation. Other examples revealed the psychiatrist's signature on the assessment documents, but a failure to complete the DISCUS with regard to the physician's conclusion of the presence or absence of a diagnosis of Tardive Dyskinesia. Of the 13 examples available, three did not include psychiatric quarterly clinical documentation. Of the remaining 10, one included psychiatric documentation that the MOSES and DISCUS scores were not available in clinic, however, per review, the assessments were performed one month prior to the clinic date. In the four 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. <u>Monitoring Team's Compliance Rating</u> Given the documentation of review of MOSES and DISCUS examinations during psychiatry clinic, this area will remain in substantial compliance. For the facility to maintain this rating again at the next onsite review, 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	<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 9/25/12. 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. With regard to integrated care, the facility had developed a policy entitled, "Integrated Clinical Services" dated 10/1/12. This policy outlined specific documentation requirements for staff members including psychiatry. It did not include	Noncompliance

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	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.	timelines within which specific tasks should be completed (e.g., acceptable time period between referral for a comprehensive psychiatric evaluation and completion of the evaluation). <u>Treatment Plan for the Psychotropic Medication</u> Per record reviews for 14 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 #582, the psychiatric evaluation was completed 6/12/12, and noted review of collateral documentation, and a conversation with the individual's mother. A signature page attached to the evaluation noted participation of the psychologist, nurse, QDDP, and direct support staff. Specific psychiatric diagnoses were indicated including Autistic Disorder, Insomnia due to Autistic Disorder, and Severe Mental Retardation, in addition to medical diagnoses, including seizure disorder, migraine headaches, and harlequin syndrome (a condition where the individual experiences sweating and flushing on one side of the body and the other half of the body does not demonstrate sweating or flushing.) Diagnoses were documented, and specific symptoms or criteria that were present were outlined for the diagnosis of Autism. In addition, "has a history of significant insomnia…Trazodone has been effective in terms of reducing the frequency and severity of SIB…has responded well to Adderall 20 mg tid (three times daily) for hyperactivity and impulsivity related to Autistic Disorder…has had periods of weight loss…which may be partially related to Adderall…dosing has not changed." Per the pharmacological intervention, the dosage of Adderall and Trazodone would remain stable, with plans to taper melatonin, which was being utilized to address insomnia. • It was concerning that the effect of the stimulant medication on this individual's sleep pattern was not addressed in the document. Non-pharmacological interventions were minimal in that they did not include any recommendations outside of the PBSP. • This example illustrated improvements with regard to the justification of a particular diagnosis, but ongoing weaknesses with regard to the development of a cogent case formulation inclusive of a behavioral/pharmacological hypothesis and recommendations for non-pharmacological interventions. 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	

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		documentation between providers. This was an area where quality assurance or peer review may be helpful. Psychiatric Participation in ISP Meetings At the time of the onsite 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. Psychiatry Clinic 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. 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. 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	

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		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 difficult to determine timeliness with regard to psychiatric follow-up. There was concern that quarterly reviews were delinquent. For example, data indicated that Individual #215 was seen for quarterly reviews 1/9/12 and 7/5/12, indicating that a second quarter review was not performed. Individual #591 was seen for a comprehensive psychiatric evaluation 2/17/12 and for a quarterly review 8/20/12, indicating that a second quarter review was not performed. Individual #542 was seen for a quarterly review 12/14/11 and 6/11/12 indicating that a first quarter review was not performed. This was not an uncommon occurrence in the data, and there was concern with regard to the accuracy and utility of these data. <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. <u>Monitoring Team's Compliance Rating</u> 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 addition to the above, 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). Individuals must be reviewed in psychiatry clinic on a quarterly basis.	

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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 9/25/12, "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, 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. There were 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. It was reported that the facility staff were mailing the information to the LAR, however, this was not documented in the record. Additionally, the consent form should include space to document the conversation or conversation attempts with the individual and the LAR. Current Practices 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 reportedly engaged in obtaining informed consent for annual medication renewals. The manner in which the data	Noncompliance

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		were presented for this review did not allow for a determination with regard to the extent that annual medication consents had been completed. A review of 14 records revealed that six records were for individuals admitted during the previous year, and eight contained documentation indicating completion of the annual consent process. One record contained no documentation of the consent process. Given these data, it was apparent that annual medication consent was occurring. A review of 10 examples of informed consent documentation regarding new medication prescriptions revealed continued improvements with regard to physician documentation. Nine of the 10 examples regarding new medication prescriptions included an attached signed IDT document regarding review of the proposed medication, with two of these 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 paucity of documentation regarding non-pharmacological interventions considered or utilized. Discussions with psychiatric clinic staff during the previous 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…" This revision remained pending at the time of this monitoring visit. 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. <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 as well as a tracking system for the completion of the consent process, both for the initiation of new medications and annual medication consents. Although some improvements were noted, given the variable quality of the documentation and the need to begin quality assurance reviews of the physician's current consent practices a noncompliance rating was appropriate.	

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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 9/25/12, 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. Per the Operational Procedures Manual, "Integrated Clinical Services" dated 10/1/12, there is no specific information included regarding neurology, however, statements of "Integration Philosophy" for both primary care providers and the psychiatrist were included. While no specific integration tasks were defined, "it is the belief of the LSSLC Psychiatry Department that the Individual should be viewed holistically when determining a course of treatment. Integration serves as the vehicle by which Psychiatry collaborates with other disciplines to discover and affect the many aspects that influences the Individual's psychiatric wellbeing and quality of life." Individuals with Seizure Disorder Enrolled in Psychiatry Clinic There were 31 individuals participating in the psychiatry clinic who had a diagnosis of seizure disorder (following the onsite review, the facility reported that there were 45 individuals). There was concern that these data may have been inaccurate. In previous reports, this number totaled 66, and the data provided for this monitoring period included information for individual's with last names beginning with A-P only. Of the 15 records available for review, two had a diagnosis of seizure disorder. A review of these two records revealed: • Individual #363 – This individual was seen by the consulting epileptologist 7/23/12. The physician recommended that given recent seizure activity, the dosage of the antiepileptic medication Keppra increase with plans to review the case in six months for consideration of a taper and discontinuation of a second seizure medication, Dilantin. A psychiatry note dated 8/22/12 revealed concerns regarding increasing behavioral challenges, and indicated this may have been related to the increased dosage of Keppra or to medical issues. At the time of this psychiatry quarterly review, this individual was hospitalized due to a diagnosis of pneumonia. Records revealed this individual was hospitalized 8/17/12 – 8/28/12 then housed in the facility infirmary 8/29/12- 9/6/12. This individual returned to neurology clinic (the physician for this review was not the same physician utilized in the 7/23/12 consultation) 9/26/12 and due to behavioral challenges attributed to Keppra, the dosage of this medication was decreased, with plans to taper to discontinuation over the next two months. Further review of the behavioral data revealed that target symptoms of physical aggression and intrusive behaviors were	Noncompliance

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		reported as totals for the quarter and revealed elevations over the previous quarter. When reviewing the monthly totals, the elevations occurred in the month of June 2012, prior to the increased dosage of Keppra. Given this information, it was unclear what contributed to the increased behavioral challenges. This case illustrated difficulties with the presentation of data, the analysis of data, the review of data with regard to pharmacological decision making, and the integration of psychiatric and neurological treatment. • Individual #305 – This individual was seen in neurology clinic 7/11/12. At that time, it was noted that he had "poorly controlled seizures" and the battery for his vagus nerve stimulator had recently been changed. It was also noted that the individual's father was requesting discontinuation of Valium. The neurologist indicated that with regard to tapering Valium, there were no concerns with regard to seizure activity, but "I am not exactly sure the Diazepam (Valium) is given for seizures or for agitation or aggressiveness." At this time, the neurologist ordered the taper of Valium over a two-week period from a total of four mg daily to a total of two mg daily. This individual was seen in psychiatry clinic 8/23/12. At that time, it was noted that behavioral data were not collected in the month of June 2012. Data for the month of July 2012 revealed an increase in physical aggression. It was not possible to determine if this was temporally related to the decreased dosage of Valium on 7/11/12 because data were reported as totals for the month rather than daily. There was also documentation that this individual had changed homes, which may also contribute to increased behavioral issues. It was not possible to determine the date the move occurred. Per the psychiatric quarterly review dated 8/23/12, the increased behavioral challenges were noted, but the contribution of the reduction in the dosage of Valium was not documented as a consideration. This case illustrated difficulties with the presentation of data, the analysis of data, and the integration of treatment between psychiatry and neurology with regard to clinical decision making. <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 neurologist's office "if need be." In July 2012, the facility obtained consultative services from an epileptologist. This physician provided services over a one-week period during which 85 individuals were scheduled for evaluation, 72 of whom were also in psychiatry clinic. Of the 31 individuals participating in psychiatric clinic who had a concomitant seizure disorder diagnosis, 24 were scheduled. Psychiatric providers attended neurology clinic four of the five available dates. Psychiatric providers interviewed indicated that the collaborative consultations were useful. Review of the documentation generated from this clinic revealed	

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		recommendations for ongoing care. It was unclear if the consultant would be returning to the facility on a regular reoccurring basis. 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 31 individuals, three had not had neurology follow-up in the past year. Individual #273 was last seen in 2002, Individual #102 was last seen in 2004, and Individual #388 was last seen in 2001. A review of the schedule of the consulting epileptologist indicated that these three individuals were not scheduled for this clinic. Given these data, the need for increased neurological clinical consultation was apparent, as 10% 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 resources 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 neurologic consultation availability, specifically increasing the contract with the current provider, exploring consultation with local medical schools and clinics, and considering telemedicine consultation with providers currently contracted in other DADS facilities. <u>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. While there were gains noted (the week-long epileptology consultation, psychiatric provider attendance at some of the epileptology clinic), ongoing issues including 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. Review Appendix B comprehensive psychiatric evaluations 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. Complete triage for all individuals requiring pretreatment sedation for medical and dental clinic and determine the need for individualized desensitization plans or other supports (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. Continue cross discipline consultation regarding pre treatment sedation options and improve documentation thereof (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 that 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. The facility should consider the development of a procedure regarding Reiss screening completion following a change in status (J7).

16. Peer review of psychiatric documentation must be performed by a peer (i.e., a psychiatric physician) with corrective action as necessary (J8).

17. 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).

18. 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 (J8, J9).

19. 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 (J8, J9).

20. Improve the documentation regarding the review of risk/benefit ratios for the prescription of psychotropic medications that are authored 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).

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

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

23. 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. This should be considered for peer review and quality assurance monitoring (J11).

24. Improve physician completion rates of MOSES and DISCUS forms with regard to the sections entitled evaluation (DISCUS) and prescriber review (MOSES) (J12).

25. Ensure that the indications for specific medications correspond to the purported diagnosis, and that appropriate defined behavioral/symptom data points are being monitored. This should include the development of a behavioral-pharmacological hypotheses included as part of the psychiatric treatment plan, 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 specific requirements of this provision as prompts on forms utilized by psychiatry (J13).

26. Consider incorporating ISP meetings and documentation of such 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. This data must be presented in a manner that is useful to the physician (i.e., in graph form, with medication adjustments, identified antecedents, and specific stressors identified) (J8, J13).

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

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

34. Complete the informed consent process for all individuals prescribed psychotropic medication (J14).

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:** Documents Reviewed: o Functional Assessments for: • Individual #91 (8/9/12), Individual #466 (4/11/12), Individual #31 (7/25/12), Individual #479 (7/9/12), Individual #4 (6/8/12), Individual #368 (5/25/12), Individual #43 (7/31/12), Individual #36 (6/29/12), Individual #298 (9/21/12), Individual #488 (7/13/12), Individual #592 (7/9/12), Individual #344 (8/20/12), Individual #484 (5/16/12) o Positive Behavior Support Plans for: • Individual #91 (8/9/12), Individual #466 (4/11/12), Individual #31 (7/25/12), Individual #479 (7/9/12), Individual #4 (6/8/12), Individual #368 (5/25/12), Individual #43 (7/31/12), Individual #36 (6/29/12), Individual #298 (9/21/12), Individual #488 (7/13/12), Individual #592 (7/9/12), Individual #344 (8/20/12), Individual #484 (5/16/12) o Six months of notes on PBSPs progress for: • Individual #91 (8/9/12), Individual #466 (4/11/12), Individual #31 (7/25/12), Individual #479 (7/9/12), Individual #4 (6/8/12), Individual #368 (5/25/12), Individual #43 (7/31/12), Individual #36 (6/29/12), Individual #298 (9/21/12), Individual #488 (7/13/12) o Full Psychological Assessments for: • Individual #91 (8/9/12), Individual #466 (4/11/12), Individual #31 (7/25/12), Individual #479 (7/9/12), Individual #4 (6/8/12), Individual #368 (5/25/12), Individual #43 (7/31/12), Individual #36 (6/29/12), Individual #298 (9/21/12), Individual #488 (7/13/12), Individual #592 (7/9/12), Individual #344 (8/20/12), Individual #484 (5/16/12) o Annual Psychological updates for: • Individual #250 (8/1/12), Individual #466 (7/20/12), Individual #298 (8/21/12), Individual #112 (9/18/12), Individual #544 (8/13/12), Individual #261 (8/16/12), Individual #370 (9/4/12), Individual #428 (8/10/12), Individual #492 (9/19/12), Individual #91 (8/16/12) o Counseling Assessment and Treatment Plan for: • Individual #466 o Section K recommendation responses, 10/12 o Section K Self-Assessment, 10/22/12 o Section K Action Plan, 10/17/12 o Peer Review/Behavior Support Committee reviewer form, undated 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 Section K Presentation book, undated o Counseling Assessment and Treatment Planning Procedures, 9/12/12 o A list of all individuals receiving counseling, undated o List of all psychology staff and status of enrollment in BCBA coursework, undated o Data Collection Reliability Spot Checks, undated o IOA Data report, 8/12 o Sample Behavior Data sheet, home 559B o Data Collection Reliability Data, 6/12-9/12 o Positive Behavior Support IOA/Program Integrity Data Form, undated o A list of individuals with full psychological assessments, undated o Positive Behavior Support IOA/Program Integrity Data Form, undated o Psychology Section K update of progress, dated 10/12 o A list of all individuals with a PBSP, undated o A list of individuals for whom a functional assessment had been completed in the last six months <u>Interviews and Meetings Held</u>: o Sylvia Middlebrook, Ph.D., BCBA, Director of Psychology o Robin McKnight, M.A., BCBA; Supervising Psychologist and Behavior Analyst I o Sylvia Middlebrook, Ph.D., BCBA, Director of Psychology; Martha Thomas, M.S., Associate Psychologist V; Robin McKnight, M.A., BCBA; Supervising Psychologist and Behavior Analyst I; Mike Fowler, M.A., Associate Psychologist V; Kari Staley, M.A., BCBA; Supervising Psychologist and Behavior Analyst I; Edward Hutchison, M.S., BCBA consultant o Donna Kimbrough, M.A., Associate Psychologist; Kenneth Elerson, M.A., Associate Psychologist; Adam Williams, M.Ed., Associate Psychologist; Kari Staley, M.A., BCBA, Supervising Psychologist and Behavior Analyst I o Julie Bradford, M.S., Associate Psychologist; Jill Harris, M.A., Associate Psychologist; Jackie Keith, M.Ed., BCBA; Associate Psychologist; Martha Thomas, M.S., Associate Psychologist V o Keith Bailey, Residential Director; Kenneth Self, Rotley Tankersley, Todd Miller, and Mary Stovall, Unit Directors <u>Observations Conducted</u>: o Psychiatric Review Meeting • Individuals presented: Individual #466, and Individual #67 o Community Living Discharge Planning meeting • Individual discussed: Individual #162 o Restraint Reduction Meeting o Peer Review Meeting • Individual presented: Individual #420 o Behavior Support Committee Meeting • Individuals discussed: Individual #170, Individual #453, Individual #555, Individual #542, Individual #102

	o Counseling Committee Meeting o PBSP Staff Trainings • For Individual #420 • For Individual #542
	Facility Self-Assessment: Overall, the self-assessment included relevant activities in the "activities engaged in" sections. As discussed in the last report, the self-assessment appeared based directly on the monitoring team's report. LSSLC's self-assessment consistently included a review for each provision item, a list 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 continued to proceed 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 continues to recommend that the facility establish, and focus their activities, on selected short-term goals. The specific provision items the monitoring team suggests that facility focus on in the next six months are summarized below, and 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 many improvements, across almost every item in this provision, since the last onsite review. These improvements included: • Three additional psychologists became certified applied behavior analysts (K1) • Expansion of the collection and graphing of replacement behaviors (K4) • Expansion of the collection of data collection reliability and inter-observer agreement (IOA) data (K4 and K10) • Improvements in the quality of functional assessments (K5) • Improvements in the number and comprehensiveness of full psychological assessments (K5)

	• Increase in the number of full psychological assessments that are current (K6) • Improvements in the comprehensiveness of the annual psychological assessments (K7) • The establishment of formalized counseling services (K8) • Improvements in the quality of PBSPs (K9) • The expansion of the collection of treatment integrity data (K11) The areas that the monitoring team suggests that LSSLC work on for the next onsite review are: • Establish minimal frequencies of data collection reliability and IOA collection per individual with a PBSP (K4) • Establish minimal acceptable data collection reliability and IOA levels, and demonstrate that those frequencies and levels are achieved (K4) • Ensure that all data systems are providing the data necessary to encourage data based treatment decisions (K4) • Increase the number of individuals with full psychological assessments (K5) • Ensure that all annual psychological assessments contain a review of medical variables (K7) • Establish minimal frequencies of treatment integrity collection per individual, establish minimal treatment integrity levels, and ensure that those levels are achieved (K11)

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision item was rated as being in noncompliance because, at the time of the onsite review, not all psychologists at LSSLC who wrote Positive Behavior Support Plans (PBSPs) were certified as applied behavior analysts (BCBAs). The facility, however, made progress on this provision item. Since the last review three psychologists received their BCBA, making a total of four BCBAs. Additionally, three more psychologists were eligible to take the national exam in January 2013. Twelve of the 15 psychologists who write PBSPs (80%) either had their BCBA, or were enrolled, or completed coursework toward attaining a BCBA. One of the psychologists that was not enrolled or completed BCBA coursework had committed to begin coursework in the spring. This percentage of psychologists with their BCBA, or enrolled in or completed BCBA coursework, is slightly less than that reported in the last review (87%). The facility provided supervision of psychologists enrolled in the BCBA program by contracting with a consulting BCBA. LSSLC and DADS are to be commended for their efforts to recruit and train staff to meet the requirements of this provision item. The facility developed a spreadsheet to track each psychologist's BCBA training and credentials. To achieve substantial compliance with this provision item, the department needs to ensure that all psychologists who write PBSPs attain BCBA certification.	Noncompliance

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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, was a BCBA, and had over 10 years of experience working with individuals with intellectual disabilities. Additionally, 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 Support Committee (BSC) meetings that contained many of the elements of internal peer review, however, these meetings continued to only review PBSPs that required annual approval. The peer review meetings provided an opportunity for psychologists to present cases that were not progressing as expected or were new to the facility. The peer review meetings also allowed more time to discuss cases. The internal peer review meeting observed by the monitoring team reviewed Individual #420's functional assessment and 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 #420's target behaviors. 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.	Substantial Compliance
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including	The monitoring team noted many improvements in this provision item that are discussed in detail below. In order to achieve substantial compliance, however, the facility needs to ensure that data collection reliability and interobserver agreement (IOA) are collected for each individual with a PBSP, establish acceptable data collection reliability and IOA frequencies and levels, and demonstrate that those frequencies and levels are achieved. Additionally, the facility needs to expand the collection and graphing of	Noncompliance

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	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.	replacement/alternative behaviors to all individuals with a PBSP. Finally, LSSLC needs to ensure that when individuals are not making expecting progress, the progress note or PBSP consistently indicates that some activity (e.g., retraining of staff, modification of PBSP) had occurred. At the time of the onsite review, LSSLC utilized two data systems. In one, the direct care professionals (DCPs) were required to record the frequency of target and replacement behaviors in one-hour intervals, 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 two-hour intervals to indicate if the target and replacement behaviors occurred. The use of multiple data systems that are flexible to individual data needs (e.g., very low frequency behaviors) can improve the practicality and usefulness of a data system. Reducing the amount of data collected, however, could result in the loss of critical information. For example, in 520A and 520B, the staff were to circle yes or no (if the behavior occurred) for both target and replacement behaviors for each 2-hour interval. For four individual data sheets reviewed (i.e., Individual #582, Individual #227, Individual #566, and Individual #578), the PBSP indicated multiple replacement behaviors, however, there was only one place to indicate if a replacement behavior occurred (at each 2-hour interval). Therefore, with this data system, it was impossible to determine which replacement behavior occurred. The facility is encouraged to review these multiple data systems and ensure that all data systems are providing the data necessary to encourage data based treatment decisions. 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 during a shift and determine if DCPs were recording data at the intervals specified (i.e., data collection reliability). As in past reviews, the monitoring team did its own data collection reliability by sampling individual data books across several homes, and noting if data were recorded up to the previous hour for target and replacement behaviors. The results were very encouraging: • The target and replacement behaviors sampled for 15 of 18 data sheets reviewed (83%) were completed up to the previous hour. This was substantially better than the last review when only 37% of the data sheets were recorded up to the previous hour. The three data sheets that were not completed up to the previous interval, ranged from data that were not completed in two previous intervals (Individual #529 and Individual #408), to data that were not filled out for the entire shift (Individual #357).	

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		One reason that data collection reliability may have improved so dramatically since the last review is that the facility modified (as recommended in the last review) and extended its collection of data collection reliability to all units. It is now recommended that the facility establish minimum frequencies for the collection of data collection reliability (i.e., how often it is collected), and ensure that those frequencies occur. Additionally, data collection reliability levels should be established (i.e., what are acceptable data collection reliability scores), and ensure that those goals are achieved. The usefulness of this form 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), however, being in the treatment site and discussing with DCPs why they were not recording data immediately after each interval has likely improved the timeliness of data recording at LSSLC. In addition, the support and involvement of the residential unit directors likely also contributed to the improvements observed. As discussed in the last review, the facility had begun to collect inter-observer agreement (IOA) data. At the time of the onsite review, IOA was expanded to all four units (however not for all PBSPs) at LSSLC. Eight of the 13 PBSPs reviewed (62%) contained a description of IOA data. This represented an improvement from the last review when 46% of PBSPs reviewed contained IOA data. The monitoring team was encouraged by the expansion of IOA at LSSLC. It is recommended that the facility now ensure that IOA is collected for each PBSP, establish the minimum acceptable frequency of IOA collection, establish specific IOA goals (i.e., how high does IOA need to be), and ensure that these frequencies of IOA collection and levels are attained. As recommended in the last report, the facility had continued to expand its collection of data on replacement behaviors. At the time of the onsite review, the collection of replacement behavior follow-up expanded to all four residential units. The monitoring team found replacement behavior in 18 of the 18 individual notebooks examined (100%). This represented an improvement from the last review when 79% of data sheets reviewed contained replacement behaviors. Another area of continued improvement at LSSSLC was the graphing of data. There was evidence of 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 #466's and Individual #592's target behaviors were graphed in hourly and daily increments to better identify a potential pattern in their undesired behaviors. Additionally, as recommended in the last report, all the graphs reviewed by the	

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		monitoring team were simplified by reducing the number of data paths and adding of phase lines to mark medication changes and/or other potentially important events. Finally, as recommended in the last report, the facility increased the graphing of replacement/alternative behaviors. Replacement/alternative behaviors were graphed in 10 of the 13 PBSPs reviewed (77%). This represented an improvement from the last review when only 23% of the PBSPs reviewed had graphed replacement behaviors. It is now recommended that the facility extend graphing of replacement behaviors to all individuals with a PBSP. The routine use of data to make treatment decisions also continued to improve. For example, in Individual #466 's psychiatric review, the psychologist presented graphs that were current (the graphs represented data that occurred up to one day 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 #466's team, and to data based decisions concerning her use of medications and various treatment interventions. In reviewing six months of PBSP data and progress notes for 10 individuals, four (40%) indicated a lack of progress in at least one severe target behavior. This represented an improvement from the last review when 58% of PBSPs reviewed indicated a lack of progress. As discussed in the last review, the monitoring found some examples of action taken to address the lack of progress. For example, • Individual #298's functional assessment and PBSP were modified prior to the annual review as a result of changes suggested in a recent internal peer review meeting (see K3) • Individual #466's April 2012 progress note indicated that her PBSP was revised due to her lack of progress • Individual #36' May 2012 progress note suggested that an increase in target behaviors may be related to an increase in mental health issues and a referral to rule out psychiatric and medical issues was made which resulted in a decrease in her target behaviors Not all progress notes reviewed however, indicated that some activity (e.g., retraining of staff, modification of PBSP) had occurred in response to an individual not making expected progress. For example, although Individual #43's progress note repeatedly stated that some of her aggressive behavior was related to pain, no action (e.g., monitoring if pain medication is administered, retraining of staff) was noted despite substantial increases in aggression in June 2012 and July of 2012. It is recommended that in those instances when an individual is not making expecting progress, that the	

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		progress note or PBSP consistently indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred. 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 LSSLC.	
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 evidence that functional assessments were reviewed at least annually. <u>Psychological Assessments</u> A spreadsheet of full psychological assessments indicated that 245 of the 359 individuals at LSSLC (68%) had a full psychological assessment. This represented an improvement from the last review when 53% of individuals had a full psychological assessment. Thirteen full psychological assessments were reviewed to evaluate their comprehensiveness. As found in the last review, all (100%) full 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. It is recommended, however, that all individuals at LSSLC have a full psychological assessment. <u>Functional Assessments</u> A spreadsheet provided to the monitoring team indicated that 162 of the 359 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 indicated that 88 functional assessments were completed since the last review. Thirteen of these functional assessments (15%) were reviewed to assess compliance with this provision item. As discussed in previous reports, the facility used a format combining psychological evaluations, PBSPs, and functional assessments that included all of the components commonly identified as necessary for an effective functional assessment. 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/administrating questionnaires, interviews, or rating scales. As found in the last report, all of the functional assessments reviewed included acceptable indirect assessment procedures. Eleven of the 13 functional assessments	Noncompliance

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		reviewed (85%) were judged to contain adequate direct assessment procedures. This represented a substantial improvement from the last review when 42% of direct observation procedures were judged to be acceptable. An example of a complete direct assessment procedure is described below: • Individual #466's functional assessment included a direct observation that included the observation of her aggressive behavior and a clear example of staff attention that was hypothesized to maintain the behavior. The two direct assessment procedures rated as unacceptable (i.e., Individual #484 and Individual #298) included direct observations, but they did not include an example of the target behavior and, therefore, did not provide any additional information about relevant antecedent or consequent events affecting the target behavior. All functional assessments should include direct functional assessments that include target behaviors and provide additional information about the variables affecting the target behavior. All of the functional assessments reviewed (100%) identified potential antecedents and consequences of the undesired behavior. This is 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 thirteen of the functional assessments reviewed (100%) were judged to have a clear summary statement. This is consistent with the last review when 100% of the functional assessments reviewed were found to have a clear summary statement. There was evidence that some functional assessments at LSSLC were reviewed and modified when an individual did not meet treatment expectations (e.g., Individual #298). Since the functional assessments and PBSPs were included in the same document at LSSLC, functional assessments are revised and reviewed when PBSPs are revised and reviewed (see K4). As discussed in K9, however, 15% of functional assessments/PBSPs were more than year old. 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 as soon as possible (rather than waiting until the annual review). Additionally, all functional assessments should be reviewed at least annually. Eleven of the 13 functional assessments reviewed (85%) were evaluated to be	

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		comprehensive and clear (Individual #484 and Individual #298 were the exceptions). This represented another significant improvement over the two previous reviews when 6% (October 2011) and 42% (last report) of the functional assessments reviewed were evaluated as acceptable.	
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.	Not all full psychological assessments were current and, therefore, this provision item was rated as being in noncompliance. A spreadsheet of the dates of all psychological assessments at LSSLC indicated that 177 of 245 (77%) were completed in the last five years. This represented a sharp increase in the percentage of individuals at LSSLC with current psychological assessments (including intellectual assessments) reported in the last review (30%). Eight of the 13 intellectual assessments (contained in the full psychological assessments reviewed) reviewed (62%) were conducted 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. As found in the last review, annual psychological assessments were completed for all individuals at LSSLC (100%). Ten annual assessments were reviewed by monitoring team to assess their comprehensiveness: • Seven annual psychological assessments (70%) were complete and contained a standardized assessment of intellectual and adaptive ability, a review of personal history, a review of behavioral/psychiatric status, and a review of medical status • The other thee annual assessments (i.e., Individual #428, Individual #492, and Individual #91) were missing a review of medical status. This represented an improvement from the last review when 36% of the annual assessments reviewed were rated as comprehensive. In order to achieve compliance with this item of the Settlement Agreement, all individuals at the facility will need to have complete annual psychological assessments that contain a standardized assessment of intellectual and adaptive ability, a review of personal history, a review of behavioral/psychiatric status, and a review of medical status.	Noncompliance

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		Psychological assessments should be conducted within 30 days for newly admitted individuals. A review of recent admissions to the facility indicated that this component of this provision item continued to be in 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.	Psychological services, other than PBSPs were beginning to be provided at LSSLC. This item was rated as being in noncompliance because, at the time of the onsite review, only one individual was beginning to receive services. The criteria for substantial compliance are detailed below. The facility recently began a counseling committee to identify all individuals that needed psychological services, other than PBSPs, and to ensure that all of these services were consistent with this provision item. At the time of the onsite review, LSSLC offered individual therapy to one individual. The treatment plan reviewed was found to be goal directed, with measurable objectives and specific treatment expectations. It also included a fail criterion and a plan for the generalization of acquired skills. Staff who provided therapeutic interventions appeared qualified to do so through specialized training, certification, or supervised practice. The treatment plan reviewed, however, did not indicate that they were derived from evidence-based practices and there were no progress notes available for review at the time of the onsite review. 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. Additionally, 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 Finally, the facility will need to demonstrate that their therapies are evidence based and steps have been taken (e.g., attended conferences, workshops, modified curriculums) to ensure that all therapies represent current best practice.	Noncompliance

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K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	This item was rated as being in noncompliance because not all PBSPs were updated at least annually, and some PBSPs reviewed did not contain all of the required components. A list of individuals with PBSPs indicated that 162 individuals at LSSLC had PBSPs and 24 of these (15%) were more than 12 months old. All PBSPs should be reviewed when necessary, and at least annually. Ninety-three PBSPs were completed since the last review, and 13 (14%) of these 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, however, three (Individual #484, Individual #479, and Individual #344) of these included definitions that were not operational (23%). This represented a decrease from the last review when all PBSPs reviewed contained operationally defined target behaviors. The reason these target behaviors were not rated as operational is highlighted below: • Individual #484's PBSP defined disruptive behavior as "…talking about inappropriate subjects…making provocative comments…" • Individual #479's PBSP defined depressive symptoms as "…depressed mood…" • Individual #344's PBSP defined putting inedibles in mouth as "Putting inedible substances into her mouth *for stimulation.*" These definitions required the reader to infer if individuals' comments were provocative, their mood depressed, or if they engaged in the target behavior for stimulation. An operational definition should not require DCPs to infer an individual's knowledge or intentions. An operational definition should only include observable behavior. All PBSPs should include operational definitions of target behaviors. All 13 (100%) of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors that appeared to be consistent with the stated function of the behavior and, therefore, were likely to be useful for weakening undesired behavior. This represented a sharp improvement from the last review when only 54% of the PBSPs reviewed were judged to be consistent with the stated function. 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 replacement behaviors were functional in 11 of the 12 PBSPs (92%). This represented a slight decrease from the last review 100% of all replacement behaviors that could be functional were functional. The replacement	Noncompliance

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		behavior that was not functional was: • Individual #484's PBSP hypothesized that his disruptive behavior was maintained by staff attention. His replacement behavior was working without disrupting others, maintaining appropriate distance, and staying on task. These behaviors were incompatible with his target behavior and, therefore, likely an appropriate goal for Individual #484, however, they did not appear to be functional. Examples of a functional replacement behavior could include teaching/reinforcing another way to gain attention, such as requesting time to talk to staff. All 13 functional replacement behaviors discussed above appeared to be behaviors already in the individual's repertoire and, therefore, the PBSP instructions were more related to actions staff needed to complete rather than skills the individual needed to acquire. For replacement behaviors that are already in the individual's repertoire, a SAP would not be required. For example: • Individual #368's replacement behavior included saying "no" to staff when he wanted a break. The PBSP included instructions for staff to encourage Individual #368 to say "no" when he wanted to avoid an undesired activity. Based only on the reading of the PBSP, the monitoring team can only speculate as to if these replacement behaviors were in the individual's repertoire, or if they required the acquisition of a new behavior. The purpose of introducing this distinction is that when the replacement behavior requires the acquisition of a new behavior, it should be written in the new format skill acquisition plan (SAP, see S1). Finally, in 11 of 12 PBSPs (the one exception was Individual's 484's PBSP) reviewed (92%), the reinforcement of functional replacement behaviors was included in the PBSP. For example: • Individual #91's PBSP included "…if (Individual #91) puts her finger to her cheek and turns it…offer a drink of water or juice." This represented another improvement from the last review when 73% of the PBSPs reviewed included functional replacement behaviors in the PBSP. Overall, 10 of the 13 PBSPs reviewed (77%) 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 (Individual #484, Individual #344, and Individual #479, are the exceptions). This represented an increase from the last review when 52% of the PBSPs reviewed were judged to be acceptable.	

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K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	There was much progress in this provision item since the last review. In order to achieve substantial compliance with this provision item, LSSLC needs to demonstrate that IOA is assessed regularly for all PBSPs and that minimum levels of IOA are established and maintained across the entire facility. Additionally, all PBSPs will need to contain graphed replacement behaviors. Since the last review, the assessment of IOA follow-up expanded to all units (see K4). At the time of the onsite review, however, IOA was not conducted for all PBSPs (62% of the PBSPs reviewed contained IOA data). Additionally, minimal acceptable levels of IOA were not established. Target behaviors were consistently graphed, and replacement behaviors were graphed in 77% of the PBSPs reviewed (see K9). As discussed in K4, the quality and usefulness of these graphs continued to improve. The graphs reviewed contained horizontal and vertical axes and labels, condition change lines, data points, and a data path.	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 expansion of the collection of treatment integrity data to all units 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 for each PBSP. 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. Since the last review, treatment integrity measures were expanded from two to all four units. The director of psychology indicated, however, that treatment integrity was not regularly occurring for all PBSPs at LSSLC. 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, schedule treatment integrity assessments at regular intervals, track those data, establish minimal treatment integrity levels, and work with DCPs to ensure that those levels are achieved.	Noncompliance

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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. 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 (including float staff) 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 who require remediation, and document that they have been retrained, and subsequently demonstrated competence in the implementation of each individual's PBSP. 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 #420's and Individual #542's PBSPs. The training included a review of the PBSP by the psychologist, role-playing, and an opportunity for DCPs to ask questions covering varying aspects of the PBSP. The training did not, however, include any 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 some of the trainings. It is therefore recommended that the facility expand the competency-based component (i.e., treatment integrity) to all trainings.	Noncompliance
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	This provision item specifies that the facility must maintain an average of one BCBA to every 30 individuals, and one psychology assistant for every two BCBAs. At the time of the onsite review, LSSLC had a census of 359 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 12 psychologists with BCBAs.	Noncompliance

Recommendations:

1. Ensure that all psychologists who write Positive Behavior Support Plans (PBSPs) attain BCBA certification (K1).
2. Review all the data systems utilized by the facility to ensure that they are providing necessary data (K4).
3. Establish minimum acceptable frequency for the collection of data collection reliability, and ensure that those frequencies occur (K4).
4. Establish data collection reliability goals (i.e., minimal scores/levels), and ensure that those goal levels are achieved (K4).
5. Establish minimum acceptable frequency of IOA collection, and ensure that those frequencies occur (K4).
6. Establish specific IOA goals (i.e., minimal scores), and ensure that those goal levels are attained (K4, K10).
7. Extend the graphing of replacement behaviors to all individuals with a PBSP (K4, K10).
8. In those instances when an individual is not making expecting progress, the progress note or PBSP should consistently indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred (K4).
9. All individuals at LSSLC should have a full psychological assessment (K5).
10. All functional assessments should include direct functional assessments that include target behaviors and provide additional information about the variables affecting the target behavior (K5).
11. When new information is learned concerning the variables affecting an individual's target behaviors, it should be included in a revision of the functional assessment (with a maximum of one year between reviews for all functional assessments) as soon as possible (rather than waiting until the annual review) (K5).
12. All psychological assessments (including assessments of intellectual ability) should be conducted at least every five years (K6).
13. All individuals should have annual psychological assessments that contain a review of a standardized assessment of intellectual and adaptive ability, a review of personal history, a review of behavioral/psychiatric status, and a review of medical status (K7).
14. 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.

15. All PBSPs should be reviewed when necessary, and at least annually (K9).

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

17. All replacement behaviors should be functional when possible and practical (K9).

18. The reinforcement of functional replacement behaviors should be included in the PBSP (K9).

19. Expand treatment integrity to each PBSP, schedule treatment integrity assessments at regular intervals, track those data, establish minimal treatment integrity levels, and work with DCPs to ensure that those levels are achieved (K9).

20. The facility needs to provide documentation that all staff assigned to work with an individual (including float staff) 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 #009.2: Medical Care, 4/19/12 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 DADS Clinical Guidelines o LSSLC Medical Services Policy, 4/26/12 o Infection Control Committee Meeting Minutes, 2012 o Clinical Daily Provider Meeting Minutes o Listing of Medical Staff o Medical Caseload Data o Medical Staff Curriculum Vitae o Primary Provider CME Data o Mortality Review Documents o Clinic Tracking Spreadsheets o Reports for Internal and External Medical Reviews 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 18 with dates of last cervical cancer screening o Listing, Individuals with DNR Orders o Listing, Individuals with diagnosis of malignancy, cardiovascular disease, diabetes mellitus, hypertension, sepsis, and GERD o Listing, Individuals hospitalized and sent to emergency department 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 #545, Individual #105, Individual #365, Individual #574, Individual #176 Individual #569 Individual #240 Individual #161, Individual #467, Individual #298 o Annual Medical Assessments the following individuals: • Individual #261, Individual #555, Individual #492, Individual #482, Individual #382,

	Individual #316, Individual #468, Individual #366, Individual #405, Individual #505, Individual #440, Individual #571, Individual #419, Individual #235, Individual #112 o Neurology Notes for the following individuals: • Individual #225 Individual #308, Individual #189, Individual #404 Individual #371Individual #366, Individual #258, Individual #321, Individual #568 Individual #422 o Consultation Referrals and IPNs and for the following individuals: • Individual #146, Individual #74, Individual #43, Individual #33, Individual #568 Individual #158 <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 Frances Mason, RN, Medical Compliance Nurse o Tammy Nelson, LVN, Medical Administrative Assistant o Paula McHenry, QA Director o Paul Vann, RN, QA Nurse o Gale Wasson, Facility Director <u>Observations Conducted</u>: o Daily Clinical Services Meetings o Observations of homes
	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) the provision action information. For each provision item, the medical compliance nurse provided a series of activities engaged in to conduct the self-assessment. For provision L1, she looked at staffing, recruitment, physician participation in the IDT process, results of medical provider audits, compliance with annual medical assessments and quarterly medical assessments. The results of each activity were then reported. The final component was the determination of the self-rating. During discussion, it appeared that she utilized previous compliance reports and attempted to evaluate the areas evaluated by the monitoring team. This approach was utilized for all four provision items. Editing and formatting problems resulted in old information being presented in the current self-assessment. Overall, this was a good effort and a significant improvement over previous self-assessments. In moving forward, the center lead should review this report noting the recommendations and comments included in the body of the report. The next self-assessment should include some measure of assessment for every item reviewed by the monitoring team. In the case of L1, the self-assessment should measure

	compliance rates for preventive care as well as compliance with requirements for documentation. There should also be some assessment of compliance with clinical protocols. This type of an assessment will help to determine the status of the facility relative to compliance. It will also provide a clearer picture of what actions need to occur to move towards substantial compliance. The facility rated itself in noncompliance with all four provisions. The monitoring team concurred with the facility's self-ratings.
	Summary of Monitor's Assessment: There was very little progress seen in the provision of medical services at LSSLC. The current medical director maintained the title, was identified as the medical director in the document request, and participated in the opening meeting as the medical director. The medical compliance nurse was identified as the lead for the medical department in the self-assessment. During the initial meeting to discuss medical care, the medical director, however, indicated that he was not functioning as the medical director because he had assumed a full caseload. He explained that he was not involved in the self-assessment and other non-clinical activities related to the provision of medical care and the Settlement Agreement. Clarification was sought from the facility director because this information was not consistent with the information provided in the opening presentation. The facility director explained that the medical director maintained the title, but functioned in a limited role. Most notably, he appeared to have been released from responsibility of addressing issues related to the Settlement Agreement, action plans, and the monitoring report. Throughout the week, the monitoring team noticed that the medical director attended meetings in capacity of the medical director, but did not participate in those meetings in the manner that would be expected from the medical leadership for the facility. It was clear that LSSLC did not have the medical leadership necessary to develop, implement, drive, and oversee the provision of medical services and other healthcare related services. The monitoring team obtained information regarding medical services from interviews with the facility director, medical compliance nurse, the medical department's administrative assistant, and the medical staff. The medical compliance nurse, who started in March 2012, was responsible for completion of the document requests and self-assessment and, overall, she did a good job in preparing the various documents. It was clear to the monitoring team that the medical compliance nurse played a significant role in the operation of the medical department while also providing support for facility QA activities in the absence of a QA nurse. The medical staff remained stable since the last compliance review. Caseloads were redistributed to become more manageable. This reduction in caseloads did not produce any noticeable positive benefits in the medical care provided. Problems related to inadequate follow-up of medical problems and diagnostics persisted. There was continued use of older and non-evidence based medical practices. The timeliness of neurological care remained problematic and compliance with cancer screenings remained low. In the absence of a functional medical director, there was no advancement in most areas relative to the Settlement Agreement. Many of the recommendations in the May 2012 report were not addressed. The

	facility director was aware of this because the self-assessment repeatedly noted no changes had occurred. There were no new policies or procedures developed and state issued protocols were not localized. Unfortunately, many processes exhibited regression rather than improvement. The external and internal medical reviews were conducted, but the external review was incomplete because the audit did not include all providers. The medical management audits were completed for the first time at LSSLC, but the data provided was not usable. Mortality reviews continued to be completed, but there was no evidence that a thorough review of the medical care was conducted. The QA department became more involved in the process by assimilating a list of all corrective actions in order to ensure that implementation occurred. It was good to see that attention was given to oversight and management of this process. No action occurred in the development of a medical quality program. In mid-October 2012, a review of hospitalizations occurred due to an infectious outbreak within the facility that resulted in hospitalization of 24 individuals. This review also appeared to be under the direction of the QA department. An objective medical review of the care was not a part of this activity. Moreover, there was no ongoing review of the care of individuals who experienced multiple hospitalizations. Finally, the requirement to develop and implement policies and procedures to guide medical care received no attention. The guidelines issued by state office were not localized. The facility director reported that the medical staff received binders that included policies, procedures, and protocols. The medical staff acknowledged that the information was likely provided along with all the other documents and communication they received. However, they were not familiar with the content. It was clear that for the medical staff, the policies, procedures, and protocols did not factor into the provision of medical care.

#	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	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 above documents reviewed list. 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, and one advanced practice registered nurse. The medical director maintained a caseload of 95. The primary care physicians maintained caseloads of 101 and 92. The medical director reported that the provider with the caseload of 92 also acted as the physician for the employee clinic and this responsibility required approximately 20 hours a week. The	Noncompliance

#	Provision	Assessment of Status	Compliance
	regard to this provision in a separate monitoring plan.	APRN's caseload was 72. The agreement between the APRN and medical director was submitted for review after the week of the onsite visit. The document was acceptable and appropriate. **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, dentist, and the hospital liaison nurse. The monitoring team attended this meeting and observed that the process provided a collaborative means of reviewing events that occurred over the previous 24 hours, including recent external consults. The meeting was brief, lasting approximately 30 minutes. The primary providers were able to conduct sick call following the meeting. The medical compliance nurse reported that physician attendance at ISPs was tracked. The self-assessment documented that over the past six months, there was no participation by the primary care medical staff in annual ISPs due to a physician shortage. Most of the medical staff indicated that they attended ISPs if requested to do so. They acknowledged that they did not attend all meetings, but most did not believe the reported attendance was accurate. **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. Additional neurology clinics were conducted in July 2012 by a locum tenens epileptologist and the neurology clinic was temporarily increased to two half days each month. 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.	

#	Provision	Assessment of Status	Compliance
		All members of the medical staff were long term and they knew the individuals quite well. The medical director reported that all of the primary providers were working overtime including weekends and holidays just to keep up with the workload. They all appeared to want to provide the best care possible, but caseloads, even after redistribution, were relatively high and other duties, such as employee health, consumed significant hours each week. Notwithstanding the good intentions to support the individuals at LSSLC, reviews of records and other documentation revealed many problems in the care provided at the facility. Follow-up care for individuals with acute medical problems was noted to be less than optimal. There was also evidence that abnormal lab studies were not consistently addressed in a timely manner. Physician notification of abnormal findings, such as elevated blood pressures, did not always occur promptly. Bowel management plans were not implemented in a timely manner and sometimes did not change in response to a change in condition. The use of non-evidence based practices, such as the use of milk and molasses enemas for management of constipation, persisted. Problems with physician orders appeared to worsen and continue without correction. Medications were prescribed when allergies existed and orders were written for incorrect drugs and doses. Many of these problems were recognized through the various audits and nursing reviews that were conducted. In many instances, audits showed recurring problems, such as issues with bowel management and the untimely completion or receipt of diagnostic studies. One particularly disturbing finding was the documentation of the lack of evaluation of an individual with a history of vomiting. The individual subsequently aspirated and suffered asphyxiation. These issues will be explored in greater detail in the various sections of this report. **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.	

#	Provision	Assessment of Status	Compliance
		For the Annual Medical Assessments included in the record sample: • 10 of 10 (100%) AMAs were current • 5 of 10 (50%) AMAs included comments on family history • 8 of 10 (80%) AMAs included information about smoking and/or substance abuse history • 9 of 10 (90%) 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 year assessment. For the sample of Annual Medical Assessments submitted by the facility: • 15 of 15 (100%) AMAs were completed in a timely manner. • 4 of 15 (27%) AMAs included comments on family history • 13 of 15 (87%) AMAs included information about smoking and/or substance abuse history • 15 of 15 (100%) AMAs included information regarding the potential to transition The AMAs were based on a standardized format and provided a good deal of information. Family history was infrequently noted. Comments, such as family history currently unavailable, but noncontributory and no new data available were found in many assessments. In some instances, the past medical history section stated "see problem list." Immunization status was limited to the comment up to date. The most recent assessments included a list of the active problems and a plan of care for each active problem. For most providers, the plans of care continued to be inadequate. <u>Quarterly Medical Summaries</u> The medical department recently adopted a template for completion of Quarterly Medical Summaries based on guidelines from state office. The template was a good one and had the ability to provide good information on a quarterly basis. For the records contained in the record sample: • 3 of 10 (30%) records included at least one QMS for the past two quarters The three records that included QMSs were all completed by the same provider. The QMS form was handwritten and very difficult to read. It was observed that interval issues, such as weight loss and refractory seizure disorder, were not always addressed.	

#	Provision	Assessment of Status	Compliance
		Active Problem List For the records contained in the record sample: • 8 of 10 (80%) records included an APL • 6 of 8 (75%) documents were adequately updated The Active Problem Lists were identified in most records included in the sample. Several of the documents did not include recent diagnoses. The problem lists should be updated as problems arise and/or resolve. The APL for Individual #574 was not updated with the diagnosis of colectomy. Individual #545 did not have small bowel obstruction included in APL. The facility audits indicated high compliance rates with updating of the APLs, but several other facility reviews noted that the APLs were not updated. The APLs are included in the transfer packet that is sent with individuals upon transfer to outside facilities. It is important for that the APL provide current and accurate information regarding the medical conditions of the individuals. Integrated Progress Notes Physicians documented in the IPN in SOAP format. The notes were usually signed, dated, and timed. Legibility of notes was problematic with many notes being illegible. The notes were extremely brief and for most of the medical staff, the IPN entries did not provide adequate documentation, such as the positive and negative findings and the plan of care. Examples are provided under case examples, below. Physician Orders Physician orders were usually signed and dated. However, there were many issues related to physician orders including incomplete orders and orders written for incorrect medications and dosages. This is discussed in further detail in section N1. Consultation Referrals The consults and IPNs for eight individuals were requested. A total of 63 consults completed after March 2012 (including those from the record sample) were reviewed: • 41 of 63 (65%) consultations were summarized by the medical providers in the IPN within five working days. Overall, the documentation of the recommendations of the consultants was brief and did not provide adequate information for the IDT. The entries also lacked the provider's statement on agreement or disagreement. In some instances, the consult being addressed was not clear. The consultation referral process is discussed in further detail in section G2.	

#	Provision	Assessment of Status	Compliance
		The monitoring team suggests that IPN documentation of consultations include a brief summary of recommendations of the consultants, contain a statement regarding agreement or disagreement, and include a decision about referral to the IDT. The primary providers should also indicate the consult that is being addressed. **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. Compliance with cervical cancer screening remained low. The data provided for prostate and colorectal cancer screenings differed from that presented in the May 2012 review. This resulted in a significant decrease in compliance rates. There was insufficient data provided to determine breast cancer screening compliance. Data from the 10 record reviews listed above and the facility's preventive care reports (databases) are summarized below: <u>Preventive Care Flow Sheets</u> For the records contained in the record sample: • 7 of 10 (70%) records included PCFSs • 0 of 7 (0%) forms were signed and dated There were no changes made in the format of the Preventive Care Flowsheets. Thus, all PCFSs reviewed included guidelines for cancer screenings that were not consistent with state issued guidelines. None of the forms reviewed were signed or dated by the medical provider. <u>Immunizations</u> • 9 of 10 (90%) individuals received the influenza, hepatitis B, and pneumococcal vaccinations • 8 of 10 (80%) individuals had documentation of varicella status. <u>Screenings</u> • 9 of 10 (90%) individuals received appropriate vision screening • 8 of 10 (80%) individuals received appropriate hearing testing	

#	Provision	Assessment of Status	Compliance
		Prostate Cancer Screening • 4 of 4 males met criteria for PSA testing • 3 of 4 (75%) 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 130 males: • 93 of 130 (72%) males had PSA results documented in 2011 or 2012 • 33 of 130 (25%) males had no PSA documented • 4 of 130 (3%) males had outdated PSA levels Breast Cancer Screening • 4 of 6 females met criteria for breast cancer screening • 3 of 4 (75%) females had current breast cancer screenings A list of females age 40 and older and the date of the last mammogram was requested. The facility did not provide these data. The list provided included the names of several females and the scheduled mammogram dates. Many of the scheduled studies were not completed. Cervical Cancer Screening • 4 of 6 females met criteria for cervical cancer screening • 1 of 4 (25%) females completed cervical cancer screening within three years A list of females age 18 and older was provided. The list included the names of 148 females, the date of the last pap smear, and explanations for lack of testing: • 17 of 148 (5%) females had documentation of cervical cancer screening within the past three years. • 120 of 148 (81%) females had no documentation of cervical cancer screening. • 52 of 148 (35%) females had no documentation of pelvic examination within the past three years. The facility continued to have very poor compliance rates with cervical cancer screenings. Many of the annual assessments included statements, such as not needed based on condition. None of the assessments actually documented a risk/benefit analysis. In some instances, it was noted that a pelvic examination was completed, but cervical cancer screening was omitted. For Individual #467 the primary provider indicated that a pelvic exam was not necessary. The monitoring team did not understand why the provider would deem that a comprehensive physical, inclusive of a pelvic examination, was not necessary. Many of the discussions related to changing guidelines are based on low risk females who are asymptomatic. The decision to completely	

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		dismiss the need for any type of examination should take into consideration the ability of an individual to adequately report symptoms or concerns. Moreover, current guidelines continue to recommend periodic examinations with the frequency determined by a risk assessment. The records reviewed did not document adequate risk assessments related to deferring pelvic examination and cervical cancer screening. <u>Colorectal Cancer Screening</u> • 7 of 10 individuals met criteria for colorectal cancer screening • 4 of 7 (57%) individuals completed colonoscopies for colorectal cancer screening A list of individuals age 50 and older was provided. The list contained 193 individuals: • 130 of 193 (67%) individuals had completed colonoscopies • 63 of 193 (33%) individuals had not completed colonoscopies <u>Additional Discussion</u> The monitoring team recommends that the medical providers thoroughly document the discussion to discontinue or not complete required screenings. This documentation should include a risk/benefit assessment as well as the discussion with the individual/LAR and the IDT. **Disease Management** The facility had access to numerous clinical guidelines issued by state office, although full the implementation of the guidelines did not seem to occur. The monitoring team reviewed records and facility documents to assess overall care provided to individuals in many areas. Data derived from record audits and the facility reports are summarized below. <u>Pneumonia</u> The facility reported 41 incidents of pneumonia from January 2012 through September 2012. Of the 41 cases, 5 (12%) were documented as aspiration events. Many of the individuals who had a documented bacterial pneumonia were at high risk for aspiration. The facility did not track pneumonia in Avatar, therefore, no data were submitted for the request. The infection control minutes for 4/1/12 documented that "unless witnessed, aspiration not aspiration." This was a serious and very flawed approach to the management of aspiration at the facility. However, it did offer some explanation for the low number of recorded aspiration events. Individuals with pneumonia were not reviewed to ascertain the likelihood that aspiration occurred. Additionally, the medical staff were not familiar with the	

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		aspiration protocols issued by state office. These were both unfortunate findings because six of the last 13 (46%) deaths were associated with either pneumonia, aspiration, or both. It stands to reason that the facility should conduct a review of the management of pneumonia and take appropriate actions. Oversight of this review should be provided by state office. In order to provide a more accurate assessment of the facility's pneumonia incidence rates, the monitoring team recommends that each individual with pneumonia undergo review by a multidisciplinary committee. The review should include chest roentgenograms, lab data, clinical history, and risk factors. Following review, a determination should be made about the classification of pneumonia. The facility may benefit from examining the pneumonia review processes that have been implemented at other SSLCs. Additional actions should include review with the medical staff of the various policies and protocols issued by state office in an effort to ensure that individuals receive maximal supports and undergo the appropriate diagnostic workups. <u>Hypertension</u> The facility conducted a DUE on the use of clonidine. There were 18 individuals who received the medication for control of hypertension. Three individuals in the record sample had a diagnosis of hypertension. Individual #105 received multiple medications for management of hypertension, including clonidine. The records reviewed did not indicate that this individual benefitted from external consultation for management of refractory hypertension. Additionally, the MARs reviewed did not specify any parameters for physician notification of blood pressures. None of the MARS reviewed included blood pressure notification parameters. **Case Examples** Individual #545 • The IPN entry on 8/27/12 documented: S-N/V this am; O- Vital signs were listed. Lungs–clear; A–enteritis?; P–labs to be obtained were listed. There was no documentation of abdominal or rectal exams. There was also no further information on how the individual would be managed and no additional medical follow-up or documentation was found in the records. The individual was admitted to the hospital on 8/30/12 with a small bowel obstruction. • The problem list was not updated with the diagnoses of small bowel obstruction and proteinuria. The allergy section was blank.	

#	Provision	Assessment of Status	Compliance
		Individual #176 • This individual had a history of diabetes mellitus and schizoaffective disorder. On 9/4/12, the individual was evaluated by a primary provider and started on antibiotics for URI symptoms. There was no medical follow-up documented. On 9/9/12, the individual experienced nausea, vomiting, and diarrhea. The lithium level reported on 9/10/12 was 1.7. The primary provider and psychiatrist were both notified. A physician did not evaluate this individual until 9/12/12 when the psychiatric medication review was completed. Individual #365 • On 8/24/12, this individual was seen by a primary provider who documented a 2.9 lithium level. There was no documentation of any signs or symptoms of toxicity. The IPN entry stated, "admit." Following discharge from the hospital, the IPN documented "lithium level 2 yesterday." There were no vital signs documented. The next physician documentation on 8/27/12 was an assessment of tooth pain. There was no discussion of lithium toxicity. • On 9/7/12, this individual was seen by a primary provider. The IPN entry stated: S - Boil O - R buttocks A - Abscess P -? Flagyl, betadine • There was no specific description, no measurements, and no notation regarding fluctuance or drainage. There was also no documentation of the individual's temperature. An order was written to obtain a culture if possible. The next physician documentation on 9/10/12 was related to anemia. There was no follow-up of the infectious process. On 9/17/12, the PCP documented that the abscess increased in size. The antibiotics were changed and the IPN entry stated "Arnold ASAP." Nursing documented on the same day that the "boil was quarter sized now 14-15 cm." The individual was seen by another physician on 9/20/12 who documented the need for a surgical consult. The individual was admitted to the hospital for incision and drainage and intravenous antibiotics. **Seizure Management** A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 179 individuals. A separate list of 175 individuals receiving AEDs was also provided. The following data regarding AED use were summarized from the list provided: • 58 of 175 (33%) individuals received 2 AEDs • 31 of 175 (18%) individuals received 3 AEDs	

#	Provision	Assessment of Status	Compliance
		• 9 of 175 (5%) individuals received 4 AEDs • 2 of 175 (1%) individuals received 5 AEDs The number of individuals seen in the on-campus clinic is summarized in the table. The on-campus clinic was conducted by a general neurologist consultant to LSSLC once or twice per month. The numbers below reflect campus visits for the neurologist.	

Neurology Clinics 2012	
	Campus Appointments
May	29
June	15
July	14
August	21
September	22

A total of 101 on-campus appointments were completed over five months. Two clinics occurred each month with the exception of the months of June 2012 and July 2012. This represented an increase in the level of services previously provided. The facility utilized a locum tenens neurologist to conduct a series of clinics for one week in July 2012. Most of the psychiatrists were able to meet with the neurologist and the members of the IDT participated in clinics for all individuals evaluated. The medical director was not certain that the neurologist had certification in epileptology, however, the facility director verified that the physician was an epileptologist. According to the facility director, this was done to help clear up the backlog of individuals who needed neurology evaluation. There was no plan, however, to have an ongoing clinic with an epileptologist and there was no mechanism to achieve integration of neurology and psychiatry on a routine basis. The exact number of individuals evaluated off campus and by the epileptologist in July 2012 was not provided. The spreadsheet submitted after the review did not provide clarification. Record reviews demonstrated that several individuals did not complete follow-up within the time frames recommended by the neurologist. The monitoring team, however, found that follow-up over the last few months appeared more prompt.

The facility reported that 21 (12%) individuals had refractory seizure disorder and 10 individuals had undergone VNS implantation. Information on the status of individuals with refractory seizures, such as the plans for further evaluation by an epileptologist to assess the need for more aggressive therapy were not provided. Two individuals were reported to experience status epilepticus since the last review.

The monitoring team requested neurology consultation notes for 10 individuals. These individuals are listed in the above documents reviewed section. The following is a summary of the review of the 10 records in addition to the six records included in the

#	Provision	Assessment of Status	Compliance
		record sample: • 8 of 16 (50%) individuals were seen at least twice over the past 12 months • 12 of 16 (60%) individuals had documentation of the seizure description • 14 of 16 (87%) individuals had documentation of current medications for seizures and dosages • 10 of 16 (67%) individuals had documentation of recent blood levels of antiepileptic medications • 9 of 16 (80%) individuals had documentation of the presence or absence of side effects, including side effects from relevant side effect monitoring forms • 15 of 16 (80%) individuals had documentation of recommendations for medications • 0 of 16 (0%) individuals had documentation of recommendations related to monitoring of bone health, etc. The following are examples of the concerns related to the provision of neurological care: • Individual #189 was evaluated on 8/29/12. The neurologist noted that drug toxicity may have been responsible for frequent falls. There was no ADR reported related to this comment. The note also documented that there were no "recent Tegretol levels" with the last being done in January 2012. • Individual #404 received phenobarbital. Consults documented that the individual was sleepy and difficult to arouse. The clinic follow-ups did not occur in a timely manner. During the last appointment on 7/11/12, the neurologist again noted that the individual was now lethargic due to high doses of Keppra. Follow-up was scheduled for October 2012. For the most part, few notes discussed quality of life measures or side effects of the medications. None of the notes included a review of the side effects rating tools, such as the MOSES and DISCUS evaluations. Labs were documented inconsistently and attention to bone health was not addressed. The facility director should work with consulting neurologists to ensure that clinic notes contain key data related to seizure management. The use of a clinic template would be helpful in achieving this goal. Individuals with refractory seizure disorder should be referred to a qualified epileptologist for evaluation. **Do Not Resuscitate** The facility submitted a list of individuals who had DNR orders in place. The list included four individuals with Level II DNRs, the dates of DNR implementation, and reasons for the DNRs. Documentation including notes and orders were reviewed for the four individuals. The following is a summary of the information submitted:	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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Individual #42 had a DNR implemented on 1/6/94 due to anencephaly.
Individual #437 had a DNR implemented on 1/1/10 due to seizure disorder.
Individual #100 had a DNR implemented on 4/26/12 due to metastatic colorectal cancer.
Individual #463 had a DNR implemented on 5/3/12 due to metastatic salivary and thyroid cancers.

Physician documentation of the rationale for the DNR was submitted for the two individuals with a cancer diagnosis. There was no documentation for any of the individuals to reflect discussion by the IDT of the appropriateness of implementation of the DNRs.

The monitoring team has recommended in previous reviews and continues to recommend that the facility review the list of individuals with DNRs and for every individual ensure that the long term DNRs are clinically justified and fulfill all requirements of state policy.
</td><td></td></tr>
<tr><td>L2</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.</td><td>
<u>Medical Reviews</u>
An external medical reviewer, from a sister SSLC, conducted Round 6 of the external reviews in August 2012. State guidelines required that a sample of records be examined for compliance with 30 requirements of the Health Care Guidelines. The requirements were divided into essential and nonessential elements. There were eight 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. Records were audited for three of the four medical providers. The data submitted by the facility are summarized in the table below:

<table>
<tr><td colspan="4">External Medical Reviews 2011 - 2012
% Compliance</td></tr>
<tr><td></td><td>Date of Review</td><td>Essential</td><td>Nonessential</td></tr>
<tr><td>Round 4</td><td>December</td><td>71</td><td>78</td></tr>
<tr><td>Round 5</td><td>March</td><td>76</td><td>88</td></tr>
<tr><td>Round 6</td><td>August</td><td>90 (97)</td><td>86 (99)</td></tr>
</table>
*() Internal reviews

Overall, compliance scores were improved from previous audits. Inter-rater reliability showed marked variations in the findings of the external and internal reviews. The areas with the lowest rates of compliance based on the external reviews included:

Documentation in the IPN of responses to abnormal lab values
Documentation in the IPN of abnormal diagnostics

</td><td>Noncompliance</td></tr>
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		• Signing, dating, and timing of IPN entries and physician orders The external reviews showed 10% compliance for documentation of abnormal results. There was 65% compliance with the requirement to sign, time, and date entries. The medical compliance nurse reported that corrective actions were implemented, but follow-up had not occurred at the time of the compliance review. In addition to the general medical reviews, medical management audits were also completed for constipation, diabetes mellitus, and osteoporosis. The graphs and data submitted did not identify the conditions evaluated. No further review of these follow-up done. Achieving substantial compliance in this provision will require that several issues are addressed: • The external audits must be completed in accordance with state issued guidelines – all providers must be reviewed. • The medical management audits will need to address clinical outcomes in addition to processes. • Corrective actions will need follow-up to closure <u>Mortality Management</u> There were six deaths in 2012 at the time of the compliance review. The average age of death for the six individuals was 48.5 years. There were four deaths from April 2012 – October 2012. One death occurred a few days prior to the compliance review. The facility death reviews were submitted for three deaths and that information is summarized below: • The average age of death was 50 years with an age range of 48 to 52 years. • The causes of death were: (1) hematochezia, sepsis, respiratory failure and shock (facility reported) (2) asphyxiation, aspiration of stomach contents/emesis, and (3) metastatic non small cell gastroesophageal carcinoma, acute repertory failure, GI bleed, and failure to thrive • One autopsy was performed. • Two individuals died during hospitalization. One died at LSSLC. There was no objective review completed within the SSLC system to assess the quality of medical care provided. The nursing review for Individual #61 documented that anemia was noted in March 2011 and in multiple studies obtained thereafter. While the precise lab values were not provided, the individual was started on ferrous sulfate for iron deficiency. A referral was made to the gastroenterologist in January 2012 because of the anemia. Endoscopy identified the malignancy in February 2012. An objective	

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		determination of the quality of care provided to this individual would need to assess the adequacy and timeliness of the assessment of the anemia given the importance of the appropriate evaluation of iron deficiency anemia. The facility director scheduled a meeting with the monitoring team to discuss mortality management at LSSLC. Participants included the facility director, medical director, CNE, QA director, QA nurse, medical compliance nurse, medical administrative assistant, and other facility staff. During this meeting, the facility and QA directors explained that retrospective reviews of mortality documents were conducted and recommendations from reviews were consolidated for improved tracking. Moreover, data generated by the Quantros death reviews were also compiled, but no analysis had occurred at the time of the meeting. These actions represented some degree of progress in how the facility managed data generated by mortality reviews. The monitoring team, however, had continued concerns regarding the mortality process. The Quantros reviews did not appear to assess longitudinal care that may have impacted the outcome of the individuals. Furthermore, reports were received many months after the death occurred. The SSLC system reviews relied on the attending physician's discharge summary, the QA nursing review, incident reports, and hospital information. There was no thorough objective review by a physician that assessed the medical care provided. To that end, the monitoring team was not confident that the current reviews adequately assessed the care provided.	
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 medical department made no significant progress in this area. The facility submitted over 1000 pages of data related to the medical audits discussed in L2. Apart from the medical audits, it was clear that the facility had not taken any specific actions to develop a quality program. Given that the medical director was not involved in this process, this was not a surprising finding. The medical department collected data on a number of areas including cancer screenings, osteoporosis, hospitalizations, and seizure disorder, but it did not appear that these data were utilized in any meaningful way. The monitoring team specifically inquired about the hospital rates due to the increase noted during the May 2012 review. While several staff reported that data were maintained, none of the staff could actually provide data or inform the monitoring team if improvements in this area had occurred. The expectation would be that the facility use these data in an ongoing basis to assess the care provided by the medical and nursing departments at LSSLC. It would be even more important to conduct record reviews for individuals hospitalized in the face of increasing hospital rates.	Noncompliance

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		Following the compliance review, the monitoring team received information resulting from a hospitalization workgroup. A review of hospitalizations occurred in mid-October 2012 in response to some 24 individuals being hospitalized with pneumonia over a six week period. That review determined individuals received appropriate and prompt care. Reviews of other conditions, such as those addressed in the state issued protocols, should also occur to determine the quality of care provided and compliance with the protocols. As recommended in the last report, the facility will need to develop a comprehensive set of indicators that includes, 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. Such analysis will define the strengths of the department as well as those areas that require improvement and need to be addressed through systems changes (also see these recommendations for all provisions of the Settlement Agreement in section E). This provision remains in noncompliance.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	State office issued a series of clinical guidelines and protocols on several diseases and medical conditions. The medical department had not developed any local policies related to the state issued guidelines. According to the facility director, the medical staff received binders that contained all of the applicable policies and state issued protocols. The monitoring team discussed the clinical protocols with the medical staff. One staff member recalled seeing the protocols at another facility. The other members of the medical staff indicated that they received a lot of information and believed that the protocols were likely distributed along with other documents and information. It was clear that over the past year, they were not provided any specific guidance or direction on the various protocols and guidelines and the expectations for their use at LSSLC. Several of the state issued clinical guidelines were multidisciplinary and offered guidance to physicians, nurses, and direct care professionals. At LSSLC, the nursing department provided information to the direct care staff and home managers on the multidisciplinary protocols. The home managers were responsible for reviewing the protocols with new staff. The facility director will need to develop a process to ensure that all state guidelines and protocols are localized and implemented. The development of policies, procedures, and guidelines related to medical care requires the participation of medical personnel. New employees should be required to review this information during the orientation process. The current process of having home managers train and retrain DCPs on clinical	Noncompliance

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		protocols must be re-examined. Training on clinical protocols for DCP should be provided by health care professionals. Protocols related to management of seizure disorder and aspiration should be given priority. This provision remains in noncompliance.	

Recommendations:

1. The facility should continue to pursue the services of a full time medical director (L1).
2. The requirements for documentation should be reviewed with the primary providers with emphasis on Annual Medical Summaries, Quarterly Medical Summaries, Active Problem Lists, and IPN requirements (L1).
3. The requirements for medication orders should be reviewed with the medical staff (L1).
4. The Preventive Care Flow Sheet should be updated to reflect state issued guidelines. The revision date should be provided for tracking purposes (L1).
5. The medical staff 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).
6. The facility director should request that consulting neurologists include key information related to seizure management in clinic notes. Recommendations for additional testing and medication management should be specific as should timelines for follow-up appointments (L1).
7. The facility director will need to determine how to achieve adequate integration of psychiatry and neurology (L1).
8. Individuals with refractory seizure disorder should be referred to a qualified epileptologist for evaluation (L1).
9. The template for the disease management component of the quality audits needs to be expanded to capture clinical outcomes in addition to processes (L2).
10. The facility director should ensure that the external audits are completed in accordance with state guidelines (L2).
11. Follow-up should be completed for the corrective actions resulting from the August 2012 external medical reviews (L2).
12. The facility director should continue efforts to improve the mortality process at the facility including the addition of an objective review of medical care (L2).
13. The facility director should ensure that mortality data is analyzed, trended, and corrective actions taken (L2).

14. 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).

15. 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).

16. The facility director should ensure that the medical staff review polices procedures and clinical protocols and have a clear understanding of the expectations for use of the information (L4).

17. The various policies, procedures, and guidelines should be reviewed to ensure that they are consistent with state issued guidelines (L4).

18. 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:** <u>Documents Reviewed</u>: 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 10/22/12) 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 5/1/12-9/30/12 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 5/1/12-10/30/12 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 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 5/1/12 - 10/30/12 UIRs o Corrective Action Plans developed since the prior review o Corrective Action Log for Individual #234 and Individual #61 o TB Compliance Monthly Reports for 9/1/12 – 11/1/12 o Transcript of LSSLC's opening presentation 10/29/12 o Quarantine Report/Summary prepared by Infection Control/Skin Integrity Nurse o Nurse Recruiter's analysis, findings, and recommendation from survey o Revised LSSLC Quarantine Policy o Medication Error Reports 9/1/12 – 10/30/12 o Medication Pass Observation Tools 9/1/12 – 10/30/12 o 10/12/12 Annual Nursing Care Plan monitoring tool for Individual #452 o 10/2/12 Chronic Respiratory Distress monitoring tool for Individual #288 o For the last six individuals who transitioned to the community, their completed nursing discharge summary o Records of: • Individual #490, Individual #428, Individual #130, Individual #102, Individual #333, Individual #507, Individual #119, Individual #240, Individual #174, Individual #440, Individual #574, Individual #298, Individual #475, Individual #248, Individual #387, Individual #108, Individual #497, Individual #584, Individual #467, Individual #488, Individual #433, Individual #465 <u>Interviews and Meetings Held</u>: o Chief Nurse Executive, Belinda Byron o Nursing Operations Officer, Laura Flowers o Infection Control/Skin Integrity Nurse, Bobbi Duke o QA Director, Paula McHenry o QA Nurse, Paul Vann o Hospital Liaison, Maria Jenkins o Nurse Educator, Zalinda Colston o Nurse Compliance Coordinator, Gerald Davis o Nurse Recruiter, Elizabeth Moody o PNMT RN, Cheryl Fraser o Infirmary Nurse Manager, Connie Russell o Immunization/Employee Health Nurse, Kathy McNeese o RN Case Manager Supervisor, Tanesha Wilson <u>Observations Conducted</u>: o Visited individuals residing on all units o Medication administration on selected units o Enteral feedings on selected units o 10/29/12 Medication Variance Committee Meeting

	o 10/29/12 Nursing Administration Team Meeting o 10/30/12 CLDP Review and Discussion o 11/1/12 Risk Process Discussion
	Facility Self-Assessment: LSSLC submitted its self-assessment, which was updated on 10/22/12. Since the prior review, LSSLC continued to use the revised form and format for its self-assessment process, and continued to separate the report into three separate sections. The self-assessment described for each provision item the (1) discrete activities, usually the results of audits and monitoring tools, (2) some data, such as the minimum numbers of nurses on duty and the percentages of nurses who attended training sessions, and (3) brief references to the status of implementation of state mandated directives and initiatives, which occurred over the past six months. Thus, the self-assessment was almost exclusively focused on the results of the facility's monitoring reviews of process and ratings of "procedural compliance" and failed to reveal evidence of an evaluation of the facility's outcomes of care to substantiate their self-ratings and show evidence of their status toward compliance with the provisions of section M. Of note, reliance upon the findings of the facility's monitoring reviews was problematic since they were of significantly limited sample size, widely varying content and quality, and months behind scheduled dates of completion. (See provision item M4 for more information related to LSSLC's quality reviews and compliance monitoring activities.) According to the Chief Nurse Executive and Center Lead for section M, who was brand new to the facility and to the Department of Aging and Disability Services (DADS), she had not had the time or the opportunity to become familiar with and knowledgeable of the self-assessment process prior to the document submission. Thus, the Nurse Compliance Coordinator, who was also not privy to the process, was assigned the responsibility of completing the facility's self-assessment of section M. During the conduct of the onsite review, the monitoring team reviewed the self-assessment with several facility staff members and provided some 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. The monitoring team also invited the CNE and Nurse Compliance Coordinator to attend any and all meetings and interviews conducted during the onsite review to help provide them with as much information as possible, as well as first-hand observations, pertaining to the review process and outcomes. In addition, similar to the prior review, the monitoring team suggested that the facility strongly consider incorporating what the monitoring team evaluates and the activities they engage in to evaluate compliance into their self-assessment activities and ratings. The facility's self-ratings indicated that it was not in compliance and 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.

	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 via 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, there were several significant changes in the Nursing Department. There was turnover in existing positions and hiring of new nurses, such as new CNE, RN Case Manager Supervisor, Immunization/Employee Health Nurse, QA Nurse, and Infirmary Nurse Manager. There were also changes in policies and procedures, and 18 assessment and reporting protocols related to significant changes in individuals' health were distributed to LSSLC's nurses with expectations for implementation and documentation. The areas of immunization, employee health, and nurse education showed improvement, and there was also evidence that the positive achievements made six months ago were sustained in the areas of oversight of hospitalized individuals and evaluations of nurses compliance with the provisions of the Settlement Agreement and Health Care Guidelines. Regrettably, however, there were a number of areas and aspects of nursing care that failed to show improvement, including some areas that declined since the prior review. One of the most striking areas that failed to show improvement was the facility's infection prevention and control program. From nurses to therapists to direct care staff members during activities, such as resident care and treatment and medication administration, violations of basic standards of infection control were noted. Nursing assessments were also not being performed and documented, in accordance with standards of practice. Plans of care were incomplete or absent from individuals' records. Health risks were not appropriately reviewed and revised, in accordance with changes in individuals' health status and needs. In addition, medications were not administered safely, hygienically, or in accordance with standards of practice. All told, the onsite activities, in-depth examination of individuals' records, and review of other numerous documents submitted by LSSLC, revealed serious problems in nursing care and untoward health outcomes suffered by the individuals who resided at the facility. The new CNE was urged to work closely with facility administration and other department directors to regroup and reestablish management, direction, guidance, leadership, and accountability across the Nursing Department.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	LSSLC's section M Action Plan indicated that, since the prior review, several of the action steps that were underway during the prior review continued to be "ongoing," but just one new action step was "started" and "in process, and only one action step was "completed." LSSLC's nurses attended the state training program on SOAP format documentation, and by 11/1/12 corrective action plans were going to be developed for areas that scored less than 80% on the facility's compliance monitoring reviews. According to the facility's self-assessment, since the prior monitoring review, the Nursing Department had made improvements in several areas. For example, 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 increased from 55% to 80% and 75% to 79%, respectively. In addition, a review of annual and quarterly comprehensive nursing assessments completed during the month of August 2012 revealed that all were completed in a timely manner. Notwithstanding these improvements, the facility reported that this provision item was not in substantial compliance because the results of audits continued to indicate that there was a "need for improvement in regards to capturing the complete picture of the individuals' clinical problems, needs, and actual/potential health risks." The monitoring team agreed with the facility's finding of noncompliance, but continued to 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 at least once, observations of nursing care were made, 17 nurses were interviewed, and 22 individuals' records were reviewed. <u>Staffing, Structure, and Supervision</u> Since the prior review, in May 2012, the CNE resigned. For the next several months, there was no acting CNE appointed to lead the Nursing Department. Rather, LSSLC's ADOP was reportedly the direct supervisor of the NOO, Infection Control Nurse, Employee Health/Immunization Nurse, Hospital Liaison Nurse, Nurse Recruiter/Staff Coordinator, and Nursing Compliance Coordinator. When the new CNE was hired, she had only very brief and limited contacts with the former CNE and almost exclusively relied upon the NOO, Infection Control Nurse, and Hospital Liaison to help orient her to the facility, its policies and procedures, the Settlement Agreement, and the individuals living at LSSLC. Over the past six months, the absence of leadership within and across the Nursing Department took a toll on nurses' compliance with the provisions of the	Noncompliance

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		Settlement Agreement, accountability, and quality of care of the individuals. An examination of the staffing data submitted by LSSLC to the monitoring team revealed reports of vacancies in the Nursing Department that ranged from 19, as of 9/30/12, to 13, as of 10/23/12, and to 7, as of 10/24/12. Of note, none of these figures came close to DADS' report of filled/unfilled LVN and RN FTEs for the Nursing Department, which indicated that, as of 9/30/12, there were 26.5 unfilled, authorized FTEs in the Nursing Department. When the monitoring team asked the CNE, NOO, and Nurse Recruiter to explain the discrepancies across these reports, they were unable to do so. This was a problem because it was unclear how the nursing leadership team would, or could, make hiring and staffing decisions and rely upon these unverified and widely varying reports of vacancies. Although LSSLC's Nursing Department submitted its 9/12 revised "Staffing Expectations for Nursing," the numbers of its minimum LVNs and RNs per unit for the day, evening, and night shifts, there was no evidence that the nursing leadership team had completed any analyses of the department's current deployment of staff members, staff minimums, and staff ratios by residential unit and in accordance with the acuity of the individuals' health needs and risks. Thus, there were no objective data analyses to guide, direct, and support the deployment of nursing staff members across the campus in order to best meet the health needs of the individuals. <u>Recordkeeping and Documentation</u> As noted in the prior review, all individuals' records were organized in a unified form/format. The format of nurses' notes was mostly in the desired SOAP (Subjective and Objective (data), Analysis, and Plan) format, which was consistent with the state's standardized protocol. Individuals' notebooks were present on their homes and available to direct caregivers. Notwithstanding these positive findings and the quality assurance checks of the records prior to their submission to the monitoring, there were a number of recordkeeping and documentation problems found in the 22 records selected and submitted by the facility for review, which raised question regarding the state and maintenance of the individuals' records on the units. For example, most of the 22 records submitted failed to have complete and up-to-date weight reports, and 10 of the 22 records submitted for review had the following problems that impacted upon the findings, and noted in detail, in other provision items, including provisions M3, M4, and M5. For example: • Four individuals' records had no completed Interdisciplinary Risk Rating Forms • Three individuals' records had no current, annual ISPs. • Three individuals' records had no current, annual nutrition assessments. • Of the two sample individuals recently admitted to LSSLC, neither had an	

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		admission assessment that was completed in a timely manner • One individual's record had no current, quarterly comprehensive nursing assessment. • One individual's record's Active Problem List was blank. • One individual's record had no physician's orders for 6/18/12 – 10/20/12. • One individual's record had no health management plan. In addition, as noted in all prior reviews, there continued to be entries that were documented on the margins of the IPNs versus starting a new page, 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, and a significant minority of nurses' names and credentials continued to be illegible. This was an especially problematic documentation issue because it made it difficult, if not impossible, to know when critically important nursing assessments were conducted and when/if certain, specific nursing interventions were delivered. Also, despite the variation in the nature of the individuals' afflictions, many nurses continued to document the same oblique references to their planned interventions, such as "DSP to report changes in s/s," and "Will continue to implement protocol." <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." Twelve of the 22 individuals selected for in-depth review were hospitalized a total of 18 times during the period of 5/1/12 – 10/31/12 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 periodically visited the individuals, reviewed their hospital records, interviewed their tertiary care providers, and reported to LSSLC interdisciplinary team members the hospitalized individuals' health status, response to treatment, and progress toward discharge.	

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		The monitoring team review revealed that all hospitalized individuals continued to benefit from the oversight of the Hospital Liaison. However, since the prior review, there was a significant and notable change in the pattern of the Hospital Liaison's visits and/or contacts with tertiary care providers. Across all individuals' reviewed, the Hospital Liaison made no visits to the individuals and/or contact with tertiary care providers on the weekends, which sometimes extended from the Friday before to the Tuesday after the weekend. In addition, during only three of the 18 hospitalizations, LSSLC's campus nurses obtained hospitalized individuals' status over the weekend. Of note, documentation of these contacts was usually one or two sentences, which were limited to phrases such as, "Doing well, " vital sign measurement, and, once, a critical lab value. For example, Individual #488 was a 33-year-old man with significant cognitive deficits including blindness, behavior challenges, and health problems. He was hospitalized on Friday, 4/27/12, for treatment of complications of a large, self-inflicted bite wound, including infection and spreading cellulitis. There was no evidence that the state and facility's policy to obtain as much up-to-date information as possible from the hospital nurse responsible for care of the individual was implemented until over 72 hours after Individual #488's admission. During the prior review, the monitoring team strongly encouraged the Hospital Liaison to attend the IDT meetings of hospitalized individuals. Although the Hospital Liaison reported that, since the prior review, she attended "a few" meetings at the IDTs' requests, due to scheduling conflicts and lack of information from the teams, she missed most of the meetings that were held. It was unclear to the monitoring team why there had been no follow-up to this recommendation since the Hospital Liaison was no longer serving as back up to the Infection Control and Employee Health nurses, and she was no longer required to complete the QA Death Reviews for Nursing. Thus, as noted in the prior report, opportunities 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 were not seized. The Hospitalization Workgroup presented yet another a missed opportunity to promote and ensure improved collaboration between the Hospital Liaison and interdisciplinary team members and clinical professionals to help achieve the purpose of the workgroup, which was, "to decrease both [hospital] admissions and recidivism." A review of the workgroup's 10/18/12 meeting minutes revealed that they failed to reference and evaluate the role of the Hospital Liaison in reducing the likelihood of these untoward health events and/or make recommendations to improve health outcomes vis a vis the role of the Hospital Liaison, who for all intents and purposes was the workgroup member with the most direct role/responsibility for oversight the health care of hospitalized individuals. In addition, most of the "strengths" cited in the workgroup's report were	

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		vaguely worded, such as "assessments were generally completed as required," and not truly indicative of quality, such as "the teams met for several people," and they completed ISPAs on less than 15% of the individuals who were hospitalized. These "strengths" coupled with the areas that the workgroup identified as needing improvement, such as the practices of sending inexperienced staff members to the infirmary and unfamiliar staff members to the hospital, and the problems associated with failure to receive the results of diagnostic studies in a timely manner, described a situation that was in dire need of immediate intervention and improvement. As of the review, however, there was no evidence that many of the workgroup's recommendations were carried out or, at least, in the early stages of implementation. <u>Wound/Skin Integrity</u> 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." 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 continued to be assigned to the Infection Control Nurse. The Infection Control Nurse continued to maintain a database of individuals with alteration in skin integrity and took photographs to track individuals with alteration in skin integrity and record their specific response to treatment interventions. She also conducted the weekly Wound Clinic, where she, along with the occasional assistance of the physical therapist, monitored and evaluated individuals with alteration in skin integrity and made recommendations for their treatment to the individuals' physicians. In addition, as noted in the prior report, the Infection Control Nurse continued to include a standing item – "Skin Integrity" - on the monthly Infection Prevention and Control Committee meeting agenda. Notwithstanding 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 continued to reveal problems and showed no improvement from the prior review. For example: • The majority of the monthly committee meetings were spartanly attended by only one-third of the members. According to the meeting minutes submitted to the monitoring team, a physician was in attendance at only two and the physical	

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		therapist attended none of the meetings that were held over the past six months. • A review of the monthly Infection Prevention and Skin Integrity meeting minutes for June through September 2012 revealed the following: o No evidence of the committee's discussion of the striking pattern of skin rashes and insect bites that were reported in June 2012 other than brief references to Unit Directors having been "made aware of all skin issues," "ants popping up everywhere," and a "scheduled program for spraying grounds and homes for insects and powder applied to sites where ants were seen," o No evidence of follow-up to these problems in the July 2012 meeting to ensure resolution, o No evidence that a review of individuals with alterations in skin integrity occurred in August 2012, and o No evidence that the committee reviewed and/or put forward plans to address the high frequency of skin infections, including abscesses and cellulitis in September 2012. • The Infection Control/Skin Integrity Nurse was not certified in wound care, and although the physical therapist reported to the monitoring team that she was indeed certified in wound care and worked closely and/or collaborated with the Infection Control/Skin Integrity Nurse to provide clinical expertise and consultation in this area, upon the monitoring team's request for verification of the physical therapist's certification, the facility reported that the physical therapist was not currently certified in wound care. The physical therapist's misrepresentation of his/her credentials to the monitoring team should be addressed by his/her supervisor and facility administration. In addition, the facility's failure to provide clinical supervision and availability of expert wound care consultation to the Infection Control/Skin Integrity Nurse should also be addressed as soon as possible. • There continued to be inadequate policies/procedures developed by LSSLC to guide/direct the facility's skin integrity/wound care program and the Infection Control/Skin Integrity Nurse's activities. The only formal wound care protocols/procedures in place at the time of the review, which were presented to the monitoring team by the Infection Control/Skin Integrity Nurse, were Medline Industries' Remedy Skin Care System product guidelines. Despite the presence of a number of problems that had not been addressed or corrected by the facility since the prior review, the monitoring team's observations of the Infection Control/Skin Integrity Nurse's delivery of wound and skin care treatments to individuals revealed that individuals' privacy was always respected, their treatments were carried out with compassionate care, and there were some individuals who were clearly	

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		benefitting from the use of the Remedy Skin Care products. <u>Infection Control</u> During the prior review, it was noted that the Infection Control/Skin Integrity Nurse had 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, at that time, 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 and 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. In addition, the Infection Control/Skin Integrity Nurse was ensuring that the facility's database pertaining to individuals' infectious disease histories was kept up to date. Since the prior review, the results of LSSLC's monitoring reviews of infection prevention and control revealed that compliance with standards of care increased from 87% to 93%. The CNE reported that the Infection Control/Skin Integrity Nurse was not being pulled away from her duties, and, in an effort to help improve her infection prevention and control acumen, she was permitted to attend the Certification in Infection Control Examination Preparation Course, which was held in Amarillo on October 16-17, 2012. Also since the prior review, the facility hired a full-time Immunization/Employee Health Nurse. Although this nurse was in the job only four short months, she had made substantial progress in ensuring staff members' and individuals' compliance with TB testing, immunizations, and vaccinations. For example, as of 11/1/12, all individuals were compliant with TB testing, and only 15 of 1,138 employees, who were on leave, were not in compliance, but slated for testing upon return to work. In addition, the Immunization/Employee Health Nurse was working closely with one of the facility's physicians to address employee health issues and injuries, fully participating in new employee orientation, conducting TB and flu shot clinics, and attending infection prevention and control meetings. Although all of the aforementioned activities 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 review of the documents submitted by the facility and observations made by the monitoring team continued to indicate that the problems identified during the prior review had not been corrected, and some of the prior weaknesses in the program had worsened. For example: • Since the prior review, the Infection Control/Skin Integrity Nurse completed	

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		only one "Weekly Walk Through Monitoring Report," which was based upon a surveillance activity and identified problems with appropriate storage of biohazardous waste. There was no evidence of follow-up to ensure that the identified problems were corrected. • 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 "bathing," "check and change" "inservices," "better communication," etc. persisted over the next six months regardless of their effectiveness or outcomes. Of note, many of the planned interventions were completely inadequate to address the problems at hand. For example, although the infection data that were presented during the past several months of meetings indicated a troubling pattern and trend of increased urinary tract infections, the committee's plans of action, which were "F/U UTIs," "Continue to monitor UTIs closely," "Keep data," "Medications," and "Working on correct [analysis] of UTIs, colonization, bacteria count" failed to provide any specific, targeted interventions to achieve the goal of reducing the frequency, if not eliminating, urinary tract infections. • During the prior review of 22 individuals' records, there was no evidence that the Infection Control/Skin Integrity Nurse was consistently informed of or involved in the plans to address incidents that posed 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: o Several individuals' physicians' orders specifically requested the Infection Control/Skin Integrity Nurse to clarify the individuals' infectious disease and immunization histories. There was no evidence that these orders were carried out. o Individual #488 sustained a serious, large, self-inflicted wound, which required hospitalization to treat the complications of wound infection and spreading cellulitis. There was no evidence that the Infection Control/Skin Integrity Nurse was notified of Individual #488's injury or involved in addressing and reducing his risk of wound infection. Rather, the Infection Control/Skin Integrity Nurse only became aware of and involved in Individual #488's care and treatment after the fact. During the review, the monitoring team learned of the facility's recent outbreak of pneumonia and upper respiratory infections and the quarantine of individuals who resided on homes 563A, 563B, and 523. The summaries of the quarantine prepared by the Infection Control/Skin Integrity Nurse and the facility's administrator were	

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		reviewed, and the positive findings were as follows: • Once the first emergency Infection Control Committee meeting was held on 8/27/12, quarantines were imposed to help contain the infection and limit its spread across the facility. • At the time of quarantines, direct care and housekeeping staff members were reminded of standard precautions and instructed on how to clean and disinfect the units. • Subsequent Infection Control Committee meetings were reportedly held on 8/29/12, 9/4/12, and 9/26/12 to help ensure that proper infection prevention and control procedures were implemented and infections/illnesses were closely monitored. • On 9/26/12, LSSLC critically evaluated its conduct during the outbreak and determined that they had not done a good job of communication; the policies and procedures for quarantine needed to be revised; risk management should have been kept in the loop; and, going forward, the Risk Management Department would make sure that the Infection Control/Skin Integrity Nurse was made aware of employees that were ill with symptoms of contagious disease. Despite LSSLC's reports of their oversight and management of the outbreak of infectious and contagious illness and the lessons they learned, the monitoring team identified that the following problems were not adequately addressed by the facility's internal reviews and reports. • For almost two months, multiple individuals suffered pneumonia and upper respiratory infections before substantive actions were taken to identify and address the outbreak. • Minutes from the four emergency Infection Control Committee meetings were not kept. • It was concerning to find that the facility's newly revised Quarantine Procedure indicated, "an emergency Infection Control Team meeting will be held the same day as the quarantine is initiated if the quarantine is initiated during regular business hours (emphasis added)." The procedure went on to say that if/when a quarantine was initiated outside "regular business hours such as after 5pm or on holidays and weekends (emphasis added)," the Infection Control Team would not meet until the "next business day (emphasis added)." Also, the concerns, needs, and effects of the quarantine were only to be reviewed and discussed by the facility's clinical leadership on "business mornings (emphasis added)" for the duration of the quarantine. Remarkably, the facility's revised procedures were overtly contrary to the state and federal regulations and expectations for ICF-MRs, which were to provide the most comprehensive, continuous, aggressive, and consistent program of treatment, health, and health-related services of all of	

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		the Medicaid programs. • The newly revised facility Quarantine Procedure also failed to define important terminology, such as "essential staff," "outside entities," etc. that were referenced throughout the procedure. • In the wake of this significant event, there was no evidence of a review of the facility's Pandemic Respiratory Infectious Disease Readiness Plan (3/1/09), especially with regard to the planned interventions to address influenza-like illnesses and to ensure that the plan was consistent with the facility's newly revised quarantine procedures and vice versa. For example, the 3/1/09 plan referenced essential/nonessential staff members, just-in-time training, internal referral system, staffing contingency plan, medical services emergency plan to address the surge in capacity to treat individuals with respiratory infectious diseases, etc., which were just some of the relevant topics that warranted a closer review. <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 equipment checklists for 10/1/12-10/31/12 revealed that most of the checks were completed. A review of the past six months of Emergency Drill Checklists and revealed that, on average, 80-85% of the drills conducted were "passed." Drills were usually not passed because direct care staff members were not knowledgeable of the use of the AED and/or the locations of emergency equipment, and failed to bring needed equipment to the drills. Since the prior review, there were improvements in the facility's self-examination of their performance with these important health and safety procedures and their responses to deficiencies. For example, a review of LSSLC's Trend Analysis for Emergency Response Drills revealed that, consistent with the monitoring team's reviews, the facility identified problems with staff members' retrieval and use of emergency medical equipment. Although follow-up to problems occurred proximate to the drills in	

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		the way of "immediate fixes" and "long-term fixes," all "fixes" tended to be the same – reminding and retraining staff members on how to implement emergency, life-saving procedures. It was strongly recommended that the facility consider additional interventions to address the problems that pertained to faulty equipment and to explore other avenues to improve staff members' conduct during drills, as well as during actual emergencies. <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. Since the prior review, a new Infirmary Nurse Manager was hired. During the monitoring team's interview with the Infirmary Nurse Manager, she reported that she received almost no training specific to the infirmary and its operations, and even though the former Infirmary Nurse Manager was still employed by the facility as the QA Nurse. There were three days set aside for the former Infirmary Nurse Manager to help train the new Infirmary Nurse Manager to his/her new position, however, all three days were full of interruptions, which frequently disrupted and ultimately halted, the training process. According to the facility's 10/22/12 self-assessment, since the prior review, there were no steps taken to address the problems identified or respond to the recommendations put forward during the prior review. Thus, during the monitoring team's interview with the former and current Infirmary Nurse Managers, it was learned that, since the prior review, the infirmary was no longer staffed by a consistent group of specially designated direct care staff members, which were trained and competent to carry out certain delegated health care duties, but by "floating DSPs" who may or may not know the individual(s) admitted to the infirmary, and with "no DSP charge." Also, although it was reported that the direct care staff members were "getting better" at communicating with one another at change of shift, there were no formal procedures in place to 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. Speaking to the absence of process and procedures, it was reported that it was not uncommon for DSP Charges/Home Managers to fail to send relief staff to the infirmary during the times when direct care staff members working in the infirmary took their meals or other breaks, which created problems ensuring continuity of care. In addition, although the infirmary continued to house a diverse and ever-changing	

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		group of individuals with compromising health needs and risks, there continued to be no policies, procedures, protocols, guidelines, etc. in place to guide and direct the leadership, management, design, staffing patterns, operations, and evaluation of the infirmary. Thus, it was not surprising that, as noted in the prior review, the current Infirmary Nurse Manager was no more able to explain the mission, vision, purpose, and scope of the facility's infirmary than the former Infirmary Nurse Manager. A review of the admissions to the infirmary over the past several months revealed that, on average, there were approximately 30 admissions per month to the infirmary with lengths-of-stay that ranged from less than 24 hours to over 95 days. At the time of the review, the infirmary was less than half-full. It was reported to the monitoring team that many of the individuals admitted to the infirmary were designated as needing only "routine supervision." So, for example, on the day of the monitoring team's observations on the infirmary, Individual #240, who was admitted to the infirmary post-hospitalization for treatment of pneumonia and dehydration and was suffering from renal failure, a serious intestinal infection, and pressure sores, isolated, and designated as DNR, was reportedly checked only once every 15 minutes and repositioned and changed only once every two hours. When the infirmary's direct care staff member was asked by the monitoring team for an introduction to Individual #240 and for an explanation as to why he was in the infirmary, the direct care staff member replied, "He's a DNR and I don't know much else about him, [because] he's not on my home." Clearly, Individual #240 would have benefitted from closer attention and more frequent care from a knowledgeable caregiver, especially since Individual #240 was admitted to the infirmary because he needed close monitoring and 24-hour nursing care. <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 their 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 all prior reviews, 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	

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		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 numerous examples of the facility's failure 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. The following examples represented the seriousness of this problem at LSSLC. • On 6/5/12, Individual #574's direct care staff member reported to his nurse that he was having shortness of breath. When Individual #574's nurse asked him if he was having chest pain, he stated, "Yes." At this time, on the basis of an incomplete assessment of Individual #574's health status and vital signs, his nurse administered nitroglycerin, a potent antihypertensive medication, and noted, "Asked DSP to tell me if [Individual #574's] chest pain does not subside X 5 minutes." Forty-five minutes later, Individual #574's nurse found that he continued to breathe deeply and had chest pain. Again, on the basis of an incomplete assessment of Individual #547's health status and vital signs, his nurse administered yet another dose of nitroglycerin and "Told DSP to let me know if [Individual #574's] breathing gets heavy again." • Over the past several months, Individual #428 suffered weight loss, such as 20 pounds in three months, and guaiac positive stools. Notwithstanding these significant and potentially serious changes in Individual #428's health status, there was no evidence of follow-up to his physician's 8/1/12 and 10/29/12 orders to schedule a colonoscopy. In addition, there was no evidence that his physician's orders to review his blood pressure measurements and encourage him to drink six to eight glasses of water a day were carried out. • On 9/12/12, Individual #387's direct care staff member reported to his nurse that he was difficult to arouse and had minimal reaction compared to his normal behavior. When his nurse assessed him, he/she found that his blood pressure, pulse, and blood/glucose levels were significantly elevated. Individual #387's nurse noted, "DSP to report changes in condition or LOC or SOB...Will pass on information to next shift for further monitoring." Notwithstanding this plan, there was no evidence of further monitoring until four days later when Individual #387 was transferred to the emergency room and hospitalized for the next 12 days for treatment of severe dehydration, hypovolemia, hypernatremia, and azotemia. • On 8/27/12, at 9:00 am, Individual #174's nurse discovered him lying in bed	

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		with a large amount of coffee ground vomit on his shirt and bed sheets. At this time, Individual #174' nurse obtained his vital signs, checked his lungs and abdomen, and placed him on sick call. There was no evidence that Individual #174's significant change in health status was further evaluated or that follow-up occurred until he was examined the next day during sick call.	
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 improved their already high compliance scores pertaining to annual and quarterly nursing assessments from 85% to 89%, and improved compliance with the timeliness of all regularly scheduled assessments up to 99%. Curiously, the facility's self-assessment also noted that their review of the assessments completed by seven RN case managers found that they were "inconsistent on how the assessments [were] documented." Thus, the facility concluded that they were not in substantial compliance with this provision item and that nursing assessments "needed improvement in regard to capturing the complete picture of the individual's clinical problems, needs, and actual/potential health risks." A review of 22 sample individuals' records revealed that current annual and/or quarterly nursing assessments were present in all but one of the 22 records reviewed. Of the 21 individuals' nursing assessments reviewed, all 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	Noncompliance

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		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 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 continued to be that a few select nurses regularly documented reviews of individuals' responses to the interventions in their health and medical cares 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. However, where these reviews fell short of meeting the standard of care was that changes in nursing care to meet the needs of each individual as indicated by his/her health status failed to occur. 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 one or more times during the period of 5/1/12 – 10/31/12. Almost one-half 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. Nurses were also required to complete comprehensive nursing assessments when individuals were admitted to the facility. A review of the assessments of two individuals who were admitted to the facility during the past six months revealed that their admission assessments were not conducted until several weeks after their admissions, and they were both incomplete. Other examples are given below: <u>Regarding specific individuals</u> • Individual #174 had many health needs and several high health risks. During the most recent quarterly nursing assessment review period, Individual #174 suffered frequent episodes of vomiting, hematemesis, elevated gastric residuals, open areas on his buttocks, and emergency medical treatment. Nonetheless, Individual #174's quarterly nursing assessment peculiarly concluded, "There are	

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		no acute health problems of concern at this time," and recommended "continuing his HMPs with no revisions needed at this time." • Several years ago, Individual #130, who was a 48-year-old man, suffered a liver transplant after an overdose of Tylenol. His most salient health needs were the sequelae of his liver transplant and his adherence to his liver transplant profile. Be that as it may, Individual #130's liver transplant was not referenced in his nursing assessment as a current, active medical problem and his responses to his liver transplant were not referenced as current nursing problems/diagnoses. • According to Individual #248's record, his physician ordered a modified barium swallow study to evaluate his ability to eat in response to his mother's requests to serve him "regular food." There was no evidence that Individual #248's nurses conducted a complete analysis and assessment of Individual #248's oral versus enteral intake of food and fluids, his responses to changes in diet orders, including changes in his enteral nutrition regimen, his behaviors at mealtime, including his response to staff members' assistance and implementation of his PNMP, and so on. In fact, a review of the past six months of Individual #248's nurses' notes, summaries, and assessments revealed almost nothing about his responses to this very significant health issue. Rather, Individual #248's comprehensive nursing assessments simply indicated that monitoring Individual #248's meal was not conducted during his assessments because he "refused to eat." <u>Regarding numerous individuals</u> • Since the prior review, there was evidence that LSSLC continued to have problems assuring that physicians' orders were accurately received and implemented as prescribed. For example, there were several records where orders for diagnostic tests were repeatedly re-ordered due to lapses in implementation, and notes from physicians indicated their frustrations over these errors. For example, Individual #174's and Individual #298's physicians' noted, "What happened to CBC/guaiac? Please do," and "Follow-up tests should be arranged while the patient is still in the office. This will help limit the chances of necessary services being omitted or delayed." • Individuals' weekly Aspiration Trigger and Gastrostomy Tube 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. • As noted in the prior review, the impact of many of the individuals' chronic conditions were not adequately portrayed by the nursing assessments and oftentimes not even referenced in the individuals' lists of nursing diagnoses.	

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		• Nursing assessments frequently failed to reference an assessment of individuals' pain beyond their numeric score on the Wong Baker pain rating scale. 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, in addition to medications, what were effective strategies to alleviate 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. • The five discharge nursing summaries that were reviewed were in need of improvement. Although they all were in the same form/format, some summaries included and referenced a complete list of the individuals' health problems, needs, and risks, and others did not. In addition, some summaries provided a short, and others provided a lengthy, rundown of the individuals' health status and risks. However, all summaries failed to describe the individuals' participation in their health care and explain their progress/lack of progress toward the achievement of their desired health goals.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	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. 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 managers 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	Noncompliance

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		individuals on their assigned caseloads. The facility reported during its opening presentation that since the prior review, two interdisciplinary teams were trained on the newly enhanced risk processes by the state's consultants and the facility's local consultant. The training included presentations of processes and procedures for ensuring that (1) discussions of health and behavioral risks, (2) completion of the Integrated Risk Rating Form, and (3) development of an Integrated Health Care Plan were incorporated into the new ISP process. Further, the facility stated that during the onsite review, the monitoring team would observe firsthand the newly enhanced risk processes in action and demonstrated by two IDTs. As the facility continues to implement its enhanced risk processes, which included the development of Integrated Health Care Plans (IHCPs), compliance with this provision item will be affected by nurses' ability to successfully transition the development of individuals' health care plans from the HMP model to the IHCP version of the process, which portends to be a higher level of collaborative plan development with interconnected roles/responsibilities for the implementation of planned interventions to achieve specific, measurable, attainable, realistic, and timely goals. According to the facility's action plan for section M3, since the prior review, there were no action steps taken toward achievement of compliance with this provision item except the Nurse Educator conducted training on the implementation of care plans. As of the review, this action step was still "in process," and, apparently, still very much needed since the facility's self-assessment indicated that the results of audits of nursing care plans revealed a decline in performance from 84% to 72% compliance with basic standards of practice. The facility reported that individuals' nursing care plans continued to need improvement in regard to "addressing each health care need of the individual, including needs associated with high risk/at-risk health conditions," and "revising nursing care plans, as necessary, based on the clinical needs of the individuals. Thus, the facility concluded that they were not in compliance with this provision item, and the monitoring team agreed with this self-rating. The monitoring team's review of 22 individuals' records revealed that 20 individuals had one or more HMPs, three individuals had one or more MCPs, and, despite the fact that all sample individuals' suffered one or more untoward health events during the past six months, less than half of the individuals had one or more ACPs. Consistent with the findings from the facility's self-assessment, the overwhelming majority of the individuals reviewed failed to have specific, individualized nursing interventions developed to address all of their health care needs, including their needs associated with their health risks. As a result, a rating of noncompliance was given to	

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		this provision item. Some general comments regarding the 20 sample individuals' care plans are below. Of note, most, if not all, of the findings were consistent with the findings from prior reviews. • As noted in the prior review, the purpose of the MCPs remained 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." In addition, 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. • 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 risk of aspiration was used to address the needs of an individual who suffered occasional episodes of vomiting, as well as the needs of an individual who had a gastrostomy tube, suffered from high gastric residuals, and a history of aspiration pneumonia. • None of the 22 individuals records contained plans that addressed all of the current health needs of the individuals at all times. • Goals and outcomes were not specific, measurable, and person-centered. For example, the goal of Individual #488's HMP to address his alteration in skin integrity and high risk of infection was, "[Individual #488] will be redirected whereas he will not self inflict open wounds upon himself in order to make as free from broken skin as possible (sic)." Examples of problems in the HMPs and ACPs of specific individuals are presented below: • Individual #488 was a 33-year-old man with multiple behavior and physical health problems. Over the past several months, his behavior problems of self-injury and meal refusals contributed to the development of serious untoward health outcomes. For example, Individual #488 was hospitalized for two weeks for treatment of a self-inflicted bite wound that was positive for MRSA bacteria and spreading cellulitis, and, he lost 14 pounds during the one-month period of September to October 2012. Despite Individual #488's health needs and risks and poor health outcomes, he failed to have an HMP to address his weight loss. In addition, his HMP to address his alteration in skin integrity, which was supposed to address all of his skin problems, including fungal infection, skin breakdown around his umbilicus, and healing bite wounds, wholly failed to adequately address any and all of these health issues.	

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		• Individual #108 was a 51-year-old man who suffered from hypothermia. He had a 3/9/12 HMP to address his hypothermia in his record. However, the planned interventions were not consistent with the state's nursing protocol related to hypothermia. For example, the state's nursing protocol indicated that during episodes of hypothermia, rectal temperatures should be obtained and documented every 30 minutes until a temporal temperature of 97 degrees is achieved and continued assessment and documentation every four hours for 24 hours, or until resolved. Individual #108's HMP to address his hypothermia instructed his direct care staff members to reuse his blankets "until they have holes in them" and that they check his temperature only twice a shift and document the measurements on the client care flow sheet. In addition, the HMP indicated that nurses were only required to document once per shift during the acute phase of his hypothermic episodes and then once a day until resolved. On 9/2/12, these discrepancies, which were significant, likely played a role in Individual #108's nurses' failure to identify his impending hypothermia and need for emergency medical treatment.	
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. Regrettably, since the prior review, there continued to be resignations, vacancies, and turnover in the Nursing Department. Changes occurred in positions with functions and duties that were critical to attaining and maintaining compliance in M4, such as the CNE, Infirmary Nurse Manager, RN case managers, etc. Thus, there were setbacks to achieving improvements and making progress toward substantial compliance, which was considered "extremely close" six months ago. The facility's action plan indicated that, since the prior monitoring review, few steps were planned and only one step was taken toward achieving compliance with this provision item. For example, four steps pertaining to the Nursing Department collaboration with the QA Department, such as conducting inter-rater reliability tests, collaboratively reviewing compliance reports, developing corrective actions plans for areas of nursing care that fell below 80% compliance, and meeting together at least quarterly to discuss progress, were either "in process" or "not started." Upon follow-up	Noncompliance

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		by the monitoring team, the steps that were reportedly "in process" were scheduled, but not implemented. The one action step that was taken was that, since the prior review, 100% of the facility's nurses were issued and trained on the state's nursing protocols. The facility's self-assessment indicated that, since the prior monitoring review, the results of audits of nurses' documentation improved from 62% to 72% compliance. However, the results of the audits revealed that nurses continued to need improvement in their documentation of comprehensive nursing assessments, monitoring of individuals' health status changes until resolved, and consistently and correctly implementing the state's nursing protocols. The facility concluded, "Although improvement was noted since the last review, based on the findings from the self-assessment, this provision is not in substantial compliance." The monitoring team was in agreement with the facility's self-rating of noncompliance. The Nursing Operations Officer (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 continued meeting with all nurse managers and the Program Compliance Nurse on a weekly basis. Inexplicably, however, the nurses' reviews of the findings from the monitoring tools and audits and the brainstorming about strategies to meet compliance with the provisions of section M were discontinued. Discussions of staffing data, schedules, call-in logs, medication variance reports, and other issues that pertained to the operations and management of the Department appeared to take up the majority of the meetings' agendas. During the weeks when there was no CNE or acting CNE, the NOO worked hard at keeping the department together, focused, and functioning. This was no small task, given the numbers of issues, problems, and concerns that needed to be addressed on any given day across the department. Thus, it was not surprising that during the monitoring team's interview with the NOO, she reported that there were "lots of changes," and that the strategies in place to affect positive change were "difficult to implement" and in need of a "new set of eyes." For example, the NOO proposed that instead of completing dozens of monitoring tools, using only three or four monitoring tools, versus 12 and focusing oversight activities on correcting and improving nurses' "responses" to events as they naturally occur may produce better results. The new CNE, who had been at the facility less than two months was looking at the assessment and reporting protocols that were in place with the intention of improving utilization and implementation of existing systems and protocols and, in her words, "working smarter." Nurses' knowledge and documentation of the implementation of the state's and facility's assessment and reporting protocols was one place in dire need of the CNE's intervention. As noted in the prior review, and despite reports of nurses training	

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		on the protocols, there was no evidence in either the IPNs, comprehensive assessments, or HMPs that the assessment and reporting 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. For multiple individuals, their records revealed the following: • Individuals who suffered temperature elevations failed to have evidence of the implementation of the protocol related to hyperthermia. Thus, there was no evidence of consistent implementation of interventions to prevent dehydration and provide comfort, save for the administration of "Tylenol 650 mg." • At least one individual who ingested foreign objects failed to have evidence that the pica protocol was followed. Thus, it was unclear whether the individual received follow-up x-rays to "rule out any coins still being in her system." • Individuals who suffered untoward adverse drug events, such as toxicity, failed to have evidence of appropriate monitoring of the side effects of their medication(s). • Individuals who suffered episodes of vomiting failed to have evidence of implementation of the protocol developed to address this problem. Thus, some developed fluid and electrolyte imbalance and required emergency medical 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. • Across all records reviewed, the SOAP documentation protocol was not consistently implemented. It was clear to the monitoring team that much work needed to be done and many more steps need be taken to ensure that their nurses become knowledgeable of and consistently implement the nursing assessment and protocols. To help nurses achieve compliance with this provision item, a number of education and training programs were already underway at LSSLC.	

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		The Nurse Educator reported that, since the prior review, she continued to conduct the facility's annual competency training and provide refresher training and re-education on the nursing protocols, respect and dignity, individual supervision levels, response to actual emergencies and emergency drills, and SOAP documentation to all nurses. It was reported that 100% of LSSLC's nurses were "checked off" during the facility's annual competency-based training/skills fair. In addition, since the prior review, the Nurse Educator implemented the updated Preceptor Program, and 18 nurses, who were interested and qualified, completed the program and were ready to mentor new nurses. Since the prior review, the Nurse Educator and her assistant initiated the new state-mandated training for RNs called, Mosby's Physical Examination Course. According to the Nurse Educator, the LSSLC nurses had both positive and negative reactions to the training program. On a positive note, some nurses viewed the training as "A good thing," but other nurses described it as, "One more thing [we] have to do." When the monitoring team asked the Nurse Educator to explain how she ensured attendance and participation at the training sessions, she reported that she sends reminders to the nurses and notifies their supervisor if they do not show up for training. Beyond that, the Nurse Educator explained, she had no authority to enforce training expectations for the nurses. Reportedly, the Nurse Managers were authorized to enforce the expectations for nurses to attend orientation and training vis a vis CT&D, but it was unclear whether or not they were similarly allowed and encouraged to enforce the expectations and support the training initiatives of the Nurse Educator. Since the prior review, a new RN Case Manager Supervisor joined the ranks of the nursing leadership team. Since her arrival, she had conducted one-on-one training sessions with the RN case managers, performed remedial training with nurses who needed additional training and support in specific nursing duties, such as assessment and development of nursing care plans, and took a lead role in conducting the "Nurse Case Manager Orientation." During the monitoring team's interview with the RN Case Manager Supervisor, she reported that she reviewed a sample of nursing assessments, and, on the basis of the findings of her review, she targeted the following areas for improvement: (1) missing nursing assessments, (2) absence of review and analysis of data, and (3) copying and pasting text from prior assessments onto new assessments without review, analysis, and revision. Of note, since the prior review, there was a significant improvement in the timeliness of nurses' completion of annual and quarterly comprehensive nursing assessments. For example, 19 of the 22 records of sample individuals reviewed showed evidence of timely completion of regularly, scheduled annual and quarterly nursing assessments. The RN Case Manager Supervisor candidly reported to the monitoring team that during her short, three-month tenure on the job she had not conducted any reviews of individuals'	

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		care plans. However, with the facility's 11/1/12 implementation of the IRRFs and IHCPs, it was clear that the RN Case Manager Supervisor should incorporate oversight of this important aspect of nursing care into her daily duties sooner rather than later. Indeed, the RN Case Manager Supervisor plays a significant role and has tremendous responsibility to help facilitate the RN case managers' transition from the old to the new ways of conceptualizing, completing, and implementing individuals' health care plans. Since the prior review, LSSLC's Nurse Recruiter no longer 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. Rather, since the prior review, she was relieved of these duties and afforded the opportunity to completely immerse herself in the recruitment and retention of nurses at the facility. Thus, the Nurse Recruiter reported to the monitoring team that although the "numbers [were] better," there was no budget for recruitment, and no advertising occurred, save for one ad, which ran on 9/30/12 in The Lufkin News. A review of the Nursing Hiring Trend report revealed the following: • Turnover was constant, and, on a monthly basis, one to eight nurses were terminated and six to 11 nurses were hired. • There were more nurses hired in September 2012 and October 2012 than in any other months. • Most of the terminations occurred in the infirmary and on the Lone Pine and Woodland Crossing units. • Most of the nurses who were terminated were either LVNs or direct care RNs. Unfortunately, these findings were not identified by the Nurse Recruiter and incorporated into her analysis. As noted in the prior review, the Nurse Recruiter continued to fail to utilize data and information, which were at her disposal, to help the nursing leadership team and facility administration become more aware of the challenges and struggles facing the department's efforts to ensure adequate and appropriate levels of nursing staff across the campus. Similarly, although the Nurse Recruiter reported that she conducted a survey of nurses to examine the problem of unscheduled absence, as recommended by the monitoring team, she failed to analyze the results of the survey because there were "only 24 respondents." Upon the urging of the monitoring team, the Nurse Recruiter examined these data and concluded, "Even though 'illness' was indicated as the number one reason for unscheduled absences, when asked for solutions to the problem, a better schedule was the number one solution. A committee was formed with representatives from each nursing unit to problem solve and get ideas for solutions. It was consensus from the committee that without an increase in nursing positions, a better schedule cannot be	

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		formulated. This directly effects recruiting and retention." The Nurse Recruiter's analysis of the survey results appeared to raise more questions than it answered. For example, there was no examination or explanation of what the nurses meant by a "better schedule," no clarification of how many nurses may be needed to address the nurses' request for a better schedule, and no evidence that the committee put forward any solutions to reduce unscheduled absences, which continued to beset progress toward compliance with the provisions of the Settlement Agreement and Health Care Guidelines and negatively affected nurses' morale and nursing care. Finally, although the Nurse Recruiter administered an Exit Survey, which referenced a number of important and relevant issues that potentially impact care and compliance, such as supervision, communication, conflict resolution, etc., there was no evidence that these data were collected, analyzed and examined for patterns and trends, and reported to nursing leadership and facility administration. Since the prior review and only one month prior to the onsite review, the former Infirmary Nurse Manager was appointed to the position of Quality Assurance Nurse. Thus, as noted in the prior review, there was no evidence that the QA Nurse and QA Director met with the CNE and other relevant nursing leadership, such as the Nurse Compliance Coordinator, to review and discuss the Nursing Department's current compliance and monitoring activities, conduct the inter-rater reliability tests, and plan how data will be shared, analyzed, and disseminated through the proper channels, such as the QAQI Council, etc. However, these activities were scheduled to occur in the near future. Presently, the QA Department, including the QA Nurse, was orienting itself to what and how data were collected and used across the facility and looking at how the various departments conducted their self-assessments. In addition, the QA Department was developing a facility-wide corrective action log that tracked all recommendations received, internally and externally, from inception to completion. Since the prior review, three deaths occurred. Of the three QA Death Reviews for Nursing that were completed, one was unsigned by the reviewer, one was conducted by the Medical Compliance Nurse, and one was completed by the new QA Nurse. A review of these reports revealed that there continued to be findings of, and recommendations to address, problems with nurses' delivery of basic nursing care, such as nurses' assessments, documentation, plans of care, reviews of individuals' health risks after significant health events, and responses to medical emergencies. For example, there were recommendations that nurses should refer individuals that vomit in their sleep to sick call, a nurse (and two direct care staff members) should be re-trained in the facility's	

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		emergency medical response protocol/procedures including contacting the physician, nurses should document on all individuals with critical health issues, nurses should document their assessments and steps taken in the IPNs, and so on. Notwithstanding these repeated and disturbing findings and recommendations, a review of the corrective action logs that were developed to monitor the implementation of recommendations associated with two individuals' deaths, revealed that only one of the logs listed the recommendations pertaining to nursing care. A review of the "Director Status Report," which was a log of the status of all recommendations from all corrective action plans across the facility, revealed that almost all of the recommendations pertaining to nurses and nursing care were "not started." This raised serious concern because all of the recommendations referenced the implementation of only very basic standard of care procedures and routine monitoring and oversight activities. And, continued delays in the implementation of these recommendations continued to jeopardize the health and safety of individuals who resided at LSSLC. As noted above in Sections M1-M3, the results of the facility's self-assessment and the findings from the evaluations and reviews conducted by the Nurse Compliance Coordinator were strikingly similar to the findings of the QA Death Reviews for Nursing. The Nurse Compliance Coordinator's monthly reports showed that there continued to be significant problems in nurses' practices of basic nursing care, failure to consistently implement the assessment and reporting protocols, and untoward health outcomes suffered by the individuals. It was disconcerting to note that the Nursing Department stopped reviewing the results of the compliance monitoring tools/audits during their weekly meetings. It was also troubling that, although the Nurse Compliance Coordinator continued to report the findings from the monitoring tools to the NOO, and included explanations for what could possibly be related to the findings, there were no strategic, corrective action plans developed and implemented to reduce the likelihood that the problems would persist and grow.	
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	At the time of the monitoring review, LSSLC had completed almost two years of its implementation of the state-approved health risk assessment rating tool and assessment of risk as part of the ISP process. However, throughout this time, there were changes in the forms and format of the processes, which set back some of the facility's implementation strategies. According to the facility's action plan, since the prior review, one action step was completed, that is, all RN case managers were trained in the latest iteration of the at-risk process, IRRFs, and IHCPs, and one action step was ongoing – that is, the Hospital Liaison	Noncompliance

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	reviews as indicated by the health status of the individual.	continued to provide hospital reports and information to hospitalized individuals' IDTs. One additional step, which included the implementation of correction action plans for compliance ratings below 80%, was referenced, but it was not implemented. According to the facility's self-assessment, since the prior monitoring review, "improvement was noted in the audit results," however, "Based on the findings of this self-assessment, this provision remains as non-substantial compliance as further training and evaluation is needed regarding the nurses' assessment and documentation of an individual's indicators of risk, and their attendance and participation in the new enhanced risk and ISP process." One of the most direct ways that the Nursing Department would improve its performance and compliance with the risk assessment and planning processes would be through nurses' implementation of the integrated risk rating assessment process, documentation of individuals' indicators of risk, attendance and participation in the IDT and ISP processes, and development of a complete, accurate integrated health care plan. According to the facility's ADOP, since the prior review, Individual #433's and Individual #465's teams were trained in the revised risk assessment and integrated health care planning process and had implemented these processes as part of the course of the individuals' annual ISP preparation and development. Thus, the monitoring team requested these individuals' records for review. Apparently, although the process had begun, no documentation had, as of yet, been completed, such as the IRRF, IHCP, or ISP. 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 serious problems with health risk ratings, which were not consistently based upon current, accurate, relevant health data and 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: • On 7/6/12, despite documentation of Individual #102's risk of and actual incidents of falls in the past year, alteration in her mobility, risky behaviors, such as unfastening her seatbelt and attempting to slide out of her wheelchair, her IDT determined that her risk for falls was "medium." In addition, on the basis of "no recent fractures," Individual #102's IDT determined that her risk for	

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		fractures was also "medium." Within less than a month of the assessment, Individual #102 fell and fractured her femur and hip. As a result of these untoward health events, Individual #102's risks for falls and fractures were increased from medium to high. Her risk action plan, however, failed to put forward adequate planned interventions and only referenced that she continue her medications, follow-up physician's orders, and follow her PNMP. • Individual #475 had many health problems. Over the past several months, he suffered significant, unexplained weight loss, poor oral intake, gastrointestinal bleeding, fever, dehydration, and hospitalization. Nonetheless, the integrated risk rating form filed in Individual #475's record was blank, there was no health management plan to address his weight loss or risks of gastrointestinal bleeding, dehydration, malnutrition, infection, etc. • Individual #488 was diagnosed with health and behavior problems. In April 2012, Individual #488 bit himself so severely that he was hospitalized for 12 days to treat his wound, which became infected with methicillin resistant staphylococcus aureus. In addition, several months ago, his physician noted that he was losing weight and had "frequent meal refusals and needed staff to take more time and patience to feed him." On 10/13/12, Individual #488's weight log revealed that, since September 2012, he lost 14 pounds. His risk ratings related to alteration in skin integrity and weight, however, were "low."	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The administration of medication and the management of the medication administration system at LSSLC failed 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 only action step reportedly completed by the facility since the prior review was that there was agreement that the certified medication aides should attend an annual refresher, competency-based, training program in medication administration. Also, although the facility's self-assessment noted that the results of their medication administration and documentation audits revealed 99% compliance with standards of care and that steps were taken to ensure that nurses will only use the PNMP for instructions related to medication administration, the facility concluded that "based on the findings of this self-assessment, this provision remains as non-substantial compliance." The monitoring team agreed with the facility's self-assessment of noncompliance, but based its rating on the presence of a pattern of serious problems in this area.	Noncompliance

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		Storage At the time of the monitoring team's examination of five units' medication areas, all medications were properly stored in locked carts, cabinets, and storage bins. Controlled substances were doubly secured and accounted for by nurses, in accordance with medication logs. Refrigerator temperatures were usually checked daily, and all temperatures were recorded on logs. The refrigerator temperatures on the days of the monitoring team's reviews were within the proper parameters for medication storage. During half of the monitoring team's observations, nurses' ensured that the carts, liquid medication bottles, and other tools, such as the pill crusher, were properly cleaned between uses, but during the other half, they were not. Administration Observations of medication administration, oral and enteral, were conducted on selected units. During all observations, nurses failed to adhere to one or more of the accepted standards of practice. For example, nurses failed to properly sanitize and/or wash their hands when they were dirty. Instead, they counted the number of individuals they could contact before they had to, by rule, wash their hands. Not one nurse checked medications three times to ensure that the rights of medication administration were upheld. Although nurses generally treated individuals with dignity and respect, at least one nurse, who despite noticing that an individual was slumped in his wheelchair, not responsive, had high gastric residual, and not his usual self, continued with the administration of his medications, which included psychotropic medication, and failed to perform an assessment of the individual's change in health status. Nurses did not consistently follow the individuals' PNMP, thus placing them at risk of choking and aspiration. Despite orders to the contrary, nurses crushed enteric-coated medications. Nurses did not follow proper infection control practices and were observed sharing topical ointments from one individual to another, failing to clean equipment between use, and not rinsing and cleaning enteral feeding equipment after use and before the equipment was stored in plastic bags. As of the monitoring review, there was no evidence that nurses were referred to the Nurse Educator to receive remedial education and training to address the problems referenced above and ensure that they were competent to administer medications, in accordance with generally accepted professional standards of care. In addition, although there was evidence that the Nursing Department was planning to teach a seven-hour medication administration course for its nurses, as of the review, it was not scheduled.	

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		Documentation As noted in all prior reviews, the MARs were still very confusing. The review of 22 individuals' current MARs for the period of 9/1/12-10/31/12 revealed a decline in performance from the prior review. Over half (64%) 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. 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. Nurses failed to consistently implemented or make reasonable attempts to implement the individuals' SAM program. Oversight and Monitoring According to the generally accepted standards of care, the goal of a facility like LSSLC was to continually improve systems to prevent harm to patients due to medication errors. They should monitor actual and potential medication errors that occur, and investigate the root cause of errors with the goal of identifying ways to improve the medication-use system to prevent future errors and potential harm to individuals. Since the prior review, the Nurse Compliance Coordinator continued to conduct quarterly monitoring of medication administration, and nursing leadership conducted 25 to 30 observations of nurses' medication passes. A review of the results of these monitoring activities revealed scores that indicated nurses performed "excellent" and scored from 95% to 100% on the monitoring tool. Despite these high scores and high praise, it was clear that there were problems with the reliability and validity of the monitoring and oversight of medication administration. For example, despite the fact that a nurse initialed the MARs before he/she administered the medications, signed for medications that he/she failed to administer, and administered a PRN medication and failed to document the time that it was given, the nurse scored 97% on the monitoring tool. During the week of the onsite review, the monitoring team attended the meeting of the Medication Variance Committee meeting. During the committee's review of the trends in medication variance, omissions, incorrect medications, incorrect dosages of medications, and wrong individuals were the top four contributors to the facility's frequency of medication variance, explaining almost two-thirds of the variance.	

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		The year-to-date variance data presented during the meeting showed that over the past six months, there was a pattern of increase and subsequent decline in total variance, which was a positive finding. Reportedly, vacancies and use of agency/contract nurses were associated with the increase in medication variance. Be that as it may, there was no discussion of how these problems would be addressed by the facility. The NOO reported to the committee that rotating medication carts across nurses to relieve some of the nurses who had heavy loads of medications to administer was one of the strategies put forward to reduce medication errors. This change was met with resistance from the nurses. In addition, there was no evidence that rotating carts was associated with increased or decreased variance. Thus, the plan to rotate medication carts was under reconsideration. The NOO also reported that there were concerns that nurses were underreporting medication variances because when the Nursing and Pharmacy Departments compared reports of medication variance with the overage and shortage forms, there were discrepancies. As a result, the Pharmacy and Nursing Departments were meeting once a week to review the reports and forms to ensure that they were consistent. The monitoring team suggested that the facility consider looking at indicators other than "reports of errors," such as blood levels of medications, breakthrough seizures, etc., to ascertain whether or not there were problems with reporting. Notwithstanding the findings and concerns referenced above, during the committee meeting, the NOO announced that the Nursing Department had unilaterally decided that the nurses were no longer going to conduct daily counting and reconciling procedures of medications because it took too long, was overly burdensome, and took time away from the care of the individuals. The monitoring team strongly urged the committee to reconsider this decision, which was tantamount to discontinuing one of the few, if not the only, facility-wide procedures in place to reconcile medications.	

Recommendations:

1. The CNE should consider developing ways in which all nurses in leadership positions show evidence of weekly progress toward achieving goals/steps toward compliance with the provisions of section M (M1-M6).

2. Re-establish an infection prevention and control program at the facility, in accordance with generally accepted standards of practice (M1-M6).

3. The QA and Nursing Departments should work together to address the repeated findings and recommendations in the QI Death Reviews for Nursing (M1-M6).

4. Re-examine the process of monitoring medication administration to ensure that results are valid and reliable measures of the process (M6).

5. Consider developing ways in which the Nurse Compliance Coordinator's monitoring activities can affect real change(s) in the delivery of nursing care (M1-M6).

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

7. Implement procedures to monitor the care and treatment of individuals who are hospitalized and/or transferred to alternate levels of care on weekends and holidays (M1).

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

9. Consider ways to improve the quality of life of individuals during their stay in the infirmary (M1).

10. Clarify the expectations of the facility's Nurse Recruiter and consider involving the Nurse Recruiter in nursing staff development activities (M1).

11. 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).

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

13. The facility should provide more training to its nurses in relation to the conduct and completion of the IRRFs and IHCPs (M3, M5).

14. Re-consider the recent discontinuation of the daily counting and reconciling procedures of medications (M6).

15. Review and revise the self-assessment process to ensure that the activities engaged in to conduct the self-assessment completely reflect and are truly relevant to the provision items (M1-M6).

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 #009.2: Medical Care, o LSSLC Self-Assessment for Section N o LSSLC Action Plan Provision N o LSSLC Provision Action Information o LSSLC Organizational Charts o Presentation Book for Section N 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 Policy: Quarterly Drug Regimen Review, 7/1/12 o LSSLC Lab Procedure Matrix, 4/5/12 o LSSLC Moses Assessments – For General Medication Side Effects Monitoring, DISCUS Assessments For Tardive Dyskinesia and Extrapyramidal Side Effects Monitoring, 9/2012 o Pharmacy and Therapeutics Committee Meeting Minutes, 2012 o Medication Variance Committee Meeting Minutes, 2012 o Adverse Drug Reactions Reports o Drug Utilization Calendar o Drug Utilization Evaluations • Clonidine • Levothyroxine o Quarterly Drug Regimen Review Schedule o Quarterly Drug Regimen Reviews for the following individuals: • Individual #545, Individual #554, Individual #105, Individual #50, Individual #308, Individual #593, Individual #328, Individual #422, Individual #497, Individual #99, Individual #12, Individual #146, Individual #160, Individual #102, Individual #31, Individual #255, Individual #507, Individual #450, Individual #515, Individual #516, Individual #574, Individual #349, Individual #317, Individual #467, Individual #340, Individual #451, Individual #161, Individual #176, Individual #431, Individual #298, Individual #569, Individual #420, Individual #240 o MOSES and/or DISCUS Evaluations for the following individuals: • Individual #545, Individual #43, Individual #363, Individual #23, Individual #305, Individual #105, Individual #328, Individual #261, Individual #517, Individual #252, Individual #99, Individual #134, Individual #473, Individual #440, Individual #160, Individual #102, Individual #316, Individual #36, Individual #365, Individual #218,

	Individual #255, Individual #175 Individual #574, Individual #513 Individual #93, Individual #135, Individual #457, Individual #380, Individual #502, Individual #447, Individual #170, Individual #300, Individual #571, Individual #592, Individual #161, Individual #370, Individual #176, Individual #298, Individual #569, Individual #420 Individual #240 Interviews and Meetings Held: o David Leeves, RPh, Pharmacy Director o Michelle Richard, PharmD, Clinical Pharmacist o Laura Luna, RPh, Staff Pharmacist Observations Conducted: o Pharmacy and Therapeutics Committee Meeting o Medication Variance Committee Meeting o Polypharmacy Oversight Committee Meeting o Daily Clinical Services Meetings o Pharmacy Department
	Facility Self-Assessment: LSSLC submitted three documents as part of the self-assessment process: self-assessment, action plan, and the provision action information. For each of the provision items, the clinical pharmacist numbered and listed each activity engaged in to conduct the self-assessment. The results of the assessment were presented in a similar fashion. Each self-rating provided a rationale for the rating. The clinical pharmacist did a relatively detailed assessment that focused on many of the issues noted in previous reports. For example, as part of the assessment for provision N1, communication with the nursing and medical staffs, the most recent Single Patient Interventions and the lab ordering monitoring reports were reviewed. The self-assessment noted that communication with nurses was documented, but prescriber communication documentation was limited. It also showed that some SPIs did not include documentation of the outcomes. This was a thoughtful approach to the self-assessment. Overall, the self-assessment was thorough and for most provision items, it provided the clinical pharmacist with an accurate snapshot of the provision status and the areas that were in need of attention. The clinical pharmacist should continue this level of assessment taking into consideration the recommendations and comments noted in this report. The facility rated itself in noncompliance with all provision items. The monitoring team concurred with the self-ratings.

	Summary of Monitor's Assessment: At the time of the onsite visit, the pharmacy department was staffed with a pharmacy director, full time pharmacist, and four technicians. A new clinical pharmacist was hired on 8/1/12. During the months of April 2012 through September 2012, a series of contract pharmacists provided part-time services. The lack of stability in the clinical pharmacist position was a key factor in the limited progress seen in the provision of pharmacy services. The clinical pharmacist, who was employed at LSSLC slightly more than two months at the time of the compliance review, was given the lead role in managing many of the issues related to the Settlement Agreement. Notwithstanding her limited tenure, she had become very familiar with the requirements of the Settlement Agreement, agency operations, and many of the issues requiring attention. She reported directly to the pharmacy director. The monitoring team, however, was concerned by the level of supervision and support provided by the pharmacy director. During interviews, it was clear that several policies, procedures, and issues related to processes, such as the QDRR, were not adequately communicated to the clinical pharmacist. Moreover, there was very little input from the medical leadership at LSSLC. This further hindered forward movement because many issues related to the pharmacy department were directly linked to the provision of medical services. Although several areas of concern remained without correction, there appeared to be a prioritized approach to managing the many outstanding issues. The pharmacists continued to document communication with staff, but most of the documentation revolved around discussions with nursing staff. There were relatively few documented discussions with the medical staff. Physician order writing presented many challenges for the pharmacy department, but little effort was expended in assessing the contributing factors. The Intelligent Alerts continued to be used during prospective reviews, but the value of the module and its use at LSSLC were uncertain. The facility made some progress in resolving the problems related to the QDRRs. Overall, the reviews lacked substantive content and most were not reviewed by the psychiatry staff. The timelines for completion began to show improvement in August 2012. The MOSES and DISCUS evaluations were completed by nursing staff. Many of the evaluations were signed, but never completed by the medical staff. There was no compelling evidence that the medical staff utilized this information in clinical decision making. The ADR reporting and monitoring system remained unchanged and without full implementation. The clinical pharmacist recognized that under reporting was problematic and training for staff was needed. The facility completed two DUEs in a timely manner and presented the findings to the Pharmacy and Therapeutics Committee. The content of the reviews will require additional work and the Pharmacy and Therapeutics Committee will need to have greater involvement in this process. LSSLC lacked a true multidisciplinary team effort in its approach to the reporting and management of

	medication variances. The facility continued to report medication variances, but there was evidence that variances, particularly prescribing variances, were under-reported. For those prescribing variances that were reported, the facility was not able to demonstrate that appropriate actions were implemented.

#	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.	This provision item is related to fundamental components of the medication use system – the prescribing and dispensing of medications. The pharmacy department completed prospective reviews for all new orders through the WORx software program. The program checked a number of parameters, such as therapeutic duplication, drug interactions, allergies, and other issues. The pharmacists documented communication with the prescribers in the Single Patient Interventions of WORx. The pharmacy director reported that 38 interventions were documented between April 2012 and September 2012. The facility submitted more than 38 SPIs, many of which were duplicates or did not reflect communication with prescribers. The SPIs submitted captured issues, such as therapeutic duplication, allergies, drug interactions, and unnecessary medications. The SPI documentation recorded the recommendations made by the pharmacists as well as the providers' responses (assessment/outcome). The response of the physicians could not be determined for several of the problems documented. The pharmacy director submitted 469 pages of physician orders as evidence of communication related to medication variances. Review of this information indicated significant problems with physician orders at LSSLC including: • Medications were prescribed when the allergies were noted at the top of the physician order form. • Many orders lacked the required components, such as indication, dose, and frequency. • Orders were written with the incorrect drug and doses. The pharmacy director reported that physician order writing was problematic and pharmacists utilized a considerable amount of time addressing and clarifying orders. In spite of these significant problems, there was no evidence that these issues had been addressed beyond the correction of each specific occurrence. The department did not maintain any data on the magnitude of the problem or prescriber patterns nor had there been any efforts outside of the pharmacy department to resolve the problems. The lack of attention to the problems with physician order writing resulted in the failure to implement the appropriate corrective actions. Thus, many problems, some of which were serious, were recurrent. Examples of prescribing issues are provided in section N8. During the May 2012 review, a monitoring team recommendation was made to develop a	Noncompliance

		process for management of the various levels of drug interactions. This recommendation was not addressed. The pharmacy director indicated that common sense was utilized in the management of drug interactions. Each pharmacist decided when the prescriber should be notified of drug interaction. The facility, therefore, had no requirements for management of the various levels of drug interactions. Finally, this provision item required "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… the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication." In April 2012, the facility implemented the Intelligent Alerts, which required laboratory monitoring for seven drugs: carbamazepine, dilantin, valproic acid, phenobarbital, lithium, levothyroxine, and warfarin. The pharmacy director provided Notes Extracts (report) for the Intelligent Alerts. The report listed by date, orders that were entered that involved drugs associated with the Intelligent Alerts. The note text provided recommendations for monitoring requirements. Many of the entries contained no text/recommendations. The monitoring team requested clarification on the requirements for text /recommendations entry. The pharmacy director was also not certain about the significance of the entries that had no text. The report clearly was not reviewed on a regular basis and the information was not shared with the medical director. Achieving substantial compliance will require several additional steps including: • Increased documentation of discussions that occur between the pharmacists and prescribers as well as documentation of the resolutions • Collaboration between the pharmacy director, clinical pharmacist, and medical leadership with regards to notification of prescribing issues and development of corrective action plans • Collaboration between the pharmacy and the medical staff to identify additional drugs that require important lab monitoring prior to dispensing • Implementation of an appropriate drug alert threshold for drug interactions. This provision remains in noncompliance.	

N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	During the May 2012 compliance review, many problems were identified with the QDRR process. The new clinical pharmacist made progress in addressing some of those problems. Document and record reviews revealed that numerous QDRRs remained delinquent several months following the May 2012 review. During this time, the evaluations were primarily completed by part time pharmacists. The facility submitted a QDRR schedule which affirmed the findings observed in the record reviews. That is, many first and second quarter QDRRs were completed several months late. While the schedule did not provide all dates for the third and fourth quarters, it appeared that by the time of the compliance review, considerable progress was made in completing the reviews. The monitoring team had extensive discussions with the clinical pharmacist and pharmacy director regarding the QDRR process. The clinical pharmacist explained that the QDRR report and worksheets were submitted to the medical staff for review and both documents were filed in the active records. The worksheet was utilized to document data, including lab results and other information. The comments section of the report presented exceptions noted by the pharmacist. A total of 48 QDRRs were reviewed. The current process for completion of QDRRs resulted in reports that lacked evidence of laboratory monitoring and other relevant information. It was necessary to review the entire worksheet in order to grasp information. The QDRR worksheet was an extensive document normally meant for use by the pharmacist completing the review. It was often four to five pages in length and as a worksheet, important information was buried within the text of a busy and difficult to read working document. The use of this format markedly diminished any value derived from completion of the evaluations. The active records did not always include the worksheets. In the absence of the worksheets, evaluations provided very little information. The monitoring team also noted that the drug profiles now included medications that were discontinued. For example, instead of the current dose of levothyroxine being listed, multiple doses over the past one to two years were listed. The current dose was not easily identified. This was seen for all drugs and resulted in drug profiles that did not focus on the current medications and were frequently two to three pages in length. The current process produced a QDRR that was very lengthy, but failed to highlight the salient medical and medication issues. Upon receipt, primary providers reviewed the QDRRs promptly. Thirty-one of the evaluations involved the use of psychotropic agents, however, only three of the 31 (9.6%) were signed by the psychiatry providers. The QDRR policy required that the psychiatrist review the QDRR only "if applicable (resident has polypharmacy) during the quarterly psychiatric review." This requirement was not consistent with the time frames for physician review issued by state office. Two of the psychiatry reviews completed were done several months following completion by the pharmacist. In fact, the psychiatry review dates were just prior to the completion of the next QDRR. The psychiatry staff	Noncompliance

		should review all QDRRs that involve the use of psychotropic agents and the review must occur in accordance with state guidelines. The pharmacists made recommendations in 24 (50%) of the evaluations. In some instances, the pharmacists made comments that should have been recommendations in order to alert the prescriber of the need to take action. The following are a few examples of problems related to content and formatting of the QDRRs: • Individual #554, 9/22/12 received antihypertensive medications, but the worksheet indicated that blood pressure monitoring was non-applicable. • Individual #365, 9/15/12, was hospitalized with lithium toxicity. The worksheet included recent drug levels, but the actual report included no comments on lithium or recommendations for monitoring. The worksheet also noted an "anemia picture" with low hemoglobin and hematocrit, but the values were not documented. The sole recommendation was to administer Alendronate weekly instead of daily. • Individual #102, 9/22/12: This individual had a documented alkaline phosphatase of 248 noted on the worksheet, but there were no comments regarding this abnormal value. The platelet count was 117k and the comments included the recommendation to monitor for bleeding. The worksheet stated, "Platelets go up and down." There was no discussion regarding any correlation with the medications received. The comments also stated that the MOSES and DISCUS evaluations were out of date and orthostatic blood pressures needed to be monitored with dose changes in Seroquel. This individual also received ferrous gluconate for anemia, but there was no discussion of the status or etiology of the iron deficiency. The only recommendation made was to add insomnia to the active problem list. The recommendations should have included completion of the MOSES and DISCUS evaluations as well as monitoring of blood pressures. Moreover, the clinical pharmacist should have made some assessment regarding the thrombocytopenia, elevated alkaline phosphatase, and anemia relative to the medications administered. • Individual #31, 9/15/12: This individual was treated with new generation antipsychotic agents, had elevated triglycerides, and a BMI of 39.7. The drug profile also listed previous use of prn insulin. While the worksheet documented the weights, BMI and HbA1cs, there was no discussion related to obesity, metabolic side effects, and how this could be impacted by the use of the medications. The report comments were limited to the need to check vitamin B12 and folic acid levels. The drug profile also included numerous inappropriate indications such as prednisone for hypoxia, and clindamycin for prophylaxis. • Individual #507, 6/29/12: The individual received pretreatment sedation, but the medication used and its effectiveness were not listed. The worksheet also noted that the individual received an anticholinergic medication, but no other comments were made. The report comments section noted that the MOSES and	

		DISCUS evaluations were out of date, but there was no recommendation related to this. The comments also noted that the individual had a very low GFR of 36ml/min, but none of the medications required dose adjustment. There was no documentation of a nephrology evaluation nor was there any recommendation for a renal evaluation to assess kidney function. The diagnosis section did not include chronic kidney disease. Concerns regarding the QDRRs were not limited to timelines and content. Inappropriate medication indications were found in numerous medication profiles reviewed. These indications were usually not consistent with ICD nomenclature. In addition to examples cited above, the monitoring team noted indications, such as Zantac for abdominal pain, levothyroxine for low thyroid, prednisone for hypoxia, olanzapine for personality changes, benztropine for side effects, and Nystatin for lip lesions. The pharmacists did not address the indications in the QDRRs. Notwithstanding formatting problems that diminished the overall value of the evaluations, there was some good information included in the worksheets. It simply was not evident in the reports. The expectation that the primary care medical staff, with caseloads of 100 individuals, would read worksheets that were not designed or formatted for easy reading and were quite lengthy was not a reasonable one. The information should be concisely summarized in the report with the worksheet serving as a resource for more detailed information. The clinical pharmacist will need to augment the content of the QDRRs by providing more clinically relevant information. The monitoring team offers the following recommendations: • The QDRR Report should comment on every medication/class of medication that is included in the lab matrix. The exact value should be provided with the date as well as an indication of the range of values. • The pharmacist should clearly state the recommendations. If the provider must take an action to remediate a finding, a recommendation should be given. • The clinical pharmacist must address the inappropriate medication indications. • Providers should document a rationale in the IPN for recommendations that are not accepted. • The clinical pharmacist should identify the level of anticholinergic burden when a medication has anticholinergic properties. When appropriate, recommendations should be given on how to decrease the overall anticholinergic burden. • Identification of polypharmacy should result in a brief statement regarding the use of multiple drugs. The statement should note, when appropriate, any recommendations for drug reduction. • For individuals who receive medications associated with metabolic and endocrine side effects, the report should provide a concise summary of the monitoring, the risk, and any recommendations for risk mitigation.	

		• The timelines for the review of QDRRs must occur in accordance with state issued guidelines. This provision remains in noncompliance.	
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 five elements required for this provision item were all monitored in the QDRR. Oversight for most was also provided by additional methods and/or committees as described below. <u>Stat and Emergency Medication and Benzodiazepine Use</u> The use of stat medications and benzodiazepines was documented in the QDRRs only by indicating the presence or absence of use. The effectiveness and justification for use of the medications was not documented in the QDRRs. The use of PRN meds is discussed further in section J. <u>Polypharmacy</u> The QDRR report form indicated the presence or absence of polypharmacy. When polypharmacy was present, the worksheet listed the drugs that contributed to polypharmacy, but no additional comments were provided. Some QDRRs failed to note the status for polypharmacy and some incorrectly identified polypharmacy. The Polypharmacy Oversight committee conducted its first meeting during the compliance review. Psychotropic polypharmacy and the Polypharmacy Oversight Committee are addressed in further detail in section J. <u>Anticholinergic Monitoring</u> While the actual report did not comment on the anticholinergic burden associated with a drug, these data were located in the worksheet. The level of burden (low, medium, or high) was infrequently documented. Generally, the QDRRs reviewed did not provide any practical advice on how to lower the anticholinergic burden. <u>Monitoring Metabolic and Endocrine Risk</u> The facility monitored individuals for the metabolic risks through the QDRRs. Again, the reports contained no information related to this monitoring. The worksheets did include information, such as weight, BMI, and Hba1c. Nonetheless, there was no overall statement related to the risk, how risk could be mitigated, or how monitoring should occur. This provision remains in noncompliance.	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. The SPIs provided information on the prescribers' responses to some issues. As discussed in section N1, the responses were not always documented. Assessing the provider's response to the recommendations in the QDRRs was difficult because only 50% of the QDRRs reviewed included formal recommendations. Many issues requiring attention were documented in the comments section. The medical staff was not required to respond to comments. Determination of the provider's response to recommendations was further complicated by the fact that the psychiatry providers reviewed and signed under 10% of the evaluations that included psychotropic reviews. Beginning in September 2012, the clinical pharmacist began tracking responses to recommendations in the QDRR Intervention Tracking log. This should assist the clinical pharmacist in tracking high priority recommendations. In order to fairly assess the response of the medical staff to recommendations, the recommendations must be clearly identified. This will require changes in how the QDRRs are currently completed, as discussed in section N2. The clinical pharmacist should continue to track the responses of the medical staff to recommendations made in the QDRRs. Much of this should occur through subsequent QDRRs. High priority recommendations should obviously receive closer follow-up. This provision item remains in noncompliance.	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: Forty-two MOSES evaluations were reviewed for timeliness and completion: • 41 of 42 (98%) were signed and dated by the prescriber • 32 of 42 (76%) documented no action necessary • 10 of 42 (24%) lacked a prescriber conclusion (blank) Thirty-nine DISCUS evaluations were reviewed for timelines and completion: • 39 of 39 (100%) were signed and dated by the prescriber • 18 of 39 (46%) indicated no TD • 2 of 39 (5%) indicated the presence of TD • 19 of 39 (49%) had no prescriber conclusion (blank)	Noncompliance

		It appeared that the evaluations were simply being signed in most instances. Providers did not comment on or even provide conclusions for several evaluations that documented problems. Although these rating instruments served as a valuable source of information, record reviews did not reveal any evidence that this information was utilized by the primary providers or the neurologists in clinical decision making. The monitoring team has and continues to recommend that the primary care providers and neurology consultants review this information. This provision item remains in noncompliance. In order to achieve substantial compliance, the facility must demonstrate that these evaluations are thoroughly completed in a timely manner. The facility's policy required completion of these evaluations every six months as a minimum standard. The QDRR worksheets required completion of the MOSES and DISCUS evaluations at six and three months respectively. In addition to timely completion, there must be evidence that the information is utilized in clinical decision-making. In order for this to occur, the data must be reviewed by the primary providers in addition to being reviewed by the psychiatrists and neurologists.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	The facility documented seven ADRs from April 2012 through September 2102 resulting in a total of 10 ADRs reported for the current year. The monitoring team found examples of several ADRs that were not reported, but should have been. Record reviews documented that Individual #365 was hospitalized with lithium toxicity, but this was not reported as an adverse drug reaction. An ADR was reported for Individual #176 who experienced lithium toxicity. Both cases of lithium toxicity warranted further review, however, that did not occur. The facility did not revise its ADR policy to include a requirement for an intense review of cases based on a risk threshold. This is an important component of the ADR monitoring and reporting system. For the two individuals with lithium toxicity, a more detailed review would have provided an opportunity to determine if the appropriate care, monitoring and interventions occurred. This is discussed further in section L1. The problems related to the ADR system also included delays in reporting ADRs to the Pharmacy and Therapeutics Committee. The clinical pharmacist stated that incomplete reports were found on her desk when she assumed the position. This resulted in delays of up to five months in reporting some ADRs to the committee responsible for review. Overall, LSSLC did not maintain an adequate system for monitoring and reporting ADRs. The number of ADRs reported was relatively low and reporting to the Pharmacy and Therapeutics Committee was delayed. The system also lacked a mechanism for triggering adequate reviews of serious cases. Finally, the facility did not implement training to ensure that health care and direct care professionals had adequate knowledge related to monitoring and reporting of ADRs.	Noncompliance

		In order to achieve substantial compliance, the facility will need to take several steps related to the ADR monitoring and reporting system: • There should be increased reporting by the medical staff. • ADRs should be reviewed by the primary provider, clinical pharmacist, and medical director. All three should be required to sign the ADR reporting form. The form should indicate who initiated it (reporter). • All ADRs should be reported to the Pharmacy and Therapeutics Committee. This committee is charged with reviewing ADR data, analyzing the data for patterns or trends, and developing preventive and corrective actions. The ADR form should reflect the final determination by the P&T Committee and should be signed by the chair. The committee should also receive follow-up on the status of the corrective actions. • There should be continuous monitoring of individual and aggregate data. • Opportunities for educational efforts to train on prevention of ADRs should be identified. The daily clinical services meeting provides a good forum for educational activities. • 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 discipline-specific training on the recognition of ADRs and the facility's reporting process. • The facility should revise the ADR policy, outlining the process and requirements for facility staff. The policy should include a requirement for a more in depth review of serious cases based on a risk threshold. The criteria for review should ensure that cases are appropriately reviewed in a timely manner and the findings formally presented to the Pharmacy and Therapeutics Committee. This provision remains in 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	The facility's DUE policy required completion of one DUE each quarter based on the schedule set by the Pharmacy and Therapeutics Committee. The DUEs were completed in a timely manner and the findings were presented at the Pharmacy and Therapeutics Committee meetings. The DUE on Synthroid was completed and presented to the P&T in August 2012. The DUE presented some good information, but overall the evaluation was difficult to follow and the evaluation lacked some essential components: • The methodology for completion of the study was not specified. • The methodology for selection of the sample was not given and the sample size was not provided.	Noncompliance

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<td>assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.</td>
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The discussion of the objectives and the results were combined. For example:

One objective was to review contraindications. None of the individuals had contraindications, but this information (results) was presented under the objectives section along with extensive citations from the literature.
The DUE did not include a section in which data were presented or summarized in a format that allowed for analysis and determination about overall compliance relative to the multiple objectives that were listed.
Additionally, the recommendations were all individual specific and most related to adding hypothyroidism to the diagnosis list. With such a large number of individuals requiring the same corrective action, it would have been important to understand the cause of the reported deficiency.

The DUE on clonidine was presented at the October 2012 meeting. The 27 individuals who received the drug were evaluated for a number of parameters, such as indication, dose, and drug interactions. The results were presented in a more succinct manner than in the previous DUE, but there was no clear summary of the information to indicate the facility's overall compliance. The DUE did include several recommendations related to systems issues, such as prescribers writing holding parameters. Specific recommendations were also provided for a few individuals.

Overall, the DUEs provided some helpful information. The P&T Committee, which provides oversight for the process, should be involved in the selection of indicators, development of the data collection form, selection of sample size, and setting the thresholds for compliance. The clinical relevance of the indicators for LSSLC should be considered in this process. The recommendations and specific corrective action plans should be thoroughly documented in the P&T Committee meeting minutes and/or attachment. Meeting minutes should also document follow-up to closure of recommendations generated by DUEs.

This provision remains in noncompliance.
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<td>N8</td>
<td>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.</td>
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The facility continued to report medication variances. The medication data provided to the monitoring team are summarized in the tables below.
<table>
<tr><td colspan="10">Medication Variances 2012</td></tr>
<tr><td></td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>July</td><td>Aug</td><td>Sep</td></tr>
<tr><td>Nursing</td><td>53</td><td>48</td><td>28</td><td>15</td><td>17</td><td>15</td><td>29</td><td>27</td><td>16</td></tr>
<tr><td>Pharmacy</td><td>77</td><td>80</td><td>54</td><td>15</td><td>16</td><td>10</td><td>27</td><td>19</td><td>12</td></tr>
<tr><td>Provider</td><td>2</td><td>4</td><td>5</td><td>1</td><td>2</td><td>0</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>Total</td><td>117</td><td>129</td><td>84</td><td>30</td><td>34</td><td>25</td><td>56</td><td>35</td><td>27</td></tr>
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<td>Noncompliance</td>
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		Although the total number of variances was trending downward, the validity of the data was uncertain. The monitoring team attended the Medication Variance Committee Meeting conducted during the week of the compliance review. It was reported during this meeting that there appeared to be under-reporting of nursing and pharmacy variances. The medical and nursing departments recently began meetings to review overage/shortage slips to detect unreported variances. The accuracy of the pharmacy data was also questioned during this meeting. The monitoring team also noted that variances were not always appropriately reviewed and assigned to all disciplines. Moreover, reviews of pharmacy orders and documents submitted by the pharmacy department suggested that prescribing errors were not accurately reported. The monitoring team identified several prescriber variances that were not reported: • Individual #307, 4/12/12, was prescribed Bacitracin even though the allergy was clearly noted at the top of the physician order form. • Individual #45, 4/16/12, was prescribed Rocephin with a PCN allergy. The order was subsequently discontinued. • Individual #543, 4/16/12, was prescribed Nitrobid for a UTI. This same error occurred a few months earlier. • Individual #305, 5/25/12, was prescribed Amoxil with a PCN allergy. The allergy was not noted on the physician order form. • Individual #323, 6/30/12, was prescribed levothyroxine 125 mg instead of 125 mcg. As noted during the previous review, the medication variance system at LSSLC focused on variances that occurred within the pharmacy and nursing departments. The nursing and pharmacy representatives reviewed medication variances and discussed problems and actions taken during the medication variance meeting. There was no discussion related to prescribing variances and problems with medication orders even though the pharmacy director reported this to be a very significant problem. There was also no documentation of how the prescriber errors were addressed or if contributory factors had been investigated. This was a troubling finding given that several of the errors occurred with the same prescriber and some errors were repetitive. The facility will need to take several actions to address the current medication variance system: • All variances must be captured and appropriately assigned to disciplines involved. • The facility must maintain adequate documentation of overages/shortages to assist in detecting unreported variances. This data should be routinely presented at the Medication Variance Committee meetings. • Problems related to physician order writing must be addressed. This will require an analysis of the contributory factors as well as a review of current processes.	

		• All disciplines must maintain appropriate documentation of corrective actions related to medication variances. • The pharmacy director should ensure that there is reconciliation of all non-pill medications. Adequate documentation of the findings should be maintained. This provision remains in noncompliance.	

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 documentation of communication with prescribers should be increased.
    b. There should be clear documentation of the prescriber who is contacted and the time of contact.
    c. The pharmacy director and clinical pharmacist must work with the medicals staff to understand the causes of the problems with physician order writing and implement appropriate corrective actions.
    d. The procedure for management of <u>all drug interactions</u> should be clearly delineated. Pharmacists and prescribers should all be aware of this process. Severe drug interactions should require direct communication with the prescriber and written information should be provided in the form of the drug monographs.
    e. The pharmacy director and clinical pharmacist will need to collaborate with the medical director/medical staff to expand the list of drugs monitored as part of the Intelligent Alerts.
    f. The pharmacy director must ensure that the Intelligent Alerts module is being utilized correctly and in accordance with state issued guidelines. Reports should be printed on a regular basis and the data reviewed with the medical director (N1).

2. The following actions should be taken into consideration with regards to the QDRR:
    a. As noted in the body of the report, the QDRR Report should comment on every medication that is included in the lab matrix. The exact value should be provided with the date as well as an indication of the range of values.
    b. The comments section of the report should provide concise and clear statements regarding clinically relevant information.
    c. The clinical pharmacist will need to capture relevant clinical recommendations that are clearly identified. Recommendations should cover all areas including the reduction of polypharmacy and anticholinergic burden.
    d. The psychiatry staff should review all QDRRs that involve the use of psychotropic agents in accordance with state guidelines.
    e. The pharmacy director and clinical pharmacist should review additional recommendations included in the body of this report (N2, N3).

3. For individuals who received new generation antipsychotics, the QDRR report should document the monitoring parameters and provide a synopsis of the risk for development of metabolic syndrome and any potential to mitigate risk (N3).

4. The clinical pharmacist should continue to track the responses of the medical staff to recommendations made in the QDRRs. Much of this should occur through subsequent QDRRs. High priority recommendations should obviously receive closer follow-up (N4).

5. All medical staff must receive proper training on the MOSES and DISCUS evaluations and understand the requirements for completion (N5).

6. The primary care physicians should review the information included in the MOSES and DISCUS evaluations and utilize, as appropriate, the information in clinical decision making. Consideration should be given to including this information in the annual and quarterly assessments (N5).

7. The facility should provide the MOSES and DISCUS evaluations to the consulting neurologists for use during consultation (N5).

8. The ADR process should be reviewed and revised, taking into consideration comments and recommendations provided in the body of this report (N6).

9. The P&T Committee should be involved in the selection of indicators, development of the data collection form, selection of sample size, and setting the thresholds for compliance for DUEs (N7).

10. The recommendations and specific corrective action plans should be thoroughly documented in the P&T Committee meeting minutes and/or attachment. Meeting minutes should also document follow-up to closure of recommendations generated by DUEs (N7).

11. The facility must ensure that an adequate medication variance system is in place. This will require reporting of variances for all disciplines and demonstration that appropriate corrective actions have occurred (N8).

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o LSSLC client list o Admissions list o PNMT Staff list and Curriculum Vitae o Staff PNMT Continuing Education documentation o Section O Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section O-Physical Nutritional Management o PNMT Assessment template o PNMT Nurse Post Hospitalization Assessment/Evaluation o PNMT Summary template o PNMT Evaluation template o HOBE PNMT Evaluation template o IRRF template o PNMT Meeting documentation (4/3/12 to 10/31/12) o PNMT Assessments and Summaries (Individual #258, Individual #361, Individual #117, Individual #47, Individual #172, and Individual #490) o PNMT Nurse Post Hospitalization Assessment/Evaluation (Individual #44, Individual #363, and Individual #504) o Individuals with PNM Needs o Dining Plan Template o Compliance Monitoring template o Comprehensive Meal Monitoring Tool template and reference sheet o PNMP Monitoring sheets submitted o List of individuals with PNMP monitoring in the last quarter o NEO curriculum materials related to PNM, tests and checklists o List of Competency-Based Training in the Past Six Months o Hospitalizations for the Past Year o ER Visits o Summary Lists of Individual Risk Levels o Individuals with Modified Diets/Thickened Liquids o Individuals with Texture Downgrades o List of Individuals with Poor Oral Hygiene o Pneumonia Report (9/28/12) o Individuals with Pain o Individuals with BMI Less Than 20

	o Individuals with BMI Greater Than 30 o Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months o Individuals Having Falls Past 12 Months o Falls With or Without Injury (9/2011 – 9/2012) o List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance o Individuals with Pressure Ulcers and Skin Breakdown o Individuals with Fractures Past 12 Months o Individuals who were non-ambulatory or require assisted ambulation o Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Individuals Who Use Ambulation Assistive Devices o Individuals with Orthotics or Braces o Documentation of competency-based staff training submitted (Dining Plans and PNMPs) o PNMPs submitted o List of Individuals with MBSS o APEN Evaluations: • Individual #245, Individual #271, Individual #539, Individual #11, Individual #172, Individual #369, Individual #441, Individual #573, Individual #36, and Individual #540. 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, Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Habilitation Therapy tab, and Nutrition tab, for the following: • Individual #597, Individual #137, Individual #182, Individual #447, Individual #144, Individual #545, Individual #298, Individual #468, Individual #172, Individual #161, Individual #265, Individual #419, Individual #361, Individual #402, Individual #480, Individual #102, Individual #296, Individual #458, Individual #240, Individual #47, and Individual #258. o PNMP section in Individual Notebooks for the following: • Individual #597, Individual #137, Individual #182, Individual #447, Individual #144, Individual #545, Individual #298, Individual #468, Individual #172, Individual #161, Individual #265, Individual #419, Individual #361, Individual #402, Individual #480, Individual #102, Individual #296, Individual #458, Individual #240, Individual #47, and Individual #258. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #597, Individual #137, Individual #182, Individual #447, Individual #144,

	Individual #545, Individual #298, Individual #468, Individual #172, Individual #161, Individual #265, Individual #419, Individual #361, Individual #402, Individual #480, Individual #102, Individual #296, Individual #458, Individual #240, Individual #47, and Individual #258. Interviews and Meetings Held: o Danielle Perry, AuD, CCC-A, Habilitation Therapies Director o Cheryl Fraser, RN o Misty Johnson, PT o James Moneer, OTR, PTA o Rhonda Hampton, MS, CCC-SLP o Cheri Marini, MS, RD, LD o Various supervisors and direct support staff o PNMT meeting o ISP Meeting for Individual #433 Observations Conducted: o Living areas o Dining rooms o Day Programs and work areas
	Facility Self-Assessment: In the self-assessment, Danielle Perry AuD, CCC-A, the Habilitation Therapies Director outlined specific assessment activities and provided specific data based on the findings from these activities. The activities were similar to the process used by the monitoring team, though did not include some of the key elements used for review and outlined in this report. In some cases, the data were not consistent with the findings of the monitoring team. For example, in O1, the findings indicated that all team positions were filled and remained unchanged in the last six months. All PNMPs were reviewed and 3% of the plans were deemed unnecessary and discontinued. By report, 100% of the ISPs reviewed by the Habilitation Therapies Director included evidence of review, approval and integration into the plan. The monitoring team did not concur with the finding for substantial compliance. While the team was fully staffed, attendance by the team members was inadequate for appropriate assessment and review of individuals at highest risk. Back-up positions had been established and this should address this issue in the future. Further as described in subsequent provisions below the PNMP was not developed and reviewed by the full IDT during ISP meetings as the attendance was poor for many key team members required for appropriate review. Evidence of actual review by the IDT was extremely limited. In many cases there was a statement only that it had been reviewed, but there was no evidence of discussion of the effectiveness of the supports. Efficacy also was not clearly identified in the assessments completed by Habilitation Therapies. The provision of the PNMP requires implementation rather than merely providing the document itself. As described below, there continued to be issues related to food texture and position, alignment, and transfers. There was definite improvement in this area noted, but collectively not yet at the level of substantial compliance. As

	such, the monitoring team did not concur with the finding of substantial compliance at this time. The facility self-rated itself as noncompliant with all the remaining provision items of O (O2 through O8). The monitoring team concurred. While actions taken by the facility, however, showed considerable progress in the direction of substantial compliance, and the monitoring team concurred. It is critical that the facility clearly establish the systems for staff compliance monitoring and routine effectiveness monitoring by the therapy clinicians. This will permit improved analysis of the effectiveness of existing staff training and guide the facility in the recognition of additional staff training needed.
	Summary of Monitor's Assessment: Progress was made towards substantial compliance with provision O. The PNMT was fully staffed, though the only dedicated team member was the nurse. Each of the members had been participating on the team since the previous review. Back-ups had been identified and should result in improved attendance at the near-weekly meetings held. They had completed a number of assessments reportedly in a timely manner, though, upon review of the reports, the signatures on these suggested that many took well more than the 30 days that would be generally acceptable. During the meeting that the monitoring team observed, the discussion was very good related to follow-up on individuals currently active. There appeared to be a significant delay/absence of referrals of individuals who would benefit from PNMT evaluation. It was also of concern that a number of individuals who may have benefitted from a comprehensive assessment were considered to be consultative and, as a result, these reviews were not comprehensive. There were three major issues identified: • The IDTs need to have a better understanding of when to refer. • The PNMT needs to clearly identify clinical indicators to track routinely, report, discuss and document. Exit criteria must be measurable and the team must routinely review the individual's status toward meeting these and make any necessary adjustments in the action plans to ensure efficacy of the supports and services provided. • The facility must review the existing databases that identify individuals with key health issues in order to effectively track them and to watch for system wide trends. Individuals who require PNMT referral may be more effectively identified and in a timely manner. These lists should be developed cooperatively by the facility. They must be accurate and routinely updated. These lists are not for use only by the monitoring team, but should be used by the facility to direct actions needed on an individual basis, but to address systems issues as well. These should be also routinely used by the PNMT during their reviews. The PNMT did not appear to be routinely and proactively reviewing individuals with a high risk of key PNM indicators or with incidences of these concerns. They did not routinely track their status in an organized manner, but rather tended to wait for a referral that there was a problem. Follow-up of individuals they provided assessment or review of was inconsistent and not well documented. Mealtimes and position and alignment were improved, though some issues related to diet texture and transfers were noted. The mealtime environments, moreover, were not dynamic and pleasant

	environments. Day programs should be an area of focus for seating, positioning, and transfer monitoring, training, and assessment. Oral hygiene was another area of concern regarding positioning, alignment, and technique. Specific strategies are needed to ensure effective oral hygiene, but also safety for those at risk for aspiration. Concerns were noted during all three observations of toothbrushing. There must be collaboration between the dental hygienists and therapy staff to identify these strategies. This must be followed by staff training with demonstration and return demonstration, as well as routine monitoring to ensure it is done properly. Monitoring of staff compliance must be consistent and effective. Monitoring should answer the following questions: • Are staff trained to do what is needed? • Are they routinely expected to what is in the plan by supervisors? If staff have demonstrated competency, there must be an expectation that the plan be implemented as written every time. This practice reinforces the training or otherwise staff forget and must be retrained. This takes away from valuable time that could be devoted to other important tasks. This must be an expectation from the facility administration, unit directors, homes managers, and supervisors. While there were notable improvements and pockets of excellence, there continued to be a significant disconnect in the provision of supports and the serious negative health outcomes evident for the individuals that live at LSSLC. The facility as a whole must identify these gaps and address them effectively in order to move forward in this section.

#	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	Core PNMT Membership: The current core team members of the PNMT included Cheryl Fraser, RN, Misty Johnson, PT, James Moneer, OTR, PTA, Rhonda Hampton, MS, CCC-SLP, and Cheri Marini, MS, RD, LD. The RN was the only team member assigned full time to the PNMT and each of the others had additional caseload duties. Each of the team members was the same as during the last review and the facility is commended for maintaining this consistency. In addition, back-ups for each member had been identified. Delisa Smiley, a PNMPC, was also a core team member, attending meetings and providing assigned monitoring, training, and other duties. The Habilitation Therapies Director, Danielle Perry, AuD, CCC-A, was an adjunct member. The dietitian was one of only two licensed dietitians for all 359 individuals. Ms. Hampton was one of two SLPs assigned to provide dysphagia and mealtime supports and services to each of the individuals. There was also a limited number of OTs and PTs. Continuing Education Continuing education was documented for some of the current core members of the team	Noncompliance

#	Provision	Assessment of Status	Compliance
	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, 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.	in the last six months and included the following. Some were attended by one or more core team members, though not all had contact hours or CEUs listed: • Duties of the PNMT Nurse (phone conference on 6/4/12) • PNMP Committee (6/11/12) • Risk Training (9/12/12 and 7/30 – 8/1/12) • ISP Training (9/11/12) • Medication Administration (9/19/12) • Habilitation Therapies Annual Conference (9/20 -9/21/12) • Kinesiotaping Fundamentals and Advanced Treatment of Clients with Neurodevelopmental Diagnoses • ITB Pump inservice • Various independent internet research topics The dietitian did not attend any of the state-sponsored continuing education opportunities. She did attend the following: • Managing Lactose Intolerance: Understanding Latest Research and Implement Practical Solutions for Maintaining a Healthy Diet (9/13/12) • Leap Therapy (9/7/12) • Nutrition and Feeding Interventions for Autism, Asperger's and ADHD (5/17/12) In most cases, the CEUs or contact hours were not documented for these courses, so a judgment as to adequacy could not be made. The monitoring team again commends the facility in their support of all clinicians participating in continuing education. This should include both state-sponsored education and alternate source as well to ensure appropriate breadth of content for all PNMT members. It was noted that the only back-up to participate was the RN. This should be considered for the other back-ups as well. It is critical that this team continue to achieve and maintain the highest possible knowledge and expertise in the area of PNM. Cross-training in areas traditionally viewed as pertaining to a specific discipline would also be highly useful to enhance team building and the interdisciplinary approach. <u>Qualifications of Core Team Members</u> The credentials of each licensed team member and back-up was verified as current online. Each of the core team members had documented experience of three or more years in the provision of services in their field for individuals with developmental disabilities and PNM with the exception of James Moneer, the OT. He had previously practiced as a PTA with a background in geriatrics for at least nine years and had worked at LSSLC and served on the PNMT as an OTR since the previous review. Based on his participation, he appeared to be sufficiently prepared for this role despite limited experience in developmental disabilities.	

#	Provision	Assessment of Status	Compliance
		PNMT Meeting Frequency and Membership Attendance There was documentation related to 23 core team meetings held from 4/4/12 through 10/31/12. There appeared to be some additional meetings with IDTs. While it appeared that the team attempted to meet weekly, which would be appropriate, there were some notable gaps of two weeks or more in June, July, August, and September 2012 and nearly one week each month in August and September 2012 (a staff habilitation training session occurred in Austin in August 2012). Meeting minutes were submitted for the following: 4/4/12, 4/9/12, 4/25/12, 5/2/12, 5/9/12, 5/16/12, 5/24/12, 6/13/12, 6/20/12, 7/10/12, 7/18/12, 7/25/12, 8/8/12, 8/29/12, 9/5/12, 9/25/12, 10/3/12, 10/10/12, 10/17/12, 10/24/12, and 10/31/12. Signature sheets were not submitted for meeting minutes dated 6/13/12 and 8/29/12. Meeting minutes were not submitted with signature sheets dated 4/19/12 and 5/30/12. The nurse and SLP were not included on the signature sheets for these dates. The monitoring team attended the meeting held during the onsite review on 10/31/12. Attendance of core team members based on signature sheets for each core team meeting for which minutes were submitted and the meeting held on 10/31/12 (19) was as follows: • RN: 100% • PT: 100% • OT: 95% • SLP: 74% • RD: 95% • PNMPC: 95% The above findings included those meetings for which an alternate was present in the absence of a core team member. This attendance frequency was acceptable for all team members with the exception of the SLP. Back-up clinicians should be in attendance in the absence of any core team members so that effective meetings may be held to address issues for the individuals served with high PNM needs and significant at-risk concerns. A physician had not attended any meetings. Physician attendance was not required, but can contribute to the effectiveness of the PNMT meeting. Role of the PNMT: Facility PNMT Policy The state PNMT process was outlined in a policy that described the referral process and PNMT member responsibilities. Appropriate referrals included individuals at high risk who were not stable and/or for whom the IDT required assistance in the development of an intervention plan to address PNM concerns. This included the IDT, of which the PCP was a member, and self-referrals by the PNMT based on review of key clinical indicators. It was stated that the policy implemented at LSSLC did not differ from the state-approved	

#	Provision	Assessment of Status	Compliance
		policy. The self-assessment indicated that LSSLC was in substantial compliance with this provision. Activities conducted to determine this included: • Review of the PNMT members to confirm team development and competency. • Review the list of individuals with PNMPs to confirm a need for these plans. • Audit 20 ISPs to ensure IDT review, approval, and inclusion of the PNMP in the annual ISP. Findings indicated that all team positions were filled and remained unchanged in the last six months. All PNMPs were reviewed and 3% of the plans were deemed unnecessary and discontinued. By report, 100% of the ISPs reviewed by the Habilitation Therapies Director included evidence of review, approval and integration into the plan. The monitoring team did not concur with the finding for substantial compliance. While the team was fully staffed, attendance by the team members was inadequate for appropriate assessment and review of individuals at highest risk. Back-up positions had been established and this should address this issue in the future. Further, as described in subsequent provisions below, the PNMP was not developed and reviewed by the full IDT during ISP meetings as the attendance was poor for many key team members. Evidence of actual review by the IDT was extremely limited. In many cases, there was a statement only that it had been reviewed, but there was no evidence of discussion. Efficacy was not clearly identified in the assessments completed by Habilitation Therapies. The provision of the PNMP requires implementation rather than merely providing the document itself. As described below, there continued to be issues related to food texture and position, alignment and transfers. There was definite improvement in this area noted, but collectively not yet at the level of substantial compliance.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and	<u>PNMT Referral Process</u> The PNMT received referrals from the IDTs, though most were self-referrals. There was a referral form requesting basic information about risk levels and changes in status that warranted the referral. A list of criteria for referrals of individuals who were deemed to be unstable constituted placing them on the active caseload of the PNMT and included: • Two or more hospitalizations for aspiration pneumonia in one year. • Two or more Stage II decubitus ulcers in one year or Stage III, IV or non-healing wound with referral by the Infection Control Nurse. • Significant unexpected weight loss. • Hospitalization due to bowel obstruction in the last year. • Any consultation that required additional assessment by the PNMT.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Consultations by the PNMT were conducted for the following: • Fracture of long bone, spine, hip, or pelvis • Abnormal MBS, upper GI, or EGD • Hospitalization for GI bleed • Any choking incident (becomes active if there were identified physical factors) • High risk in five or more PNM-related categories with hospitalization in last year • Unresolved triggers for aspiration referred by Case Manager • New tube placement for enteral nutrition • Any nutritional or physical issue not successfully resolved by the IDT for high risk indicators Based on meeting minutes from 4/3/12 through 10/24/12, there were six individuals identified as on the active caseload of the PNMT (Individual #140, Individual #172, Individual #361, Individual #102, Individual #47, and Individual #235) and another 21 individuals who were listed as consultations. There were a number of individuals listed as consultation only, but who should have been considered to be active based on the criteria identified by the PNMT (e.g., Individual #267, Individual #161, Individual #516, Individual #490). Individuals with serious fractures and high risk in five or more PNM-related areas currently listed as consultations may likely require assessment by the PNMT. In addition individuals who were being considered for enteral tube placement (Individual #597), who experienced multiple pneumonias or PNM-related hospitalizations in a year's time (Individual #468), and multiple falls would likely also require assessment by the PNMT. These elements should be tracked for individuals listed in the weekly incident reviews, so that the PNMT could track established thresholds for specific incidents or health events. This would permit individuals to be identified sooner for referral and assessment. A PNMT meeting was observed by the monitoring team. This meeting was led by the RN. The agenda was basically the weekly summary from the previous week. The meeting conducted was generally well-organized and there was productive discussion and participation by all team members. The meeting minutes were consistent and easy to follow. It would be important to identify what specific indicators required tracking for the individual and this information should be routinely reported and documented in a manner that permitted comparison and analysis. Specific exit criteria should be clearly stated and the individual's status related to these should be routinely documented. For example: • Individual #235 was being reviewed for weight, yet her weight was not reported during the meeting and the information needed to trend weight loss or gain was not presented. When the monitoring team asked for her weight, one was	

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provided for 10/29/12, but it was not clear if this was an increase or decrease.
• Individual #240 had a new enteral tube placement and during the meeting, the PNMT reported that his pre-hospitalization weight was 180 and was 155 on 10/23/12. Specific data were missing, including his weights and date of tube placement. It was stated that a hospital bed was ordered, but projected delivery date was not documented. It was reported that the RD would follow-up with dietary changes and progress, but specific data to be tracked were not outlined.
• Individual #545 was being followed by the PNMT secondary to weight loss and meal refusals, but there were no specific data related to either problem.
• Individual #140 was listed on the active caseload for the PNMT. On 4/4/12 it was reported that the PNMT would continue to follow his progress until his exit criteria were met. There was no statement as to what the specific criteria were.

<u>PNMT Assessment and Review</u>
Comprehensive PNMT Assessments completed within the last two months were requested and assessments for Individual #490 (2/9/2), Individual #172 (4/26/12), Individual #117 (5/15/12), Individual #361 (7/25/12), and Individual #47 (6/6/12) were submitted for review. The referral dates and dates of assessments submitted was as follows:

<table>
<tr><th>Name</th><th>Date of Referral</th><th>Date of PNMT Evaluation</th></tr>
<tr><td>Individual #490</td><td>1/30/12</td><td>2/9/12</td></tr>
<tr><td>Individual #172</td><td>2/9/12</td><td>4/26/12</td></tr>
<tr><td>Individual #117</td><td>5/1/12</td><td>5/15/12</td></tr>
<tr><td>Individual #361</td><td>7/12/12</td><td>7/25/12</td></tr>
<tr><td>Individual #47</td><td>6/6/12</td><td>6/6/12</td></tr>
<tr><td>Individual #258</td><td>6/13/12</td><td>9/26/12</td></tr>
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There were no dates for the signatures in assessments for Individual #172 and Individual #117, so it was not known when these assessments were actually completed. The signatures on the other assessments were each dated 9/26/12, so it was presumed that even the assessment for Individual #490, with a referral date of 1/30/12, was not completed until that time. The date that the PNMT evaluation was initiated should be clearly documented and the signature dates should represent the date that the assessment was finalized by the team members.

The assessments completed by the PNMT should be comprehensive. It was noted that in each case, the assessment contained limited data and the analysis of findings, recommendations, measurable outcomes, monitoring schedule, and criteria for discharge were either missing or not adequate. Some examples included:
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#	Provision	Assessment of Status	Compliance
		• There was no assessment of physical status (Individual #47, Individual #258, Individual #117, and Individual #172). • There was no discussion as to whether existing supports were effective or appropriate (Individual #47, Individual #258, Individual #117, and Individual #172). • Laboratory values were not reported (Individual #172, Individual #258, Individual #490, Individual #361). While some were reported for Individual #47, the date was not documented. • There was no evidence that the PNMT had conducted any hands-on assessment because the information reported was primarily facts that could be obtained from a record review (Individual #47, Individual #490, Individual #117, Individual #361 and Individual #172). • There was no evidence that the PNMT evaluated motor skills or posture and alignment in bed, wheelchair, or alternate positioning (Individual #47, Individual #117, Individual #361, and Individual #172). • There was no evidence that they observed transfers, enteral tube feedings, or toothbrushing (Individual #47, Individual #117, Individual #258, Individual #490, Individual #361, and Individual #172). • There was no evidence that they evaluated oral motor/swallowing skills, skin integrity, respiratory status, or musculoskeletal status, or reviewed oral hygiene status (Individual #47, Individual #117, Individual #490, Individual #361, and Individual #172). • There was no review of potential and/or actual drug/nutrient or drug/drug interactions (Individual #47, Individual #361, Individual #490, and Individual #172). • There was no assessment of height, weight or weight history, intake, nutritional needs, feeding schedule, and/or residuals (Individual #47, Individual #490, Individual #361, Individual #258, and Individual #172). There were nutritional summaries contained within the PNMT evaluation for Individual #117 and Individual #490, but it could not be determined if the team merely copied the annual assessments or whether the dietitian completed a new assessment. • The analysis of findings was not appropriate and did not offer a foundation for the recommendations or actions (Individual #47, Individual #490, Individual #258, Individual #117, Individual #361). In the case of Individual #172, the statements were actions taken by the team rather than clinical reasoning. There was no discussion related to vomiting for Individual #361 despite 32 episodes of vomiting in the last year, fundoplication in February 2011, and numerous medications for GERD, GI dysmotility and vomiting. • There was no analysis as to risk levels and whether they needed to be revised with an associated action plan (Individual #47, Individual #490, Individual #117,	

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		Individual #361 and Individual #172). The PNMT merely copied what the IDT provided a rationale for the levels they had identified. In some cases, this information conflicted with data reported in other sections of the PNMT evaluation (Individual #490) related to weight and nutritional requirements. • There were no measurable outcomes identified (Individual #47, Individual #258, Individual #490, Individual #117, Individual #361). Only one of two for Individual #172 was measurable and there were no baselines established for either in the assessment data reported. • There were no recommendations for monitoring, tracking or follow-up by the PNMT (Individual #47, Individual #117, Individual #361 and Individual #172). It was stated that Individual #47 had recurrent respiratory difficulties requiring breathing treatments and frequent suctioning. How frequently either of these was prescribed or required, or any other information related to these was not documented. It was stated that DSPs noticed that coughed up phlegm after breathing treatments, but could not expel it, thus either swallowing it or gagging. There was no evidence that the PNMT had observed a treatment to observe this first hand. The only recommendations were to obtain an order for suctioning after breathing treatments and increase free water flushes for better hydration for bowel management. There was no clinical reasoning offered or rationale documented for these. This assessment presumed that all current interventions were appropriate and yet clearly they had not been effective in preventing his recurrent health issues. There were blank sections in Individual #172's report including dental, behavioral challenges, and active medical problems. The information contained in his assessment report could have been gathered in a brief record review, yet the assessment took nearly three months to complete. The only action taken was to lock the tilt of his wheelchair at 30 degrees to reduce the risk of aspiration (3/13/12). Yet over a month later it was discovered that instead it was locked at 60 degrees, allowing his oxygen saturation to drop into the 80s. It was of concern that the team did not notice this and he potentially was in a state of desaturation during that time. There were no recommendations for follow-up, tracking or monitoring by the PNMT. The positioning, transfers, motor and musculoskeletal sections of the assessment for Individual #361 were copied from her annual OT/PT assessment dated 5/14/12. It was of concern that the only recommendation that the PNMT could identify was one that had been previously identified by the OT and PT and had yet to be implemented effectively. It was noted in the weekly PNMT summary for 7/18/12, that a new wheelchair was ready for fitting, though she was in the infirmary with aspiration pneumonia at that time. As of 8/8/12, trials had been completed and the new tilt-in-space wheelchair was to be issued after the completion of staff training. On 9/26/12, it was reported that the IDT was not	

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		clear on how long Individual #361 could remain in her new wheelchair. This should have been clearly defined through the trials and staff training. Criteria were not established. The section of the evaluation for Individual #490 related to behavioral challenges and medication review was merely copied from a previous evaluation by the psychologist or psychiatrist on 4/28/11. It was of concern that the PNMT had not been involved prior to the time of the recommendation for enteral nutrition, as she had experienced a significant change in status requiring hospitalization due to her psychiatric state in early 2011. She was further hospitalized at Rusk State Hospital for psychiatric stabilization where she was chemically restrained almost daily. There was no description of her more recent status that led to weight loss and tube placement. There was no evaluation of Individual #490 or the effectiveness of the supports provided to her. The evaluation for Individual #258 was called a summary rather than an evaluation and was of a completely different format than the others. There was no rationale for this and there was no date of referral identified, reason for referral, health or medical history or baseline information as to weight, intake, seizure activity, frequency of vomiting, falls, or other PNM-related issues. There is an urgency to complete the PNMT assessments that are thorough, current, and accurate, and to implement appropriate and effective interventions to address the identified needs for individuals. This should be completed in 30 days, at most, though some interventions may be implemented based on recommendations from the evaluation itself. It is critical that the assessments be completed in a timely manner because these individuals had significant identified needs for supports and services to address PNM health concerns. The referral to the PNMT is to capitalize on the collective expertise of the team members in order to see the problem in a new way and to identify new strategies to address ongoing issues that had not yet been resolved. It was not clear that the PNMT actually provided that service based on their documentation. <u>Risk Assessment</u> Risk rating tools and/or action plans were submitted for the 19 of 21 individuals (90%) in the sample for whom individual records were requested. No ISPs were submitted for Individual #447 or Individual #298. These tools were to be completed by the IDT at the time of the annual ISP with routine review after hospitalizations or other changes in status. An action plan was developed to manage or mitigate identified risks. Only nine individuals had both the risk assessment and an action plan. The other 10 had one or the other attached to the ISP. For the most part, risk ratings and the rationales provided improved since the previous review. The teams appeared to do a better job of considering other issues that may	

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		predispose an individual to special health concerns. The instructions for the newly implemented Integrated Risk Rating Form (IRRF) indicated that the team should post all risk-related data for each risk factor, supports provided and the baseline to include current data and the efficacy of supports and services provided relevant to each risk factor. The baseline was described as essential as it often functioned as a predictor of an impending change in status. The IDT's discussion of each of these should provide the foundation for evidence-based decision making as to the need for a revision to the action plan. Only the IRRF for Individual #419 (ISP date 9/12/12) was using this revised version. The others used a similar format, but the IDTs had not yet received the training for the most current version. During the ISP meeting the team was to discuss and analyze the baseline information, determine the risk rating with rationale, identify individual triggers and criteria for IDT review. The monitoring team looks forward to full implementation of the new IRRF in the next onsite review. The most common issue identified was that the IDTs generally did not consider new supports or interventions to mitigate identified risks, but rather indicated that they would continue the existing plan, even in cases where the individual had experienced health events that suggested the plan was not effective (Individual #419, Individual #361, Individual #172, and Individual #258). Some other issues included: • Individual #419 was described with a significant history of aspiration pneumonia with hospitalizations in September 2011 and April 2012. She had seven episodes of vomiting in the last year. There was no discussion of the efficacy of the supports provided yet it was stated that no new supports were indicated. Though she had met criteria for referral to the PNMT, she had not been referred. • Individual #258 experienced weight loss since March 2011, though initially this had been planned. He weighed 176 in March 2011, but was down from 163 in December 2011 to 135 in May 2012. Due to the fact that he remained within his weight range the IDT assessed him only at medium risk for weight. Regardless of his weight range, this represented an unplanned 27.6 pound loss in less than six months, that is, greater than 15% loss. • Individual #265 was assessed at medium risk for gastrointestinal concerns, though he had a diagnosis of hiatal hernia with ulcerative esophagitis and gastritis. He took medications for esophagitis and gastritis. He had several hospitalizations for possible GI bleed though no active bleeding was found. He was also listed only as medium risk for constipation though he had an active diagnosis of chronic constipation and required bisacodyl and Miralax twice daily.	

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O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	<u>PNMP Format and Content</u> It was reported that 355 (99% of the current census) individuals at LSSLC had identified PNM needs and, as such, were provided PNMPs. Comments below relate only to the PNMPs submitted for the individuals in the sample (20). Improvements in the format and content were noted. Additional improvements in the implementation of the plans since the last onsite review were also observed. • 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. • PNMPs for 0 of 20 individuals in the sample (0%) were consistent with the most current state-established format that included risk levels, triggers, and outcomes. • PNMPs for 20 of 20 individuals in the sample (100%) included a list of risk areas. The plans listed risk levels (high and medium only). There was no rationale listed for these. None of the risk areas listed associated triggers, though the plans indicated whether the individual had an Aspiration Trigger Sheet (12 individuals). • In 20 of 20 PNMPs (100%), there were pictures other than of the individual, but these had to be specifically requested by the monitoring team. These should be considered a key element of the plans and, if available, should always be associated with a plan. • In 20 of 20 PNMPs (100%), positioning was addressed. Positioning for Individual #480 was described as not applicable because he was independently mobile. • In 8 of 15 PNMPs (53%) for individuals who used a wheelchair as their primary mobility, some positioning instructions for the wheelchair were included, though this was generally very minimal and limited to primarily tilt for pressure relief. • In 20 of 20 PNMPs (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 (100%), the PNMP had a distinct heading for bathing instructions. The bathing equipment was listed with staff assistance needed as indicated including other instructions for transfers and positioning as indicated. • In 20 of 20 (100%) of the PNMPs, toileting-related instructions were provided. There were no specific instructions, however, for those requiring staff assistance. • In 20 of 20 (100%) of the PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning or the individual was listed as independent. • In 20 of 20 PNMPs (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. Each also had a Dining Plan current within the last 12 months at the time of this review • There were 11 of 20 individuals who had feeding tubes. Eight of these PNMPs indicated nothing by mouth. The PNMP for Individual #298 indicated that he had	Noncompliance

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		a gastrostomy tube for scheduled feedings, though he received oral intake. The PNMPs for Individual #597 and Individual #137 indicated that they received part of their nutrition via tube, but there were instructions for oral intake at meals. • In 20 of 20 dining plans (100%), position for meals or enteral nutrition was provided via photographs, though these were extremely small and it was difficult to see sufficient detail for accuracy with alignment. The pictures associated with the PNMPs were larger and included a photograph of mealtime positions. • In 12 of 12 PNMPs (100%) for individuals who ate orally, diet orders for food texture were included. • In 7 of 12 PNMPs for individuals who received liquids orally (58%), the liquid consistency was clearly identified. In some cases the liquid consistency was liquid at the top under diet and in others it was listed within the instructions making it more difficult to identify. • In 12 of the 12 PNMPs for individuals who ate orally (100%), dining equipment was specified in the mealtime instructions section or it was stated that they did not have any adaptive equipment. • In 20 of 20 PNMPs (100%), a heading for medication administration was included in the plan. This did not include positioning, adaptive equipment or for those who received oral medication, form or preparation was also not outlined. Instead each referred to the MAR for instructions and included the directive to ensure proper positioning and to follow eating/nutritional instructions. • In 20 of 20 PNMPs (100%), oral hygiene, including some brushing instructions, times and type of toothbrush and toothpaste in most cases. There were no specific positioning instructions, but rather referred staff to use the positioning instructions listed elsewhere in the PNMP. There were no aspiration precautions related to head position, liquids, or liquid consistency as indicated. • 20 of 20 PNMPs (100%) included information related to communication. Each of these described how the individual communicated including use of AAC. Each also described vision and hearing as well. A formal plan for auditing the PNMPs had not yet been implemented to ensure that all content areas were included and to ensure consistency of content, though clearly these had improved since the previous onsite review. <u>Integration of the PNMPs in the ISPs/ISPAs</u> There were 18 ISPs submitted for the 21 individuals included in the sample selected by the monitoring team. Each was current within the last 12 months. ISP meeting attendance was as follows: • Medical: 4% (1/16) • Psychiatry: 0% (0/16)	

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		• Nursing: 100% (16/16) • RD: 13% (2/16) • Physical Therapy: 44% (7/16) • Communication: 19% (3/16) • Occupational Therapy: 13% (2/16) • Psychology: 75% (12/16) • Dental: 0% (0/16) It is not 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 plans to address these issues in the absence of key support staff and without comprehensive and timely assessment information. PNMPs cannot be reviewed and revised in a comprehensive manner by the IDTs unless each of the team members is present to participate in that process. The Physical Nutritional Management Plan was identified as reviewed in 17 of the 18 current ISPs submitted (94%). The content varied greatly, however, most of the ISPs contained a section for content related to the IDT's review of the PNMP. There was no evidence that the IDT reviewed the PNMP for Individual #468. The PNMP reviews for Individual #258 and Individual #102 were more thorough than most. In most cases, this section addressed the language or written instructions in the plan rather than specifically addressing how well the strategies worked for the individual or the rationale behind them. In most cases, specific strategies were not included. Some examples included: • The ISP stated that the IDT reviewed, updated, and approved the revised PNMP, and made changes as needed, though none were specified (Individual #458). • The ISP review stated that the "following changes" would be made, but then none were listed (Individual #182 and Individual #144). • The review of PNMP section stated that Habilitation had not made any recommendations for changes. This review should be an interdisciplinary process and would not necessitate a recommendation by the therapists for changes to be identified (Individual #419). Only two reflected a substantial discussion and review of the efficacy of the strategies included in the plan. Even so, there was an improvement in this area since the previous review. Guidelines should be identified to ensure consistency across ISPs and to assist the QDDPs in meeting this standard in their facilitation of ISP meetings and subsequent documentation of PNMP review and approval. Continued training for QDDPs was indicated to ensure an appropriate description of the annual and quarterly reviews.	

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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.	PNMP Implementation PNMPs and Dining Plans were developed by the therapy clinicians with variable input by other IDT members as described above. Attendance by PNM-related professionals at the ISP meetings was limited and, as such, discussion and input were limited. There was evidence of ISPAs for required changes in the PNMPs. 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. The PNMP should be reviewed during all ISPs (and most ISPAs) to determine if any of the outcomes require a change to the plan. 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 readily available nearby. General practice guidelines (foundational training) with regard to transfers, position and alignment of the pelvis, and consistent use of foot rests and seat belts were taught in NEO and in individual-specific training by the therapists and PNMPCs. Observations There was continued improvement related to mealtimes in the homes observed by the monitoring team. There were only a few notable concerns related to implementation and presented below: • Individual #66: She was served whole cornbread, though her diet order indicated that she was on a modified diet. Staff had to be prompted to cut smaller pieces. • Individual #423 and Individual #524: Cornbread was cut into pieces that were larger than one inch as per the Dining Plan. • Individual #354: Staff did not provide the prescribed lemon ice until well into the meal as per his Dining Plan. • Individual #44: Staff did not wait for him to swallow two times before presenting another bite as instructed in the Dining Plan. • Individual #467: Staff presented lemon ice using a fork instead of the spoon prescribed in her Dining Plan. A home supervisor was seated at the table observing this staff and completing a monitoring form, but did not recognize that this was happening. The monitoring team prompted the staff to use the correct utensil. Positioning and alignment were also improved. Some examples of concerns were: • Individual #33: Staff could not locate her individual notebook. They reported that it had been left in her classroom after they looked for it in the home. Staff reported that she had just returned from the infirmary and could not identify her risks without looking in her book. • Individual #599: Staff did not tell him what was going to happen before quickly	Noncompliance

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		tilting him backward in preparation for a transfer. One staff set up the transfer alone and it was not correctly done. A second staff came into the room and corrected the setup, though did not follow the PNMP related to angle of recline. Oral hygiene was another area of concern regarding positioning, alignment, and technique. Specific strategies are needed to ensure effective oral hygiene, but also safety for those at risk for aspiration. Concerns were noted during all three observations of toothbrushing. There must be collaboration between the dental hygienists and therapy staff to identify these strategies. This must be followed by staff training with demonstration and return demonstration, as well as routine monitoring to ensure it is done properly. This should be part of the Oral Hygiene Program, described in section Q. The majority of staff struggled to verbalize the rationale for the strategies in the plans and to answer questions related to individual health risks, but there were some others who demonstrated excellence with regard to this. <u>Choking/Aspiration Events</u> There were 36 individuals identified at high risk for choking and 220 others considered to be at medium risk. There were no choking incidents reported by the facility since the previous review. This was an important achievement representing hard work related to staff training and compliance with the Dining Plans prescribed for individuals at risk for choking. It was noted, however, that there were 58 individuals with food texture or liquid consistency downgrades in the last year (10/29/11 to 10/29/12). Overall, there were 198 individuals on modified diets and/or thickened liquids. While these modifications are often indicated for individuals with dysphagia to protect and minimize their risk of choking and aspiration, this strategy should not be used exclusively in the absence of staff supervision and assistance techniques as well as skill acquisition training for individuals who display impulsivity with rapid eating and drinking or large bites.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how	<u>New Employee Orientation</u> The NEO training included 16 hours dedicated to lifting, transfers, handling, positioning and flexibility. Competency check-offs were included for the stand pivot transfer, two person manual lift, and mechanical lift and a written test and skill competency check-offs were conducted. This was not observed during this onsite review, but had been observed during the previous review. Content issues were identified at that time and, by report, these had been corrected. It was of concern, however, that, even so, issues related to transfers were observed by the monitoring team during this onsite review.	Noncompliance

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	to implement the mealtime and positioning plans that they are responsible for implementing.	Eating and oral motor skills, including food textures, liquid consistencies, and Dining Plans, were covered in a three hour session with only written tests on the content. The content of this curriculum had been revised since the previous review. The competency check-off form indicated that there were only verbal responses required for each of the skills, including providing hand-over-hand assistance, cutting foods to quarter size, and providing lemon ice. There was no evidence of a skills-based competency for this. Each of these content areas included practicums, permitting opportunities for participants to practice the skills required for implementation of PNMPs and Dining Plans. In addition, there was on-the-job training time (four hours). Lifting and transfers were included in the annual retraining required for all DSPs and eating skills training had recently been added. This will be offered two times a month and paired with lifting and transfers beginning 12/1/12. Each was a four hour class. The facility is commended on the addition of this important training. Consideration of skills-based competency testing is encouraged by the monitoring team. <u>Individual-Specific PNMP Training</u> Inservice training for changes in the Dining Plans and PNMPs were conducted by therapists and by PNMPCs. A general inservice was completed with check-offs conducted with specific staff. Attachments to the training signature sheets included the plan and listed specific training content. Though this training was described as competency-based, most of the training elements were not skills-based with return demonstration, but rather required only verbal responses. In most cases, this was clearly delineated and was appropriate. The clear establishment of foundation skills taught in NEO and annual refresher training with skills-based check-offs requiring return demonstration may assist in delineating which individual specific skills would require further check-offs rather than verbal responses. Effective monitoring should be in place to ensure that staff retain competency and in the implementation of both foundation and non-foundational skills. Additional staff training was provided as needs were identified (Castle Pines and wheelchair tilting). An iLearn class related to oral care was initiated in October 2012. In the case that a PNMPC or home manager was expected to conduct further staff training, there was a statement that they had demonstrated competency for teaching the elements of the plan. It was not clear, however, if this was competency (with return demonstration) in implementation of the plan or competency in training staff. It was observed that a supervisor was conducting mealtime monitoring in one home and did not notice some significant implementation errors by her staff. He was the third staff on that same home who demonstrated inadequate training related to transfers. There should be serious concerns about whether this supervisor could effectively train others to competency. LSSLC was progressing in the process of determining which plans contained only	

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		foundational skills (i.e., trained in NEO) versus those that required additional competency training and check-offs. It is important that staff not to work with an individual at high risk until they are trained and checked off. Pulled staff should receive this training by supervisors, managers, and/or habilitation therapies as necessary. Training for pulled staff should not be limited to merely reading the plans. There did not appear to be a clear protocol related to ensuring that training for pulled staff was provided in a timely manner. Many of the staff observed by the monitoring team were pulled staff and most were not able to state that they had received specific training related to the individuals to whom they were assigned regarding PNM supports and risk issues. Many seemed to use the fact that they were pulled staff as an excuse for not knowing specific information about the individuals they were assisting. The facility's own monitoring findings revealed that an extremely high percentage of staff indicated that they had not been trained on the plan being monitored. This was of significant concern and was consistent with the monitoring team's findings. It was interesting and of further concern that the internal monitoring results found that compliance scores were high (88%). On a positive note, the facility was aware of this issue. The Habilitation Therapies Director was implementing plans to address this. <u>Trainer Competencies</u> There were significant concerns identified by the Habilitation Therapies Director as to the competence of the PNMPCs related to training and monitoring and, thus, their role in these activities was being evaluated at this time. This will be a focus for the next review by the monitoring team.	
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>Individual-Specific Monitoring</u> The current monitoring system for implementation compliance and staff competency was to be based on individual risk levels. While this type of monitoring focused on staff performance, it was tracked per individual rather than per staff. As such, it was not possible to ensure that all staff were monitored for continued and consistent compliance. (This is different than monitoring that focuses on the individual's health status and the impact of supports and services on health, function, and risk levels and that should be a key element in an effective PNM system.) Thus, there was a need for greater focus on individual status monitoring and review of triggers, in addition to staff compliance monitoring. There was no clear system of monitoring individual status routinely and effectively. Compliance monitoring data were not utilized consistently during the ISP meetings, PNMT meetings, or in the therapy assessments. Recommendations related to the frequency of monitoring were not included in the assessments or identified in the ISP. The potential links between the individual status monitoring and staff compliance monitoring should be identified via routine trend	Noncompliance

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		analysis. There was little evidence of this type of review. The list of individuals for whom PNM monitoring had been completed in the last quarter was requested and submitted. These lists identified the monitoring conducted per individual in July, August, and September 2012. Approximately 303 monitorings were completed in September 2012, 154 in July 2012, and 237 in August 2012. The type of monitoring was not reported on this list. Completed monitoring forms for the individuals included in the sample selected by the monitoring team were requested for the last quarter. They were not consistent with the list of monitorings. For example: • Individual #265 was listed as monitored on three occasions on 7/23/12, and twice on 9/13/12. Two forms, one dated 7/23/12 (Compliance Monitoring) and the other 8/10/12 (Comprehensive Meal Monitoring Tool) were submitted. The form completed on 7/23/12 identified that he was monitored related to his meal and to communication by a PNMPC. It was not clear why two different forms were used to monitor mealtimes. • Only two forms were submitted for Individual #298, though he was listed as monitored on four different dates (7/9/12, 7/26/12, 8/23/12 (2 times), and 8/29/12). The forms submitted were dated 8/29/12 and 8/23/12. A third form was also submitted, dated 10/14/12, but this was not within the range of the tracking list submitted. • Individual #447 was listed as monitored on eight occasions across six dates. Forms submitted within the range of the tracking list were dated 7/12/12, 8/22/12, 8/30/12, 9/4/12, 9/10/12, and 9/24/12). Forms were consistent with four of the dates on the list (7/12/12, 9/4/12, 9/10/12, and 9/24/12) only. The other dates were not included in the list. This suggested that the tracking system was inaccurate. This system needs refinement and improvement to ensure accurate tracking and reliability of the data. The monitoring team also requested monitoring forms completed by OTs and PTs in the last month. Sixty-four Compliance Monitoring forms were submitted. Twenty-three of these were marked as reliability checks. In 12 cases, only the reliability column was marked and the name of the PNMPC was identified as well as the therapist's name. It was not clear how reliability was established or what the staff compliance ratings were, though the average in the reliability column was reported (as 69%). In 11 cases, compliance ratings were marked. The average compliance score in those cases was 87% and reliability was 97%. This was a significant variance and reflected a significant flaw in the system. This should be addressed as the facility begins to revise this system.	

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		There were a total of 141 completed forms submitted. The forms were not culled for duplications due to the number submitted. The following was noted: • There was no monitoring conducted on third shift. • Only eight (6%) forms were marked as completed after 2:00 pm (second shift) and only three of these were completed after 5:00 pm. • Seven forms were did not designate a time. • 55 forms were completed between 12 noon and before 2:00 pm. • 72 forms were completed between 7:00 am and before 12 noon. • Only seven forms were completed prior to 8:00 am. If the facility truly intends to examine staff compliance and effectiveness of supports throughout the day, monitoring must be reflected across the times the supports are provided and not focused during the times that are the most convenient for professional staff and the PNMPCs. Note that the most significant issues identified by the monitoring team were observed on the second shift.	
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.	<u>Effectiveness Monitoring</u> There was no evidence of routine effectiveness monitoring of the PNMPs and dining plans by the professional staff. Consideration for how this could be addressed was needed. The universal form used for PNMP monitoring had an option for the clinical therapist monitor to mark if the plan was effective or ineffective, but this was not used with any consistency. In short, it appeared that no effectiveness monitoring occurred beyond the annual assessments or in response to identified problems/referrals. There was no proactive review. In the assessments reviewed, equipment and supports were described, but often stopped short of actually assessing or analyzing the impact on function, health, or risk levels. In many cases, the effectiveness of interventions and supports were not consistently and specifically addressed in the annual assessments. This should be a key function of the professional staff clinicians. This should be incorporated into routine quarterly/monthly reviews. Findings should be included in the IPNs rather than on a separate form filed in the habilitation therapies section of the individual record. Similarly, this kind of analysis should be incorporated into routine documentation of other direct/indirect interventions. Effectiveness monitoring and additional staff training was indicated related to implementation of programs across all environments.	Noncompliance

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		Validation of Monitoring by PNMPCs Specific and focused training was provided to the PNMPCs, but had proven to be ineffective. The facility reported a lack of confidence in the findings and, as such, was planning to revise the system. This will be a focus of review in the next six months. Trend Analysis There was no evidence of trending or tracking of the monitoring data for self-review, but rather only in preparation for the monitoring team's visit.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	Individuals Who Received Enteral Nutrition There were 74 individuals who received enteral nutrition (21%), one of which was a gastrostomy/jejunostomy tube (Individual #540). Seven individuals were listed as having received a new tube placement since the previous review. There were 16 individuals listed as receiving pleasure feedings of some type, though not specified. Nine received medications via the tube and 10 received tube feedings in the case of meal refusals. All others were NPO (nothing by mouth). At least 16 individuals who received enteral nutrition were also listed to have poor oral hygiene from 4/4/12 to 8/30/12. This list was not provided for any period outside of that period so there were likely additional individuals. Some were listed in multiple months. It was of great concern as many of these individuals likely had tube placement due to aspiration risk. Poor oral hygiene promotes bacterial growth and the risk of aspiration pneumonia would be increased for those individuals. The list that identified individuals with pneumonia in the last 12 months included 45 incidences for 35 individuals from 10/11/11 to 9/28/12. Fourteen of those individuals received enteral nutrition and the others were reported to eat orally. Seven individuals had more than one incidence of pneumonia. Four had pneumonia two times (Individual #102, Individual #267, Individual #504, and Individual #161), and three were listed with pneumonia three times (Individual #258, Individual #47, and Individual #172) in the last year. There were at least six cases of aspiration pneumonia for six individuals. Two of these were listed with more than one incidence of pneumonia (Individual #172 and Individual #161). All but one of the others were incidences of pneumonia categorized as bacterial. These cases should not be ruled out as aspiration-related because bacterial pneumonia may be secondary to bacteria present in the oral and pharyngeal areas, as is often the case for individuals with poor oral hygiene.	Noncompliance

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		It was of concern that Individual #258 had experienced at least three occurrences of bacterial pneumonia over four months, yet was provided only a brief summary rather than a comprehensive assessment. The summary identified an additional incidence of pneumonia (aspiration) on 3/15/12 (not included in the list of pneumonia cases submitted by the facility). A PNMT weekly summary identified incidences of pneumonia in December 2011 and 5/24/12 (aspiration) (also not included on the list submitted). One of the recommendations included strategies to address oral hygiene. It was also reported that a new air ventilation system should improve the air quality in his home. The only follow-up identified was related to diagnostics, including a gallbladder ultrasound and bone density scan. The PNMT weekly summary reported another hospital admission with a diagnosis of pneumonia on 10/13/12. Clearly Individual #258 presented with significant and complicated health concerns and should be provided a comprehensive assessment. During the PNMT meeting attended by the monitoring team, it was reported that he had been hospitalized 11 times since July 2011. It was not clear why the IDT had not previously referred him to the PNMT or why the PNMT had not completed a comprehensive assessment to address his needs. There were eight individuals with existing enteral tube placements who were listed with unplanned weight loss of 10% or greater in the last six months (Individual #321, Individual #323, Individual #468, Individual #353, Individual #161, Individual #262, Individual #387 and Individual #298) who may benefit from assessment by the PNMT to determine the issues related to this. Enteral nutrition permits a prescribed intake and weight loss of this nature may suggest other health issues or that the intake provided was less than prescribed. Individual #387 and Individual #298 were identified as also eating orally with tube use for medication administration and meal refusals. There were 10 APEN assessments submitted for review that were completed in the last six months. Per policy, these were to be completed for individuals with aspiration pneumonia in the last year and/or individuals who received enteral nutrition. There were only two assessments that were actually fully completed (Individual #245, 5/25/12 and Individual #271, 5/25/12). Although it was positive that these assessments were completed, they did not provide a sufficient rationale for continued enteral tube use or clearly present the rationale for the interventions and supports provided. For example: • In the case of Individual #245, it was stated that she ate orally and received enteral (gravity feedings) to assist with weight maintenance and medication administration. It did not provide a rationale for initial tube placement in 2010 or for continued tube use for weight maintenance. Her weight was not reported. • In the case of Individual #271, the evaluation did not clearly state the rationale for initial tube placement other than the MBS recommended NPO. That alone would not necessarily justify tube placement. There was no rationale for	

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		continued tube use or discussion why she was not a candidate for oral intake. Though there were strategies in place to address HOB elevation and oral hygiene, she was reported to have experienced aspiration pneumonia most recently on 1/28/12 and another previous episode in May 2011. The monitoring team does not challenge whether these individuals should have a tube or receive enteral intake, but improvements in documenting the rationale were needed. In addition, there did not appear to be sufficient accuracy in the tracking of individuals with pneumonia and there was inadequate analysis of the relationship of specific health issues in the development of supports and services. This should be a function of the PNMT, but it requires that they improve their system of identification of individual's with PNM-needs and complete appropriate and comprehensive evaluations. <u>PNMPs</u> All individuals who received enteral nutrition in the selected sample had been provided a PNMP and Dining Plan that included the same elements as described above.	

Recommendations:

1. Complete PNMT Assessments in 30 days. Can use addendums or updates to add pertinent information subsequent to the first comprehensive assessment. Clearly state referral date, date the assessment was initiated and team member signatures may reflect completion (O1, O2).

2. Refine system of follow-up for individuals reviewed by the team. Identify specific clinical indicators for tracking individuals (O2).

3. Review specific measurable exit criteria established in the assessment and include these routinely in PNMT documentation. These should pertain to the reason for referral but also other issues identified as a function of the comprehensive assessment (O2).

4. The IDTs should utilize referral criteria developed by the PNMT for improved consistency of referral of individuals in a timely manner (O2, O3).

5. Collaborate on implementation of guidelines to incorporate pertinent findings and improve PNMT analysis of findings and recommendations (O2).

6. Review existing facility databases to ensure they are current and accurate. This should be a facility-side project that includes key staff. This information should be updated routinely. These may be used by the PNMT to track individuals who meet certain thresholds for health issues that would indicate a need for referral (O2).

7. Focus staff training and monitoring throughout the day to include day programs, work settings and the homes, particularly on 2nd shift (O3, O5, O6).

8. Report monitoring data in assessments and use this information during meetings to better evaluate the effectiveness of interventions, supports and plans, as well as staff competency and compliance (O7).

9. Focus on methods to improve content in the PNMT assessments, most specifically related to clinical analysis, outcomes and exit criteria (O2).

10. PNMPs require better integration into the ISP via descriptions of PNM strategies and clear evidence of review of these and their effectiveness relative to risk levels (O3).

11. Staff training and compliance/effectiveness monitoring related to oral hygiene is needed. This should be a collaboration between dental hygienists, therapists and psychology to ensure effective methods are integrated into the daily routine (O4, O5).

12. Clarify the existing system of compliance and effectiveness monitoring including the role of technicians and PNMCs (O6, O7).

13. Clarify the purpose and process for completion of the APENs. These have been typically incomplete and without clear purpose in the existing format at many facilities. Perhaps this should be a function of the ISP process. Integration into that document may be more meaningful and useful (O8).

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o LSSLC client list o Admissions list o Staff list o Continuing Education documentation o Section P Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section O-Physical Nutritional Management o Individuals with PNM Needs o Dining Plan Template o Compliance Monitoring template o Comprehensive Meal Monitoring Tool template and reference sheet o PNMP Monitoring sheets submitted o List of individuals with PNMP monitoring in the last quarter o NEO curriculum materials related to PNM, tests and checklists o List of Competency-Based Training in the Past Six Months o Hospitalizations for the Past Year o ER Visits o Summary Lists of Individual Risk Levels o Individuals with Modified Diets/Thickened Liquids o Individuals with Texture Downgrades o List of Individuals with Poor Oral Hygiene o Pneumonia Report (9/28/12) o Individuals with Pain o Individuals with BMI Less Than 20 o Individuals with BMI Greater Than 30 o Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months o Individuals Having Falls Past 12 Months o Falls With or Without Injury (9/2011 – 9/2012) o List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance o Individuals with Pressure Ulcers and Skin Breakdown o Individuals with Fractures Past 12 Months o Individuals who were non-ambulatory or require assisted ambulation o Primary Mobility Wheelchairs

	o Individuals Who Use Transport Wheelchairs o Individuals Who Use Ambulation Assistive Devices o Individuals with Orthotics or Braces o Documentation of competency-based staff training submitted (Dining Plans and PNMPs) o PNMPs submitted o PNM Maintenance Log o Wheelchair Assessment template o Wheelchair evaluations submitted o Therapy Logs for Individuals Who Received Direct OT and/or PT Services o OT/PT Assessment template and instructions o OT/PT Assessment log o OT/PT Assessments for individuals recently admitted to LSSLC: Individual #428 and Individual #227. o OT/PT Assessments and ISPs for the following individuals: • Individual #490, Individual #376, Individual #235, Individual #518, Individual #271, Individual #261, Individual #11, Individual #382, Individual #370, Individual #520, Individual #388, Individual #316, and Individual #203 o OT/PT Assessments, ISPs, ISPAs, and other related documentation for the following individuals: • Individual #238, Individual #542, Individual #156, Individual #302, Individual #207, Individual #1, Individual #76, Individual #468. 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, Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Habilitation Therapy tab, and Nutrition tab, for the following: • Individual #597, Individual #137, Individual #182, Individual #447, Individual #144, Individual #545, Individual #298, Individual #468, Individual #172, Individual #161, Individual #265, Individual #419, Individual #361, Individual #402, Individual #480, Individual #102, Individual #296, Individual #458, Individual #240, Individual #47, and Individual #258. o PNMP section in Individual Notebooks for the following: • Individual #597, Individual #137, Individual #182, Individual #447, Individual #144, Individual #545, Individual #298, Individual #468, Individual #172, Individual #161, Individual #265, Individual #419, Individual #361, Individual #402, Individual #480, Individual #102, Individual #296, Individual #458, Individual #240, Individual #47, and Individual #258. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #597, Individual #137, Individual #182, Individual #447, Individual #144, Individual #545, Individual #298, Individual #468, Individual #172, Individual #161,

	Individual #265, Individual #419, Individual #361, Individual #402, Individual #480, Individual #102, Individual #296, Individual #458, Individual #240, Individual #47, and Individual #258. Interviews and Meetings Held: o Danielle Perry, AuD, CCC-A, Habilitation Therapies Director o Gail Harris, PT o Misty Johnson, PT o James Moneer, OTR, PTA o Rhonda Hampton, MS, CCC-SLP o Aaron Kropp, PTA o Melissa Coley, COTA o Various supervisors and direct support staff o PNMT meeting o ISP Meeting for Individual #433 o IDT meeting related to Community Placement for Individual #162 Observations Conducted: o Living areas o Dining rooms o Day Programs and work areas
	Facility Self-Assessment: In the self-assessment, Danielle Perry AuD, CCC-A, the Habilitation Therapies Director outlined specific assessment activities and provided specific data based on the findings from these activities. The activities were similar to the process used by the monitoring team, but did not include some of the key elements used for review and outlined in this report. In some cases, the data were not consistent with the findings of the monitoring team. For example, in P1, the activities conducted for self-assessment included review of only of screenings and assessments for individuals newly admitted to LSSLC. This provision item also requires that the SSLC shall ensure that individuals with therapy needs will receive a comprehensive assessment that considered significant medical issues and health risk indicators. The monitoring team views this as applying to all individuals living at LSSLC, rather than limited only to new admissions. As such, the monitoring team did not concur with the finding of substantial compliance at this time. This was also the facility's approach to P2, that is, it was not consistent with how the monitoring team approached the review. Implementation of a system of assessment audits will be an important addition and will promote better shaping of the assessments and updates to include the content necessary for compliance with both of these provisions. In addition, the PNMP is only one aspect of necessary supports and services. Skill acquisition to promote and enhance movement and independence and direct/indirect interventions to remediate or prevent regression are also key elements required for P2 that were not addressed in any way in the current self-assessment. The monitoring team concurred that LSSLC was not in compliance at this

	time. The facility self-rated itself as noncompliant with all the two remaining elements of P (P3 and P4). The monitoring team concurred. While actions taken showed significant steps in the direction of substantial compliance, the monitoring team concurred. These two elements were also closely linked to elements of section O above, related to training and monitoring. It is critical that the facility clearly establish the systems for staff compliance monitoring and routine effectiveness monitoring by the therapy clinicians. This will permit improved analysis of the effectiveness of existing staff training and guide the facility in the recognition of additional staff training needed.
	Summary of Monitor's Assessment: The monitoring team noted continued progress with this provision. Staffing continued to be a concern and the continued turnover of contract staff will be an ongoing challenge. Therapists were not completing assessments and updates in a timely manner for the IDTs to apply the information in the ISPs. The clinicians had difficulty routinely attending meetings and, in some cases, IDTs had to table discussions (as noted in an ISP observed during this review) or send action referrals to request supports or further information. This only delayed the provision of key supports and services identified as needed by individuals. A system of assessment audits is needed to better shape the consistency of content in the assessments and updates completed by the therapists. Many individuals were identified for assessments, when an update was indicated because the individual was already provided supports and services. The need for updates was not clear in the recommendations. Frequency of monitoring was not addressed as a recommendation and the findings over the year were not reported and, as such, were not considered in the analysis of effectiveness of supports and services provided in the last year for individuals. There was no routine effectiveness monitoring conducted by the clinicians. Staff compliance monitoring by the PNMPCs was deemed to be inaccurate and both should be implemented in a manner that is thoughtful, meaningful, and accurate. Therapists need to routinely observe the implementation of strategies and ensure that staff are able to correctly integrate supports throughout the day. Some of the therapists had been spending more time in the day program areas to address integration. This needs to be expanded so they can model, coach, and support staff and individuals in the homes, day programs and work settings. This will require adequate staffing and time management. This will also ensure that more meaningful and functional information is captured in the assessments. One area of ongoing confusion by some therapists was the issue of maintenance versus skill acquisition types of interventions. In previous reviews, the monitoring team expressed concerns that there were routine interventions, such as passive range of motion provided to individuals, but with limited assessment to establish the need and a lack of baseline function documented. There were no measurable outcomes associated with these. As such, these interventions were identified as not appropriate. Rather than address the underlying problems, the facility chose to discontinue the programs at that time.

	LSSLC has an important role in the provision of training and skill acquisition. The therapy clinicians have expertise in movement skill performance that should result in the identification of direct interventions and programs to promote improvement in this area as well as enhance the motor aspects of programs designed and implemented by other team members. These should be a major focus of services provided beyond those foundational supports offered via the PNMP. There is also a role of interventions, in some cases, to address underlying impairments, such as range of motion. There must, however, be a clearly stated outcome associated with the provision of that intervention. For example, in the case that increased range of motion is needed for the functional performance of a skill, such as ambulation or reaching, there should be a baseline documented for the range of movement, and also for the functional skill and how limitations impact performance (clinical analysis). In some cases, the outcome may be related to improved skin integrity or ease of providing hygiene. The progress related to the range of movement as well as the functional skill or other outcome should be routinely evaluated and reported to document the effectiveness of the interventions. If the functional skill or skin status do not improve or cannot be maintained, the clinician would have to question the analysis of whether that was the underlying issue and/or the efficacy of the intervention. Habilitation Therapies should consider these concepts in the review of content for assessments, the design of programs and direct therapy interventions, routine documentation and in the development of a system of effectiveness monitoring over the next six months.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	<u>Current Staffing</u> Danielle Perry, AuD, CCC-A continued to serve as the Director of Habilitation Therapies. OT/PT staffing was generally consistent with that found during the previous review, though the contract staff had begun to rotate in and out of service. There were three physical therapists, Gail Harris, PT (full-time state employee), Misty Johnson, PT, and Cristen Nerren, PT (full-time state employees). PTAs were Marybeth Coates and Aaron Kropp. The occupational therapists were James Moneer, OTR, PTA, Bruce Shaw, OTR, and Stacy Kadrmas, OTR. COTAs were Martha Bigsby and Melissa Coley. Ms. Harris and Ms. Johnson had been working at the facility for longer than a year. Nine of 10 (90%) therapy clinicians were verified with current licenses to practice in the State of Texas. It was not possible to verify Martha's license online. Her license number was not provided and no matches were provided using her name. Verification of a current license should be conducted by the facility immediately. The license numbers identified for James Moneer (OT) and Stacy Kadrmas (OT) were not correct, but verification was completed using their names. Also, one PT who reported that she was certified in wound care turned out to not be certified (see detail in section M1). There were 5 vacant positions for occupational therapy and 3.4 for physical therapy.	Noncompliance

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		There were seven PNMPCs and two vacant positions. Their role as PNMP monitors had been recently discontinued and new job responsibilities had not yet been established. There were also therapy technicians within the department, but these had not been included in the documentation submitted. The census at LSSLC was 359 individuals and 355 were listed with PNM needs. Another eight individuals were identified with discontinued PNMPs. Thus, the majority of individuals were identified with PNM needs. It was reported that the ratio for OT was 1:100 and 1:75 for PT. It was not clear how these ratios were calculated, but based on the current staffing and census, actual service ratios for the entire census were 1:120 for OT and PT and was essentially the same when considering only those listed with PNM needs. The monitoring team calculated ratios based on the OTs and PTs only and did not include assistants because they were not licensed to conduct assessments, required supervision, and could not independently design programs and interventions. They were, however, extremely valuable members of the team because they extended the therapeutic contact with individuals, and provided interventions, staff training and monitoring. These ratios were very high and impacted the clinician's ability to provide comprehensive supports and services. Based on the documentation submitted: • There were 128 individuals listed as seated in wheelchairs as their primary means of mobility and another 50 who required wheelchairs for transportation. • Approximately 90 individuals required assistive devices for ambulation, such as gait belts, walkers, and canes for safety while ambulating, 34 of whom were also listed as requiring transport wheelchairs, likely for long distances. • Over 100 individuals had orthotics or braces. Merely providing services for the individuals who required these assistive supports would be a caseload of nearly 80 individuals for each clinician and there were certainly others with additional needs requiring the supports and services of an OT and/or PT. <u>Continuing Education</u> Nine of 10 clinicians reported participation in continuing education during the last six months. Each of these had attended the three-day DADS-sponsored Annual Habilitation Therapy Conference in September 2012. Only three clinicians had attended other continuing education conferences. Topic areas included: • Effective Neurological Management of Sensory Processing Disorder • Integrating Multi-Sensory Processing: Theory and Practical Advanced Strategies for Children with Sensory Dysfunction • Learning to Operate the Baclofen Pump • Basic Incident command System	

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		This was adequate participation for the clinicians who participated. It continued to be important that all clinicians be encouraged to attend annual educational opportunities beyond just those offered by the state to ensure that they continue to expand their knowledge and skills. Participation in ongoing continuing education is critical and should be encouraged throughout the year for all clinicians. New Admissions Three individuals were listed as admitted to the facility since the last onsite review. Samples of new admission assessments completed since the previous review were requested and two were submitted (Individual #428 and Individual #227). OT and PT each conducted a screening for Individual #130 that was documented in the IPN, indicating that he did not have any OT or PT needs and did not require a PNMP. Each of the assessments for these individuals was completed within 30 days of admission. The screening was also completed within 30 days. It is suggested that the facility consider using a separate screening form rather than only documenting in the IPNs. These are purged routinely and this information would not be retained. The screening form could be marked as "do not purge" and remain in the individual record until replaced by a subsequent screening or assessment. The screening should include what factors were reviewed, as well as a statement that no further assessment was indicated, or that a comprehensive assessment was needed and the projected date of completion. The screening should also indicate the frequency of subsequent review, if indicated and a reference for the IDT to make a referral in the case of a change in functional status. Habilitation Therapies staff might work with recordkeeping department staff to set up the active record in this way. OT/PT Assessments The state OT/PT assessment format instructions indicated that the assessment should provide a current picture of the individual's status, in terms of functional abilities, health risks, and potential for community placement. The template used at LSSLC was requested and the template submitted was consistent with the state approved format. This included content guidelines for use by the clinicians in the development of their reports. Per the guidelines, the comprehensive assessment was to be completed within 29 days of admission and an update was to be completed at least annually regarding services provided during the past year. A comprehensive assessment of specific systems and related areas was to occur upon a change in health status. A schedule for re-assessment was to be included in the written report. The content guidelines for each of these areas were extensive and comprehensive in nature.	

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		These guidelines also indicated that recommendations for supports and activities, other than direct therapy requiring a licensed professional, should be incorporated into the ISP so they may be integrated throughout the individual's daily routine. This was of significant concern to the monitoring team because all aspects of supports and services should be included in the ISP and should include established measurable and functional objectives. The five most current assessments for each clinician (15 randomly selected due to duplication), new admission assessments (2), and the OT/PT assessments for 20 individuals in the sample selected by the monitoring team were submitted for review. The assessment for Individual #298, dated 8/20/12, was duplicated in multiple requests. A current assessment was not submitted for Individual #240. The assessment for Individual #468 was missing pages. Thus, the total sample was 35 for this review. ISPs were also requested for each individual, except those who were newly admitted. Twenty-eight (28/35) were submitted and each was current within the last 12 months. Not including the new admission assessments, 13 assessments submitted were completed 10 days prior to the ISP date identified in the assessment. In two cases, however, the report date did not correspond to the date of signature and, as such, was completed only one or two days prior to the ISP. Seventeen others appeared to be completed prior to the ISP and three on or after, though 14 of these had signature dates on or after the date of the ISP. A variety of assessments were submitted: • 40% (14 of 35) were identified as OT/PT/ST comprehensive evaluations (one of these for Individual #227 was a brief screening and was not considered comprehensive). • 17% (6 of 35) were identified as OT/PT/ST evaluations. • 14% (5 of 35) were identified as OT/PT comprehensive evaluations. • 3% (1 of 35) were identified as OT/PT evaluations. • 17% (6 of 35) were identified as OT/PT evaluation updates. • 3% (1 of 35) were identified as OT/PT/ST evaluation updates. • 6% (2 of 35) were identified as occupational/physical therapy updates. The templates submitted were titled "Occupational Therapy/Physical Therapy Comprehensive Evaluation" and "OT/PT Evaluation Update." The template included a heading for considerations and no heading for recommendations. None of the updates submitted included the considerations heading, but rather recommendations. Aside from this difference, only three of the nine updates were consistent with the template submitted. The OT/PT and OT/PT/ST evaluations were loosely consistent with the template submitted, though none included all of the content areas outlined per the guidelines. It was unclear if these were intended to be comprehensive evaluations.	

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		While an area may not be applicable to an individual, the heading should be included with the statement that it did not apply with a rationale. This would ensure that all areas were considered for a comprehensive assessment. It was not clear why some evaluations included the SLP and others did not. The department should provide retraining to the clinicians to ensure consistency across titles, section headings, and content. Implementation of an audit system would quickly address this issue. Only assessments titled as comprehensive were included in the following analysis with the exception of the evaluation for Individual #227 and Individual #468 (17). The evaluation for Individual #468 was incomplete, though titled as comprehensive. • 0 of 17 (0%) individuals had comprehensive assessments that contained each of the 23 elements outlined below. • Overall, however, some of the assessments were acceptable for some elements, but many were missing key content. As such, a number of these were comprehensive based on the headings included, but not based on the content. The elements listed below are the minimum basic elements necessary for an adequate comprehensive OT/PT assessment. The current state assessment format and content guidelines required that these elements be contained within the assessments. The percentage of assessments (17) that contained each element are listed below: • Signed and dated by the clinician upon completion of the written report (18%). All were signed, but many of the signatures were undated. • Dated as completed 10 days prior to the annual ISP (41%). The state required these to be completed 10 working days prior to the ISP per the ISP meeting guide. • Diagnoses and relevance to functional status (35%). Some did a good job of describing the clinical relevance of the diagnoses. Most merely listed them. • Individual preferences, strengths, interests, likes, and dislikes were described (100%). The content of this section varied. • Medical history and relevance to functional status (18%). This also varied significantly. In some cases, there was a list of events or issues. In others, this was absent. • Health status over the last year (53%). • Medications and potential side effects relevant to functional status (41%). Some assessments listed only the purpose of the medications, others provided some potential side effects. It would be useful to report if any of these were experienced by the individual and/or if they impacted function. • Documentation of how the individual's risk levels impact performance of functional skills (71%). It would be important to address all areas of risk relevant	

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		to PNM to determine if the current ratings were accurate and if changes were necessary based on findings and to ensure supports and services sufficiently addressed these needs. The approach to this section was very inconsistent. • Functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day (82%). The quality of the content in this area varied. Many descriptions were very clinical in nature. Many of the assessments provided more descriptions of the supports and services provided under each heading rather than a description of the individual relative to each of these. This was noted particularly under the heading for positioning. There were very few descriptions of the individual's posture or alignment. Movement skills were often described more clinically than functional. The more functional the description, the more useful the information would be to the team for programming in other areas. • Description of the current seating system for those requiring a wheelchair with a rationale for each component and need for changes to the system outlined as indicated (29%). This was often limited to a "modified' wheelchair, rather than a description of the components with a rationale for each. • Evidence of observations by OTs and PTs in the individual's natural environments (e.g., day program, home, work) (29%). • Evidence of discussion of the PNMP as well as the effectiveness of the current version of the plan with necessary changes as required for individuals with PNM needs (76%). Many of the assessments reviewed the document, but only recommended changes in language rather than discussing the effectiveness of the plan or rationale for changes to strategies. This was often scattered throughout the assessment because it was included under other headings rather than a functional description of the individual. While most referenced the PNMP and even stated that it was effective, the approach to this varied significantly. • Discussion of the <u>expansion</u> of the individual's current abilities (13%). • Discussion of the individual's potential to <u>develop new</u> functional skills (0%). • Comparative analysis of health and impact on functional status over the last year (12%). This should be addressed in the clinical analysis of findings. • Comparative analysis of current functional motor and activities of daily living skills with previous assessments (12%). This should be addressed in the clinical analysis of findings. • Addressed the individual's foundational PNM and functional skill needs including clear clinical justification and rationale (29%). The analyses were largely summaries and lists of what supports the individual should have rather than the clinical reasoning behind them. Again there was great variability from assessment to assessment. • Identify need for direct or indirect OT and/or PT services (38%). This was	

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		generally more implied than stated. For example, the recommendations generally identified the need for indirect supports, but did not state that the individual did not need direct OT or PT, and a rationale was not given. Only one individual was recommended for direct intervention. • Reassessment schedule (100%). • Monitoring schedule (0%). The frequency of PNMP monitoring or effectiveness monitoring was not outlined in any case. • Recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs (15%). • Factors for community placement (0%). This section was omitted in a number of assessments. In some cases that there was a heading, there was only a standardized statement whether the individual's need could be met in the community. In no case did the clinicians outline what supports and services would be necessary. • Manner in which strategies, interventions, and programs should be utilized throughout the day (73%). This was generally accomplished via the PNMP and mobility skills only. While most of the elements listed above were included in the current state assessment format and guidelines, the clinicians should consider the specific content in each heading to ensure assessments were comprehensive as required by the Settlement Agreement. Additional prompts or cues in the form of guiding questions may be helpful to ensure that key elements are addressed in each assessment. Additional findings: • There were 69 assessments completed from 8/1/12 to 9/27/12, per the tracking log submitted. Approximately only 20 (29%) of these were completed 10 or more days prior to the ISP per the established due date. Twenty-three were completed after the ISP (33%), 23 were completed on the day of the ISP (33%), five were completed the day of the ISP (7%), and 21 others were completed prior to the ISP (30%), but not on, or before, the established due date. • 12% of the assessments contained 0 to five of the 23 minimum elements. • 65% of the assessments contained six to 10 of the 23 minimum elements. • 24% of the assessments contained 11 to 15 of the 23 minimum elements. • 0% of the assessments contained 16 to 20 of the 23 minimum elements. • 0% of the assessments contained more than 18 of the 23 minimum elements. Some of the assessments submitted were updates, though only two were updating an evaluation completed the previous year (Individual #47 and Individual #402). Others updated assessments that were 15 to 18 years old (Individual #545, Individual #161,	

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Individual #480, Individual #458, Individual #102). Assessments in their individual records were as follows:

Name	Baseline	Update	Update
Individual #545	4/17/95	4/5/10	3/15/12
Individual #161	2/12/97	2/2/09	2/1/12
Individual #480	1/14/97		12/15/11
Individual #458	8/25/94	8/12/09	7/21/12
Individual #102	8/4/95	7/23/07	7/5/12

These assessments should be updates to a comprehensive assessment, the date of which should be identified. It is unacceptable to update an old assessment that did not meet the standards established by the Settlement Agreement. In the case that the previous baseline or other assessment is older than 2011, a comprehensive assessment should be completed with subsequent interim updates for individuals who received OT and/or PT supports and services, including a PNMP during the year. References to changes (health and function) over the previous year and since the comprehensive should be documented. Typically, a comprehensive would be repeated approximately every three years with an update in the interim years for individuals who received direct and/or indirect supports and services from OT and PT, unless there was a change in status requiring assessment at that time. Recommendations for the next year should be based on a sound rationale described in the clinical analysis. Comprehensives and associated updates should be retained in the individual record.

This process would be more time effective, rather than duplicating the extensive format of the comprehensive assessment every year. It is often common practice for individuals who did not require any supports and services to receive a comprehensive assessment every three to five years. At the time a new comprehensive was completed, the previous comprehensive and updates could be purged. Of course, a repeat comprehensive assessment would continue to be indicated in cases of a significant change in status and for individuals newly admitted to the facility. Some individuals were provided a screening at admission to determine a need for a full assessment and this would be appropriate, in the case that it was clearly stated with a rationale and a definitive statement regarding the need for future assessments and a timeframe if indicated.

For the ISPs (28):

- 100% (28 of 28) of the ISPs submitted were current within the last 12 months. ISPs were not requested for the new admission assessments. Ten of the current ISPs did not have an attached signature sheet.
- 0% (0 of 28) of the current ISPs with signature pages submitted were attended by

#	Provision	Assessment of Status	Compliance
		both OT and PT. • 32% (9 of 28) were attended by PT only. • 4% (1 of 28) were attended by OT only. • 29% (8 of 28) of the current ISPs had no representation by an OT or PT. Formal assessment audits for editing and teaching to improve the quality were not completed. There was no system to establish and ensure continued competency for new and existing clinicians. The implementation of an audit system should shape the format and content of these assessments, resulting in improvements and greater consistency. An audit tool should be developed to guide these reviews and to ensure that the same standards are used for each. The elements listed above should be considered for inclusion in the audit tool. Training and corrective strategies should be developed as needed to address issues as indicated both for individual clinicians. LSSLC self-rated that it was in substantial compliance with this provision, however, this was entirely based on assessments of individuals who were newly admitted to the facility. The monitoring team monitored assessments for all individuals who lived there. While there had been some progress in this area, there were too many variables that did not support substantial compliance at this time. The number of therapists was inadequate, approximately 33% of the assessments were completed in less than 10 days before the ISP, and another 17% were completed after the ISP. Attendance by the therapists was very low and, in combination with the lack of assessments available for the ISP meeting, integration with ISP and the development of a comprehensive plan would not be possible for individuals with PNM needs. In addition, the assessments contained 46% or less of the elements necessary to ensure that an adequate assessment was provided. There was no formalized system to establish and maintain competency and no clear method to provide support and training to the clinicians to promote improvement in this area. Therefore, the monitoring team did not find the facility in substantial compliance with this provision.	
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	<u>OT/PT Interventions</u> There were 22 individuals listed as receiving interventions provided beyond the PNMPs, including treatments and programs implemented by OT or PT. Thirteen were listed as supervised by a PT and nine were listed as supervised by OT. A sample of six of the 22 records were reviewed by the monitoring team. The documentation did not consistently meet the basic standards, which are outlined below, for Individual #468, Individual #207, Individual #1, Individual #76, Individual #156, and Individual #302: • Current OT/PT assessment identified the need for intervention with rationale. These could be annual assessments or interim assessments completed during the year in response to changes in status or identified needs. • There were measurable objectives related to functional individual outcomes	Noncompliance

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	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.	included in the ISP. • Routine IPN or other SAP documentation contained information regarding whether the individual showed progress with the stated goal. • Routine IPN or other SAP documentation described the benefit of goal to the individual. • Routine IPN or other SAP documentation reported the consistency of implementation. • Routine IPN or other SAP documentation identified recommendations/revisions to the intervention plan related to the individual's progress or lack of progress. • Termination of the intervention was well justified and clearly documented in a timely manner. Findings for the interventions provided to these six individuals included: • None of these interventions were integrated in the annual ISP. It was noted that a recommendation for intervention was made in the OT/PT evaluation for Individual #468 and the ISP indicated that the IDT agreed to this, but no SAP or action step was included. • The therapist was not in attendance at the ISP meeting (Individual #1, Individual #156, or Individual #302). • There were no ISPAs in five of the six cases. In the case of Individual #302, there was an ISPA (7/21/12) to add splints and palm grips to her PNMP, but there was no addendum to address the intervention provided prior to that time. • A current OT/PT evaluation was not available (Individual #468). Recommendations for interventions were not recommended in four of five of the other assessments/updates. Two of these were updates to evaluations that were 15 or 16 years old (Individual #302 and Individual #156). These individuals should have received a new comprehensive evaluation. • There was no evidence of documentation related to these interventions in six of the six cases, though this was requested by the monitoring team. • None of these had associated measurable objectives identified in the documentation submitted. Three other individuals who were listed with direct OT or PT services were also included in the sample selected by the monitoring team (Individual #296, Individual #447 and Individual #240). Though documentation for these was better, there continued to be missing components as described below: • Individual #296: Her OT/PT evaluation dated 3/13/12 included a recommendation for skilled OT services to address bilateral elbow contractures and provide elbow splints and left palm guard. There were no measurable objectives identified, and her ISP dated 4/2/12 did not address direct OT	

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		intervention or measurable objectives. There was no evidence of a SAP and there was no IPN to initiate intervention. A ROM evaluation was completed on 4/12/12. Measurable objectives were established and the frequency and duration of treatment were clearly stated (three times a week for four weeks). Per IPN entries, she was seen two to three times a week and had met her goal as of 5/24/12. Therapy continued until 6/6/12 and recommendations for carry-over to the home with monthly follow-up with documentation were given. There was no evidence of follow-up (through 10/2/12). • Individual #240: There was no evidence of an OT/PT evaluation. There was no ISP submitted. There was an ISPA held on 5/5/12 for direct PT services per a guardian and IDT request due to a decrease in strength and ambulation skills. If he refused, PT was to make seven attempts to implement interventions. There was a doctor's order for ambulation per the PT IPN on 7/23/12. The PT stated that she believed he would not be consistent, that he was stubborn, had behaviors and refusals, and that he had been sick with cancer and that she predicted he would continue to refuse. There was no evidence of any effort to continue to try to provide this service and no evidence of a rationale to discontinue (through 8/3/12). On that date there was an IPN by another clinician related to his transfers with no mention of direct PT services for ambulation. • Individual #447: No ISP was submitted for Individual #447. His OT/PT evaluation dated 6/11/12 did not make a recommendation for direct OT. On 4/11/12, measurable objectives were listed with statement of frequency and duration for OT intervention. He was seen two to three times per week through 6/7/12 when it was reported that the doctor's order was to expire and he had not achieved all of his goals. This was attributed to his positioning and that a new wheelchair had been trialed during that period that he had not been comfortable in. A referral on 7/10/12 requested assessment for a power wheelchair, but this was ruled out by the therapist due to fine motor skill deficits. There were three serious problems with this conclusion. First it did not appear that he had actually been evaluated in a power chair. Second, if fine motor skills were an issue, that would have been an important functional skill acquisition program to consider. Third, there are numerous options for power chair use that do not require any fine motor skills at all, such as head array systems. It was of further concern to the monitoring team that he still in the last year had not been provided an effective means to address this extremely key issue that impacted every aspect of his life, health, and functional skill performance. Documentation of routine supports and services provided was minimal, or very limited, and follow-up was inconsistent related to acute issues and upon discharge from the hospital for PNM-related concerns: • Individual #542: He experienced multiple falls (two serious injuries to the head	

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		requiring staples in four months) and there was limited timely follow-up documented by PT. Some actions were taken (5/24/12, 5/31/12, 6/6/12) related to issuing new AFOs and orthopedic shoes, but there was inconsistent review or effectiveness monitoring after that time. PT attendance at ISPA meetings related to falls was not consistent (3 of 6 since 1/24/12). Individual #542 was to participate in direct PT as an outcome of one of these meetings, but there was no evidence that this was provided. Following a serious injury from a fall (9/13/12), the PT conducted an evaluation with follow-up, but there was no evidence that the team met regarding this. Individual #542 was rated at high risk for falls since 5/16/12. Clearly the associated action plan was not effective. • Individual #238: Despite multiple falls, some serious, there was evidence of review by Habilitation Therapies on two occasions in the last six months. Once was to document the findings from Orthotic Clinic that indicated orthotics were not indicated (5/24/12) and the other on 8/16/12 to issue a temporary helmet until a soft helmet was delivered. By report, he had several falls with 12 injuries and 3 serious injuries in the past year (per ISPA 8/9/12). After the fall on 8/9/12, at least five more falls were documented, one of which involved him rolling out of bed. A number of ISPAs were held to address falls and there was Habilitation representation for 5 of 7 of these, however, there was no evidence that either OT or PT conducted assessments after any fall since 3/31/12. Assessments and progress notes were also requested for Individual #357 and Individual #119, but no progress notes were submitted, therefore, OT/PT supports and services for these individuals could not be adequately reviewed. Even given the above examples, definite progress towards substantial compliance was noted for this provision item, but due to the inconsistencies in services and documentation, the monitoring team did not find it to be in substantial compliance. Proactive post-hospitalization assessments by the IDT therapy teams should be initiated to anticipate specific needs, rather than waiting for the IDT to send action referrals for supports. In addition, there was more of a focus, though inconsistently so, on responding to problems identified by the IDT, rather than a focus also on new skill acquisition via SAPs. This is an important element of this provision and time spent throughout the daily routines of individuals, potentials and opportunities for this will be more readily recognized by the therapy clinicians. Some of the therapists have been spending more time each week in the day program areas to address integration. This needs to be expanded so they can model, coach, and support staff and individuals in the homes, day programs and work settings. This will require adequate staffing and time management, however. This will also ensure that more meaningful (less clinical) information is captured in the assessments and updates.	

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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 were addressed in detail in section O above. This provision was not found in substantial compliance concurring with facility's self-assessment of this provision. Per PNMP monitoring, staff reported that they were not trained on individualized programs. Therefore, the finding that 89% of staff were 100% compliant with implementation was questionable. This monitoring was completed by PNMPCs, who by report, were not competently completing this task and as a result had been pulled from monitoring. At the time of this review, their alternate roles had not yet been established.	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, for staff compliance with the implementation of physical supports and the condition and availability of adaptive equipment was implemented at LSSLC, though this was in the process of review and revision at the time of the onsite review. This was addressed in section O above. There was no routine or consistent method of effectiveness monitoring conducted by the clinicians at that time. Recommended frequency of PNMP monitoring was not included in the OT/PT assessments. Findings from either type of monitoring were not reported. Monitoring of wheelchairs, assistive devices for ambulation, and other equipment provided by OT/PT was included in the PNMP monitoring completed. A log of work orders was generated. The log appeared to be a response to identified problems only. There was no evidence that a routine system of maintenance checks was conducted and tracked. It was also noted that the delivery of new wheelchairs and completion of modifications was slow based on the data in the wheelchair tracking log submitted. Some examples included Individual #296, Individual #441, Individual #388, Individual #223, and Individual #361. There should be a system of at least quarterly maintenance checks with timely response to requests generated through routine PNMP monitoring, random checks, and reports by direct support and home management staff. The log for modifications and repairs or maintenance should be reviewed routinely by the habilitation therapies director to ensure that these are completed routinely and in a timely manner. This element was self-rated to be in noncompliance at this time and the monitoring team concurred with the self-assessment. The system of monitoring was undergoing revision	Noncompliance

#	Provision	Assessment of Status	Compliance
		because the data were believed to be unreliable. The PNMPC role was being evaluated and the monitoring looks forward to the system implemented over the next six months. There was also no system of routine effectiveness monitoring conducted by the therapy clinicians at this time.	

Recommendations:

1. Continue to recruit experienced OT/PT clinicians to at least maintain or improve staffing ratios (P1).
2. Develop content guidelines for the OT/PT assessments. Consider the state guidelines and those outlined in this report. Assessments need to be completed within the established ISP timeframes (P1).
3. Standardize the use of the screening process for new admissions. These should be clearly identified as such (P1).
4. Implement an assessment audit system to address elements of review applied by the monitoring team (P1 and P4).
5. Clearly establish baselines in the OT/PT assessments as the foundation for interventions and measurable, functional outcomes (P1 and P2).
6. Include measurable performance criteria in the objectives for interventions and refer to these in all documentation (P1 and P2).
7. Recommendations for re-evaluations and annual updates should be clearly stated (P1).
8. Explore ways in which attendance at the ISPs/ISPAs can be improved (P1).
9. Include a discussion of the current PNMP in the assessments including other supports and services provided throughout the last year and effectiveness, including monitoring findings. While each presented a description of supports and services provided over the last year, none incorporated findings from the monitoring conducted related to compliance with implementation and effectiveness monitoring (P1).
10. 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 (P2).
11. Results and findings from PNM monitoring during the last year should consistently be reviewed and summarized (P1).
12. Documentation of direct therapy services should state a clear rationale to initiate, continue the service, modify the plan, or discharge. Measurable 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).
13. Implement a consistent system of quarterly maintenance checks for adaptive equipment, particularly wheelchairs (P4).

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o LSSLC Dental Services Policy and Procedure, 5/1/12 o LSSLC Organizational Charts o LSSLC Self -Assessment Section Q o LSSLC Action Plan Section Q o LSSLC Provision Action Plan o Presentation Book, Section Q o Dental Data: Refusals, missed appointments, extractions, emergencies, preventive services and annual exams o Listing, Individuals Receiving Suction Toothbrushing o Dental Clinic Attendance Tracking Data o Oral Hygiene Ratings o Dental Records for the Individuals listed in Section L o Desensitization Plans for the following individuals: • Individual #235, Individual #286, Individual #319, Individual #102, Individual #584, Individual #144, Individual #34 o Annual Dental Assessments for the following individuals: • Individual #545, Individual #554, Individual #323 Individual #75, Individual #425, Individual #258, Individual #133, Individual #519, Individual #144, Individual #428 o Emergency Documentation for the following individuals: • Individual #365, Individual #569 o Oral Surgery Consultations for the following individuals: • Individual #288, Individual #492, Individual #526 Individual #470, Individual #267, Individual #354, Individual #178 o Annual Dental Summaries Interviews and Meetings Held: o Tina Murray, DDS, Staff Dentist o LSSLC Contract Dentist, DDS 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 Informal observation of oral hygiene regimens in residences o Desensitization Committee Meeting
	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) provision action information. For each provision item, a numbered list of activities engaged in to conduct the self-assessment was provided. The results of each activity were listed. Based on the results, a self-rating was determined. This format was utilized in the previous assessment. The activities engaged in examined many of the issues reviewed by the monitoring g team. For Provision Q1, the assessment reviewed compliance with annual assessment, and initial exams. Oral hygiene ratings were reviewed as well as compliance with provision of hygiene instructions. There were some areas that were not assessed, such as staffing levels and the level of services provided. To take this process forward, the monitoring team recommends that the center lead continue this type of self-assessment, but expand upon it by adding more items included in the review of the monitoring report. 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 dental clinic made progress in the Oral Hygiene Maintenance program and it was good to see that resources were invested in the routine and preventive care that was provided in the homes. The staff remained enthusiastic and dedicated to serving the individuals living at LSSLC. However, the clinic did not have a dental director or a full time dentist. Treatment continued with the part time dentist as well as a contract dentist. Overall, services continued, but at a reduced rate and most individuals who accepted care benefitted from basic dental services. In addition to the basic services provided onsite, more advanced services were provided by a local oral surgeon. Most individuals referred to the dental specialist or oral surgeon required extensive restorations and/or multiple extractions, respectively. The facility continued to provide services with the use of TIVA. Those individuals who had treatment with TIVA received extensive dental treatment, including prophylactic treatment, x-rays, restorations, and extractions. Unfortunately, records indicated that many of the individuals who received this treatment had advanced dental disease. A reduction in services and a relatively high failure rate resulted in only 68% compliance with the requirement to complete annual dental assessments within the anniversary month. A significant percentage of the failed appointments were due to a lack of staff in the dental clinic. Refusals continued

	and were addressed through a psychology driven desensitization program. The format for the plans was recently revised and some success was noted for those individuals. Generally, individuals who accepted care received basic dental services. The overall provision of care was impeded by the lack of a full time dentist and the need for the hygienist to utilize more than half of her work hours for administrative activities. Individuals who refused treatment presented significant challenges for the facility, but were being addressed through the desensitization program. However, this was not a swift process and many individuals suffered a deterioration in oral health while awaiting assessment.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this 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 the members of the clinic staff, medical staff, the medical compliance nurse, and the facility director. <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 facility did not have a dental director. The part time dentist worked Monday through Friday mornings for a total of 20 hours each week. A locum tenens dentist was providing services two days each week. The facility was in the process of recruiting a full time dental director. <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. Dental Clinic Appointments April / May / June / July / August / September Preventive: 23 / 35 / 84 / 86 / 77 / 53 Emergency: 5 / 6 / 6 / 4 / 3 / 0 Extractions: 6 / 1 / 4 / 5 / 3 / 0 Restorative: 4 / 3 / 6 / 7 / 2 / 0 Total: 59 / 125 / 159 / 159 / 154 / 104 The total appointments represented the number of scheduled appointments. While the scheduled appointments increased since the last review, a failure rate of 28% translated into fewer appointments being completed compared to the period when there was a full time dental director.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Emergency Care Emergency care was available during normal business hours. After business hours, the facility did not have access to a dentist on call. The primary care provider made decisions related to the need for urgent dental care. In order to evaluate the provision of emergency care, the IPNs, from start of emergency to closure, and a copy of the dental evaluation and treatment were requested. The dental department did not submit adequate documentation of the emergency treatment provided. Records for individuals who transitioned or were referred for community placement were not provided. For many other individuals, a single IPN entry was provided. The emergency treatment provided for two individual in the record sample was reviewed. The records of Individual #365 and Individual #569 were reviewed. The unscheduled care provided appeared appropriate for the clinical presentations. Oral Surgery The facility continued to refer individuals to the oral surgeon who completed procedures at a local surgery center. Seven individuals were referred to the oral surgeon during the reporting period. One individual needed evaluation for a possible oral lesion. The other six individuals were referred for extractions. Three individuals required full mouth extractions: • Individual #178 had four teeth extracted at LSSLC in April 2012. Dental documentation noted advanced periodontal disease of a "hopeless condition" and the need for additional dental work. • Individual #267 was seen by the oral surgeon who documented that many teeth were non-restorable and a full mouth extraction was recommended. • Individual #288 was seen in the dental clinic on 7/11/12 and noted to have one tooth with dental caries. The oral surgery consult on 7/17/12 documented extensive dental decay requiring six fillings. Oral Hygiene Oral hygiene ratings were documented during annual exams and clinic visits. The table below summarizes the quarterly ratings.	

Oral Hygiene Ratings 2012			
Quarter	Poor %	Fair %	Good %
1st	26	27	47
2nd	24	34	42
3rd	25	42	33
4th	22	41	37

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		Overall, the percentage of poor ratings decreased. For the 17 annual dental summaries reviewed, the monitoring team noted oral hygiene ratings of 35%, 30%, and 30% for good, fair, and poor categories respectively. Some individuals were not rated. The Oral Health Maintenance Program continued to make progress. This program promoted optimal oral health by providing oral hygiene care and instruction to individuals and their support staff in their home environments. The unit directors reported that the dental department staff were active and present, and that they were appreciative of the work of the dental staff. Each individual was evaluated every four months. In recent months, the facility had made changes in selection of the oral care products used. This was described as an upgrading of products. The dental clinic sent notification of individuals with poor oral hygiene to the unit managers so that greater attention could be focused on hygiene. This was implemented shortly before the compliance review. Suction toothbrushing was provided for 51 individuals. Dental hygienists and nursing staff provided training to direct care professionals and nursing staff. The direct care professionals provided the treatment to the individuals in accordance with orders written by the primary providers. <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 through the home based hygiene program. Additionally, as of November 2012, the Oral Care refresher course, developed by the state dental services coordinator, was available on iLearn. All direct care professionals and housekeepers were required to complete the training.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services;	<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. <u>Annual/Comprehensive Assessments</u> In order to determine compliance with this requirement, a list of all annual/comprehensive assessments completed during the past six months, along with the date of previous annual assessment, was requested. Assessments completed by the	Noncompliance

#	Provision	Assessment of Status	Compliance
	provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	end of the anniversary month were considered to be in compliance. The available data were used to calculate compliance rates that are summarized below.	

Annual Dental Assessments 2012						
	Apr	May	June	July	Aug	Sept
Number of Exams	25	20	41	29	30	22
Compliant Exams	17	15	27	19	19	15
% Compliance	68	75	66	66	63	68

The overall compliance score was 68%. The comprehensive dental records for 10 individuals were reviewed. The documentation submitted was for individuals who received treatment with TIVA. The following is a summary of information found in the their most recent comprehensive dental assessment:

- 10 of 10 (100%) assessments included an entry on cooperation, behavioral issues, and the need for sedation/restraint use
- 10 of 10 (100%) assessments had entries for oral hygiene, teeth and restorations, and periodontal conditions
- 10 of 10 (100%) assessments included documentation of oral cancer screenings
- 10 of 10 (100%) assessments included documentation that oral hygiene recommendations were provided to the individual and/or staff
- 0 of 10 (0%) assessments documented the risk rating
- 10 of 10 (100%) assessments documented x-rays or the need for x-rays

For the individuals in the document submission, nine of 10 had poor oral hygiene documented and one had fair hygiene. Six of the individuals required extractions. Two individuals needed full mouth extractions and one needed multiple extractions.
It was difficult to understand the reason that most individuals required such extensive treatment. A review of other documents revealed that several had a history of refusing treatment. The assessment forms indicated that oral hygiene instructions were provided to the individual and staff, but the recommendations were not included in the assessment. The RDHs frequently documented in the IPNs the assessments and instructions that were provided. Risk ratings were not included as part of the annual assessment.

As part of the facility's requirement to provide assessments and evaluate the quality of those assessments, the state dental service coordinator will need to develop tools to assess the quality of dental assessments. This should fold into the facility's dental peer review process. Management of assessments is discussed further in section H1.

#	Provision	Assessment of Status	Compliance
		Initial Exams The facility submitted data for four individuals admitted since the last onsite review. Three of the individuals completed initial dental evaluations within 30 days. Dental Records Dental records consisted of initial/annual exams, annual dental summary, 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 typically included no documentation, but pointed the reader to the IPN entries that were written in SOAP format and were generally dated, timed, and signed. Failed Appointments The facility reported data on refusals, failed/no show, and missed appointments. The numbers as identified and reported by LSSLC in the document request are summarized in the table below:	

Failed Appointments 2012						
	April	May	June	July	August	September
Refused	3	19	25	23	7	10
Missed	1	33	10	19	36	14
Failed	4 (7%)	52 (41%)	35(22%)	42 (26%)	43 (27%)	24 (23%)
Total	59	125	159	159	154	104

Missed Appointments 2012					
	May	June	July	August	September
Clinic Staff	19 (58%)	0	14 (74%)	15 (42%)	2(14%)
Quarantine	0	0	0	8	9
Total Missed	33	10	19	36	14

During the May 2012 review, the facility reported essentially zero missed appointments. The appropriate tracking of missed appointments began in May 2012 and the data showed that a significant a number of appointments were missed. The erroneous April 2012 data was not included in the calculation of the failure rate. The overall failure rate for May 2012 through September 2012 was 28%.

Even more striking was the fact that 37% of missed appointments resulted from the lack of dental clinic staff. Most often, it was noted that there was no RDH in clinic due to administrative meetings and duties. However, appointments were also cancelled because there was no dental assistant or dentist in clinic. Other explanations for missed

#	Provision	Assessment of Status	Compliance
		appointments included a lack of home staff, medical appointments, and illness. No interventions were provided to address the significant number of missed appointments. The facility director will need to address the clinic staffing with some sense of urgency. <u>Dental Restraints</u> The facility continued to utilize oral sedation and TIVA to facilitate dental treatment. The use of both modalities required the approval of the Human Rights Committee. A board certified dental anesthesiologist conducted TIVA each month for two days. Individuals were also referred to the local oral surgeon who completed dental work at the hospital or surgical center with the use of general anesthesia.	

Sedation/General Anesthesia 2012						
	Apr	May	June	July	Aug	Sep
Oral Sedation	4	4	4	2	0	8
TIVA	8	0	8	7	7	0
Off-Campus Gen. Anesthesia	0	0	1	1	1	0
Total	12	4	13	10	8	8

<u>Strategies to Overcome Barriers to Dental Treatment</u>
The facility's refusal rate for May 2012 through September 2012 was 17%. A desensitization program was piloted. Individuals were identified based on previous need for sedation for routine care and/or behavior. Once the assessment was completed, the appropriate course of treatment was decided, such as development of skill acquisition plans, dental simulation training, or dental desensitization.

The monitoring team requested information, such as documentation of IDT discussions regarding implementation of plans to overcome barriers to dental treatment for individuals who refused treatment. The facility submitted a single spreadsheet listing 17 individuals who had at least two documented refusals. The comments were very limited and included statements regarding the psychologist accompanying individuals to clinic. This provided very little insight to the monitoring team on how many of the refusals were addressed.

A separate listing of individuals who were evaluated by psychology and had desensitization plans was also submitted. Twenty-two individuals with treatment plans were listed. Most of the individuals had SAPs developed while others were involved in dental simulation activities or had support plans developed.

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		The facility submitted seven "desensitization" documents or plans. Some of the plans addressed refusal through dental education. Dental simulation was noted for most individuals. Overall, each of the plans targeted the particular problems that were determined to be the obstacles in the provision of treatment. The monitoring team was concerned about those individuals with refusals who had no specific plan, but were listed on the refusal list, with very brief comments. This concern was rooted in the findings that many individuals continued to undergo treatment for extensive decay and non-restorable teeth after having a history of refusals over some period of time. This finding was also noted in the last compliance review. The monitoring team discussed Individual #105 with the dental clinic staff. They were familiar with the individual and reported that there was a long history of refusals. The following information was taken from a review of the records: • In February 2010, dental notes documented that the individual had fair oral hygiene by a visual exam, but refused treatment. The annual assessment completed on 10/1/10 noted excellent oral hygiene, but again noted refusal of treatment. On 4/13/11, the dental director forwarded an email to the QDDP regarding refusals. The annual assessment completed on 10/10/11 documented fair oral hygiene and areas of decay. This documentation noted the issue was being referred to psychology. This was the first documentation regarding referral due to refusal of treatment. The individual was assessed by the oral surgeon in January 2012 who noted fractures and multiple retained roots. The IPN contained documentation regarding desensitization on 4/26/12. The individual received further dental treatment on 6/4/12 with the use of TIVA, but ultimately required endodontic treatment for restoration. Documentation for this individual consistently noted a refusal of treatment. It was also clear that the individual's oral health showed decline. The record also showed that significant time lapsed before psychology was formally involved in order to develop a plan to overcome the history of refusals. It was also quite striking that the annual medical assessment completed in October 2012 included no discussion of dental care, oral health, or the history of refusals. This provision remains in noncompliance.	

Recommendations:

1. The facility director should continue efforts to recruit a full time dental director (Q1).
2. A corrective action plan should be developed to address the issue of the low compliance with the annual assessments (Q1).
3. The facility needs to ensure that all individuals who refuse treatment are being appropriately identified, evaluated and managed (Q2).
4. The facility must ensure that community resources are utilized as needed to provide advanced services to individuals supported by the facility (Q1).
5. The facility must ensure that those with poor oral hygiene have adequate plans in place to assist in improvement of oral health. Individuals who demonstrate deterioration in hygiene status should also have development of a plan (Q1).
6. Given the multiple reports of poor hygiene encountered in record reviews and the dental director's comments on the oral hygiene of edentulous individuals, the facility must examine the current oral hygiene program and the care that is being provided in the homes (Q1).
7. The state dental services coordinator should develop tools to determine the quality of the dental assessments completed at the facility (Q2).
8. The facility should continue its desensitization efforts and ensure that all individuals with continued refusals are promptly assessed. (Q2).
9. The facility must address the problem of missed appointments due to staffing, transportation, unknown appointments, etc. (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, Section I 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 Communication Evaluation Guidelines o Communication ISPA Checklist o Communication Master Plan o Speech Pathology Assessment template o Individuals with Behavioral Issues and Coexisting Language Deficits o Individuals with PBSPs and Replacement Behaviors Related to Communication o List of individuals with PBSPs o List of individuals with AAC o Compliance Monitoring tool template o Completed Compliance Monitoring forms submitted o List of individuals receiving direct speech services o Behavior Therapy Committee meeting minutes o Communication Skills Evaluation template o NEO curriculum materials related to PNM, tests and checklists o Communication Assessments, ISPs, and ISPAs for the following: • Individual #128, Individual #490, Individual #112, Individual #502, Individual #271, Individual #387, Individual #375, Individual #126, Individual #33, and Individual #68. o Communication Assessments, ISPs, ISPAs, SPOs, and communication and AAC-related documentation for the following: • Individual #410, Individual #542, Individual #285, Individual #425, and Individual #352 o Communication Assessments for individuals recently admitted to LSSLC: • Individual #428, Individual #227 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, Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Habilitation Therapy tab, and Nutrition tab, for the following:

	• Individual #597, Individual #137, Individual #182, Individual #447, Individual #144, Individual #545, Individual #298, Individual #468, Individual #172, Individual #161, Individual #265, Individual #419, Individual #361, Individual #402, Individual #480, Individual #102, Individual #296, Individual #458, Individual #240, Individual #47, and Individual #258. o PNMP section in Individual Notebooks for the following: • Individual #597, Individual #137, Individual #182, Individual #447, Individual #144, Individual #545, Individual #298, Individual #468, Individual #172, Individual #161, Individual #265, Individual #419, Individual #361, Individual #402, Individual #480, Individual #102, Individual #296, Individual #458, Individual #240, Individual #47, and Individual #258. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #597, Individual #137, Individual #182, Individual #447, Individual #144, Individual #545, Individual #298, Individual #468, Individual #172, Individual #161, Individual #265, Individual #419, Individual #361, Individual #402, Individual #480, Individual #102, Individual #296, Individual #458, Individual #240, Individual #47, and Individual #258. <u>Interviews and Meetings Held</u>: o Danielle Perry, AuD, CCC-A, Habilitation Therapies Director o Rhonda Hampton, MS, CCC-SLP o Vickie McCarley, MS, CCC-SLP o Maegan Melton, MS, CF6-SLP o Kristi Hodges, MS, CCC-SLP o Christina Pedroni, MS, CCC-SLP o Various supervisors and direct support staff o PNMT meeting o ISP Meeting for Individual #433 o IDT meeting related to Community Placement for Individual #162 <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs and work areas o Communication Interventions with • Individual #425, Individual #248, Individual #506, and Individual #126

	Facility Self-Assessment: In the self-assessment, Danielle Perry AuD, CCC-A, the Habilitation Therapies Director, outlined specific self-assessment activities and provided specific data based on the findings from these activities. The activities were similar to the process used by the monitoring team, but did not include some of the key elements used for review and outlined in this report. In some cases, the data were not consistent with the findings of the monitoring team. For example, in R1, the activities conducted for self-assessment included review of staffing vacancies and reviewed the Certificates of Clinical Competence for the SLPs. Each of these was appropriate and consistent with the monitoring team review, however, the finding by LSSLC was that the speech department was staffed at 100% and the average caseloads were 60 individuals for each clinician. This calculation was based on six staff. As R1 addresses communication services only, the reference to sufficient SLPs can only pertain to the provision of communication services only. Two of the SLPs provided supports and services related to dysphagia and mealtime rather than communication and the SLP assistant was not licensed to conduct assessments. As assessment was a key element to the delivery of services and the SLPA required supervision, she could not figure into the calculation of caseload ratios equal the SLPs. The monitoring team calculated this ratio as 1:120, double that identified by LSSLC. The SLPA was a valuable team member related to implementation, training and monitoring of communication programs and was a key adjunctive clinician, but without the SLP to conduct the assessment and provide supervision, would not be able to provide any service at all. Thus this position was not included. It was true that all budgeted positions were filled, but a caseload of 120 individuals (based on the entire census) was too high to ensure appropriate services were provided. While it was likely that not all individuals required ongoing communication supports and services beyond a comprehensive assessment, there were still a large percentage of these identified as high priority needs. Consider that there were 239 individuals identified as Priority 1 and 2. Another 59 were Priority 3. Based on these priority levels only, the ratio was 1:100, still too high to provide adequate services. Thus, as a result, only 13% of these had been provided AAC and only 7% had been provided a comprehensive assessment. Based on these findings, the monitoring team did not concur with the facilities finding for substantial compliance with this element at this time. R3 was also found to be in substantial compliance by the facility. This self-assessment was based on review of seven speech assessments for AAC recommendations and implementation, review of ISPs for a description of how the individual communicated, and 36 AAC systems in use to determine if they were functional, readily available, and adaptable to a variety of settings. While the small number of AAC systems implemented was appropriate, there were too many individuals who did not benefit from these supports to meet the intent of the Settlement Agreement. It would not be possible to know the actual need without completed assessments. It was also noted that the majority of ISPs reviewed contained information about how the individual communicated, most was very limited and very few contained information related to strategies staff could use as communication partners. This area needs improvement and the monitoring team is hopeful that the new ISP process will address this. As a result the monitoring found this element to be in noncompliance at this time.

	The facility self-rated itself as noncompliant with all the two remaining elements of R (R2 and R4). While actions taken showed considerable steps in the direction of substantial compliance, the monitoring team concurred.
	Summary of Monitor's Assessment: The monitoring team was extremely impressed with the continued progress of LSSLC with this provision. The therapists had implemented some very excellent programs and the completed assessments were improved. They are commended for their efforts in moving forward toward substantial compliance. Staffing levels were stable at the time of this review, with the addition of a speech assistant and the use of graduate students. Progress with the completion of assessments had been slow. The assessments as a whole were improved, but continued to need improvement in some areas. A system of audits should be implemented. The therapists had begun to complete the assessments based on priority, but were also attempting to coordinate this with the ISPs. This will be a key change and should result in improved integration and better time management. Attendance at the ISPs was inconsistent. As always, the SLPs were responsible for communication supports and services for all of the individuals and, as such, the current ratio for caseloads continued to be high. The therapists are commended for the level of therapeutic interventions provided. The documentation related to these must be tightened up with clear rationale for initiation and termination with consistent reporting of progress toward measurable objectives. NEO training was very limited related to communication and increasing the time allotted to this should be considered. Training should focus on teaching staff to be effective communication partners as well as to implement AAC. Staff tend to see these systems as an exercise or a single activity rather than as a way to interact with others. This cannot only be taught or trained in an inservice class, but must also be modeled and coached in the moment. Integration of communication strategies and AAC systems should not be the sole responsibility of direct support and day program staff. Engagement in more functional skill acquisition activities designed to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology, should be an ongoing 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 these programs for individuals and groups. This requires significant time from the professional staff. This was initiated several months ago. The therapists are encouraged to continue to step up their efforts to immerse themselves into the routines of the individuals they support to capitalize on the teachable moments with staff so that they may learn to capture teachable moments with individuals.

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R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	<u>Staffing</u> At the time of this review, there were five full-time SLPs, Rhonda Hampton, MS, CCC-SLP, Vickie McCarley, MS, CCC-SLP, Maegan Melton, MS, CF6-SLP, Kristi Hodges, MS, CCC-SLP, and Christina Pedroni, MS, CCC-SLP. Additionally, there was a Speech Assistant, Amber Hodges, BS. She was a new graduate and had just acquired her license. There was also an audiologist, Rosemary Simpson, AuD, FAAA, who provided services to 360 individuals. Graduate students were available on a regular basis and were key to the provision of services. Ms. Hampton and Ms. McCarley provided services related only to dysphagia and mealtimes, so they will not be included in the review of this section related to communication. The other three predominately provided communication services with occasional supports related to dysphagia or mealtimes. A list submitted related to positions budgeted and filled identified that there were eight positions budgeted and all were filled. The documented ratio was 1:45, and included the speech language pathologists (5), the speech assistant, the audiologist and presumably the Director of Habilitation Therapies. The Director did not carry a caseload for speech or audiology. The audiologist provided hearing services only and did not completed communication assessments. The speech assistant provided a very valuable service related to interventions, training and monitoring, but only under the supervision of an SLP and was not able to conduct assessment per the State practice act. Given the actual staffing for the three therapists who provided communication services (including assessment), the ratio was 1:120 based on the census of 359. These caseloads were very high. The assigned caseloads as reported by the facility, were as follows, though these total more than the current census: • Melton: 152 individuals • Hodges: 120 individuals • Pedroni: 107 individuals These ratios were significantly high given that all individuals communicate, though some require more support than others. <u>Qualifications</u> • 3 of 3 SLPs (100%) were licensed to practice in the state of Texas. • The licenses of both the Assistant and Audiologist were also verified as current. Evidence that the facility consistently verified both state licensure and ASHA certification for each clinician will be requested prior to the next compliance review. <u>Continuing Education:</u> A list was submitted as evidence of participation in communication-related continuing education in the last 12 months.	Noncompliance

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		• 3 of the 3 (100%) current SLPs participated in continuing education related to communication including the following: o TX Assistive Technology Network Statewide Conf. 2012 (11.5 hours) o Evidence-based Practices for AAC Evaluations – From A&P to Recommendations (12 hours) o DADS Habilitation Therapy Annual Conference 2012 (11 hours) o PATH (Professional Association of Therapeutic Horsemanship) International and Region 8 Conference (10 hours) This level of participation was excellent for each of the clinicians. The monitoring team congratulates the facility and their support of continuing education for these clinicians. There was a noted benefit in that the clinicians gained knowledge and skills and they were applying this information into the supports they provided to individuals at LSSLC. The monitoring team further urges that each of the clinicians be provided continued support to participate in additional communication-related continuing education courses over the next year. This is critical to ensure improved clinical assessment and program development for AAC and language for individuals with developmental disabilities. <u>Facility Policy</u> No local policy existed for the provision of communication services at LSSLC. Procedures related to completing communication assessments in preparation for ISPs and ISPAs, however, had been developed. The following components should be considered in the development of a facility policy: • Outlined assessment schedule • Timelines for completion of new admission assessments (within 30 days of admission or readmission) • Roles and responsibilities of the SLPs (meeting attendance, staff training etc.) • Frequency of assessments/updates • Timelines for completion of comprehensive assessments (within 30 days of identification via screening, if conducted) • Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (within five days of identification as indicated by the IDT) • A process for effectiveness monitoring by the SLP • Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment • Methods of tracking progress and documentation standards related to intervention plans • Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as,	

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		problem resolution. The facility proposed that it was in substantial compliance with this provision due to full staffing and competence of the SLPs on staff. The elements used for self-assessment included review of staffing levels and review of the Certificates of Clinical Competence for SLPs. Certification, however, was only one of a number of key elements in the determination of competence as there was a continuing education requirement, too. However, this requirement was not limited to communication and, as such, a clinician could meet the requirements for re-certification without participation in communication-related continuing education that would apply to the needs of individuals living at LSSLC. Additional methods to identify competence would be needed. As described below, the three SLPs were viewed as competent by the monitoring team, though some needed improvements were identified. It was also noted in the self-assessment that the department was staffed at 100% with an average caseload of 60 individuals for each therapist, including the speech assistant. A ratio at this level would be very acceptable, but while the department was fully staffed based on the budgeted positions (eight), the ratio was calculated using all SLPs (5) and the assistant, who did not carry a caseload own her own. As described above, two of the SLPs did not provide communication-related services, so should not be included in the ratio for this provision because it only pertains to communication supports and services. Based on the assigned caseloads reported by the facility and the calculations by the monitoring team based on the current census, the caseloads were each well over 100 for the three SLPs. This was not an acceptable level to ensure that all individuals received appropriate and adequate communication supports and services. As such, this provision item was not considered in substantial compliance due to the diminished staff ratios at the time of this review. A local policy as noted above was also needed.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	<u>Assessment Plan</u> The Master Plan submitted was undated. It listed approximately 125 individuals who were considered to be Priority 1. Of those, one was deceased and six had been placed in the community. None of these had received a comprehensive communication assessment. Of the remaining 118 individuals, only 21 were listed with these assessments completed in 2012, with previous assessments two to five years earlier. Based on previous reviews by the monitoring team, these were not considered to be comprehensive. Another 82% of individuals identified with the most significant communication needs had not received an assessment per this plan. There were approximately 126 individuals who were listed as Priority 2. Of those, four were deceased and one had been placed in the community. None of these had previously received a comprehensive assessment and only one of the others at this level had been	Noncompliance

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		provided a communication assessment per the plan. The other 99% of individuals at this priority level with communication needs had not received a comprehensive assessment per this plan. There were 64 individuals listed at Priority 3 and another 68 who were listed as Priority 4. Of these, two were deceased, one was transferred, and eight were placed in the community. None had been provided an assessment, as well as none of the others at these two levels. One had received a screening in March 2012 (Individual #240) and in August 2012 (Individual #130). There were 17 individuals with no priority level listed and each was identified as deceased or placed in the community. Two others with no priority classification had been provided a screening in April 2012 (Individual #110). None of the existing communication assessments had been audited to determine if they met the current state-established format, though this process was in the planning stages. The tracking log submitted listed only 23 assessments completed in the last year and only 10 since the last review. There were three individuals listed for whom there was no evidence of an assessment previously or in the last year (Individual #582, Individual #340, and Individual #279). There were three individuals listed with screenings rather than assessments. For the others, there was no evidence of assessments completed in 2011 and only 23% of the others listed had received an assessment as recently as 2010. Others were in 2009 (141), 2008 (128), and 2007 (34), with no evidence of a communication assessment since that time. At least 93 were listed with a PBSP. Based on review of the documents submitted: • 3 of 3 individuals (100%) admitted since the previous review had received a communication screening or assessment. As assessment dates were not listed, it was not possible to determine if these were completed within 30 days of admission from the Master Plan. Two new admission assessments were submitted (Individual #428, Individual #227). The ISP date was not identified in the assessment, but each was completed within 30 days of admission. • The facility recently initiated a process whereby individuals newly admitted would receive a screening upon admission. Based on the findings, a baseline comprehensive assessment would be completed, only if indicated. It was not clear whether two of those individuals newly admitted received a screening and a subsequent assessment because only the assessment was listed (Individual #428, Individual #227). For Individual #130, only a screening was listed. • 4 of 23 individuals (17%) had communication assessments completed on or before the due date listed in the tracking log. Only one was completed 10 or more working days prior to the ISP. There were three assessments and one screening that were completed during the month of the ISP, but the date of the	

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		assessments/screening were not listed. At least 17 were either completed well after the previous ISP or three or more months prior to the subsequent one. These were not completed in conjunction with the ISP schedule and it was not known if an ISPA was held upon completion of the assessment. o By report, the clinicians had recently begun an initiative to coordinate the assessments with the ISP whenever possible, rather than merely working through the priority list. This will be important, particularly with the new ISP process to ensure that communication information is integrated into the annual planning process. • Documentation indicated that 12 comprehensive assessments were completed from April 2012 to October 2012. Completion by the three clinicians during that period was as follows: Hodges (4), Pedroni (1), and Melton (7). It was not clear why there was such a significant difference in the number of assessments they completed. <u>Communication Assessments</u> Communication assessments were requested and submitted as follows: • Individuals in the sample selected by the monitoring team (15 of 21 were submitted) • Five of the most current assessments by each speech clinician (10 were submitted for three SLPs) • Individuals newly admitted to LSSLC (two were submitted) • Individuals who participated in direct communication intervention, had SAPs, were provided AAC, had PBSPs, and/or presented with severe language deficits (assessments for 5 individuals were requested and submitted). The most current assessments for some individuals were completed more than 12 months ago, though annual assessments/updates would be expected for each based on supports and services or assessment recommendations (Individual #410 and Individual #190). The most current assessment for Individual #128 (7/5/12), Individual #428 (8/10/12), and Individual #227 (8/24/12) were duplicated in multiple requests. All totaled, there were current assessments for 14 individuals available for review. Each was a Communication Skills Evaluation. A comprehensive assessment should be completed for each individual living at LSSLC. In the case that supports and services were not indicated (because the individual presented with very functional communication skills and did not present with challenging behaviors related to communication deficits), it should be stated that no supports and services were needed and that a reevaluation would be completed in three years, certainly no longer than five years, unless there was a change in their health or functional performance status that	

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		potentially impacted communication. In the case that any supports or services were provided over the previous year, an annual update should be completed that reports the individual's health status, risk ratings, and any changes over the last year. This assessment, at a minimum, should describe the supports and services provided the effectiveness of these and recommendations for the upcoming year. By report, these critical updates were not generally completed. Also, it was reported that for individuals preparing to transition to the community, an assessment was not necessarily completed, but rather a summary. The monitoring team attended a meeting with the IDT for Individual #162, who had recently been placed in the community. This meeting was to review the process to identify any potential for improvement. During this discussion, it was identified that Individual #162 had not been provided a comprehensive assessment prior to moving. The summary that was completed did not offer current communication status information, but rather referred to an assessment completed over three years ago. At that time she was 16 years old with a diagnosis of conduct disorder with severe language deficits. The school district had completed an evaluation and provided a Dynavox V. It was documented that this device now needed a new cord and battery and were ordered prior to her discharge from LSSLC. It was unclear why this had not been done as a part of the supports and services she received at LSSLC rather than as a function of her community placement. Recommendations were made for community home staff to use a home poster and the Dynavox and that the new school district should provide a new communication assessment. • It was of concern that she had not received any communication supports and services while living at the facility and had not been provided a current comprehensive assessment there. This information should be current and updated rather than merely passing along this responsibility to community providers and the school district. She was identified as Priority 1 related to communication needs. The therapist indicated that Individual #162 was in school and, therefore, LSSLC did not provide services. LSSLC had a primary responsibility for all individuals who reside there and schedules of the staff must be modified to accommodate school-age children. A template for the speech pathology assessments was submitted as adopted at LSSLC. Very limited guidelines were identified only for the AAC and Clinical Impressions sections, and some template language was noted for several other sections, but more specific content guidelines were not provided. There was no format for an update assessment. None of the assessments submitted were fully consistent with the template submitted. Approximately 86% (12 of 14) of the assessments included in this review were generally consistent with the template submitted.	

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		Zero of 14 individuals had a comprehensive assessment that contained all of the 23 elements outlined below, however, there were seven elements present in more than 80% of the assessments reviewed. These were the minimum basic elements necessary for an adequate comprehensive communication assessment as identified by the monitoring team. Many of these elements were missing or they were inadequately addressed. The current state assessment format and content guidelines required that these elements be contained within the assessments. There were very limited content guidelines used by the clinicians to ensure that the required content was addressed in each assessment. The elements most consistently included (contained in more than 80% of the assessments reviewed) were: • Individual preferences, strengths, interests, likes, dislikes • Description of verbal and nonverbal skills, with examples of how these skills were utilized in a functional manner throughout the day. • Description of receptive communication skills with examples of how these skills were utilized in a functional manner throughout the day. • Discussion of the expansion of the individual's current abilities • Reassessment schedule • Recommendations for direct interventions and/or skill acquisition programs including the use of AAC as indicated for individuals with identified communication deficits • Manner in which strategies, interventions, and programs should be utilized throughout the day The percentage of assessments that included each individual element are listed below: • Dated as completed 10 days prior to the annual ISP (21%). • Diagnoses and relevance of impact on communication (64%). Though present, some were very general statements. Others merely listed the diagnoses. • Individual preferences, strengths, interests, likes, and dislikes (93%). This was a strength. • Medical history (over at least the previous 12 months) and relevance to communication (0%). There was no discussion of the individuals' medical history during the last year. A few listed consults related to health issues. Relevance to communication was not discussed. If there was no significant history that impacted communication, this should be stated. • Medications and side effects relevant to communication (64%). Most of the assessments listed the medications and some identified general side effects. Others did a very good job of tying these to communication. • Documentation of how the individuals' communication abilities related to their	

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		health risk levels (17%). This was not noted in most cases. Most merely listed the risk levels in areas considered to be relevant to the assessment. This was presented in the assessment after the clinical analysis and, as such, there was no evidence that these were considered in the analysis, identification of needs, and the selection of interventions and supports. In addition, there was no comment as to whether the clinician had identified issues that might impact on the risk rating that should be considered by the team during the ISP discussion. • Description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day (100%). This was a strength. • Description of receptive communication skills with examples of how these skills were utilized in a functional manner throughout the day (100%). This was a strength. • Evidence of observations by SLPs in the individual's natural environments (day program, home, work) (36%). • Evidence of discussion of the use of a Communication Dictionary as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who were nonverbal (0%). The clinicians did not provide examples of information included in the dictionaries, did not discuss if these were still accurate and effective, and did not discuss specific changes needed. The only reference to this support was in the recommendations that staff should refer to the dictionary. • Discussion of the expansion of the individual's current abilities (86%). • Discussion of the individual's potential to develop new communication skills (64%). • Effectiveness of current supports, including monitoring findings (0%). This was not consistently present in the assessments reviewed and none presented findings from monitoring conducted throughout the last year. • Addressed the individual's AAC needs including clear clinical justification and rationale as to whether the individual would benefit from AAC (71%). Content varied somewhat, but was improved from previous reviews. • Comparative analysis of health/functional status from the previous year (0%). • Comparative analysis of current communication function with previous assessments (8%). • Identify need for direct or indirect speech language services (36%). These should specify whether direct or indirect therapy was indicated and a description of these with the rationale contained in the analysis. • Reassessment schedule (86%). • Monitoring schedule (0%). Frequency of monitoring for effectiveness, compliance and maintenance should be outlined.	

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		• Recommendations for direct interventions and/or skill acquisition programs including the use of AAC as indicated for individuals with identified communication deficits (93%). • Factors for community placement (0%). Each merely stated whether the existing supports could be provided in the community. Considerations for placement as they related to communication were not stated. • Recommendations for services and supports in the community (0%). • Manner in which strategies, interventions, and programs should be utilized throughout the day (100%). In the cases in which specific communication strategies were listed in the assessment, they were generally functional and could be applied throughout the day. Consideration of more suggestions related to guide staff interactions as communication partners should be considered. Additional findings: • 0 of 14 (0%) assessments contained five or fewer elements outlined above. • 7 of 14 (50%) assessments contained six to 10 of the elements outlined above. • 7 of 14 (50%) assessments contained 11 to 15 of the elements outlined above. • 0 of 14 (0%) assessments contained more than 15 of the 23 elements above. • Augmentative/Alternative Communication and Assistive Technology: This section was much improved and in most cases there were recommendations related to AAC or other supports (12 of 14 individuals). • Clinical Impressions: The analysis sections of these reports continued to be weak and provided insufficient rationale for the recommendations. • The assessments consistently identified preferences, likes, or dislikes, but did not consistently apply this information in the analysis of findings. These were important for establishing contexts for communication opportunities, but the clinicians did not establish a link between these and functional participation in the daily routine. Observations in natural environments would also provide clues as to preferences as well as individual potentials for enhancing or expanding existing communication skills. • The assessments did not identify important life activities or inventory ways for greater meaningful participation in them. • At least four individuals were recommended for direct intervention with SLPs. It was noted that in the other cases, most of the recommendations were related to supports provided by the IDT and direct support staff without clearly outlining what role the SLP would play in program development, training, monitoring, or documentation. Nine were recommended for SAPs related to communication that should involve SLP participation. Most did not outline specific measurable objectives for wither therapeutic interventions or SAPs.	

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		There were 126 individuals listed with severe language deficits, though six had been placed in the community and one was deceased. It was not possible to determine how many of these 119 individuals (33% of the current census) were considered to be nonverbal, however, each was identified as Priority 1. Only 22 were listed with communication assessments, each completed in the last year. Seven others had not received an assessment since 2007, 37 since 2008, 32 since 2009, and 21 since 2010. <u>SLP and Psychology Collaboration</u> There were 69 individuals identified with PBSPs that included replacement behaviors related to communication. Thirty-eight of these 69 were identified as Priority 1, but only 10 had received a comprehensive communication assessment. Six of these individuals were included in the sample selected by the monitoring team and PBSPs were requested. Their PBSPs and communication assessments were reviewed to determine if the communication strategies identified were integrated into their PBSP and ISPs. Comments are below: • Individual #447: There was no evidence of a PBSP in his record. In his Communication Skills Evaluation dated 4/6/12, a previous assessment was cited that included recommendations to assist in decreasing negative behaviors. The target behaviors identified in the assessment included self-injurious behavior. There was no explanation offered as to the relationship of SIB to communication and no strategies were offered to aid staff in preventing or responding to this behavior that were developed in conjunction with the psychologist. • Individual #102: Her communication assessment was 8/8/07, over five years ago. Her PBSP was dated 11/1/10, two years ago. It targeted aggression and property destruction. The replacement behavior was pointing to what she wanted, though the communication assessment stated that she was not able to do this. She did not shake her head to indicate "yes" or "no" nor did she touch a person to reinstate an action. The assessment stated that she was not able to communicate her basic needs and that staff had to anticipate all needs for her. The psychology portion of the ISP dated 7/6/12 indicated that she had a renewed interest in interacting with others. Supports from the SLP were not provided to her to build on this. • Individual #161: Her most current assessment was 1/23/09 and it did not address behavioral challenges or reference a PBSP. It was reported in her ISP dated 2/2/12, however, that her behavior problems were a form of communicating that she was unhappy, was in pain, or to avoid tasks or conditions she wanted to avoid or escape from. While Individual #161 was 80 years old and not likely to acquire new skills related to communication, collaboration between the SLP and psychologist would ensure that the most effective communication strategies were used by staff and applied in her PBSP.	

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		• Individual #265: His most current assessment was 4/24/09 and was incomplete per the copy submitted (only two pages and no signature page). His PBSP was dated 2/1/12 targeted SIB and disruptive behavior. The recommended replacement behaviors were to indicate his wants through gestures and verbalizations, verbalize when he was in pain or discomfort, and perform relaxation techniques. Without a current assessment there was no evidence of collaboration between the SLP and psychology related to his identified needs. • Individual #298: The most current communication assessment was 3/12/12, though no PBSP was submitted in the individual record. Collaboration between the SLP and psychologist was not evident in the assessment or ISP. There was consistency, however, in the descriptions of his use of sign language and a communication book. Behavior Management Committee meeting minutes from 5/1/12 to 10/30/12 were reviewed. A SLP attended 11 of 26 meetings (only 42%). Observation by the monitoring team at a BMC meeting during the onsite review showed that the SLP was a valuable member of the team and brought valuable information and insight to the discussion. The SLP completed documentation related to these meetings in order to capture changes that were indicated to plans and programs (Individual #298, Individual #558, Individual #203, Individual #535, and Individual #175). This was a key opportunity for discussions regarding effective communication strategies and for collaboration between the SLPs and psychologists in the review of PBSPs. Collaboration during assessments would also be an important element to ensure consistency and optimal effectiveness. SLP attendance at these meetings should be more consistent. There was, however, potential for additional collaboration. The current communication assessment format included a section titled Behavioral Considerations, which indicated if the individual had a PBSP and the types of behaviors noted during the assessment. While each of these were steps toward compliance in this area, the quality of content of this section varied greatly across assessments, did not describe any collaboration between these disciplines, and was not used in the analysis of assessment findings section for the design of communication supports and services, or for making recommendations. <u>Assessment Audits</u> There was no documented evidence of a formal or informal system of communication assessment audits. Reviews conducted pertained only to the completion of annual assessments and the number of individuals identified as needing AAC. There was a need for a formalized process to establish clinician competency and ensure ongoing compliance with the assessment format and content guidelines in a constructive learning context.	

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		The self-assessment reviewed progress on the Master Plan and identified that 100% of all individuals newly admitted to LSSLC had received at least a screening and it was reported that as of 9/25/12, 11 of the evaluations had been completed. The self-rating was noncompliance, but there was no evidence of an action plan to promote greater progress with this. Though improvement was noted, this provision (R2) was not in substantial compliance due to the documented weaknesses in the existing assessments and the absence of a system of assessment audits.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	<u>Integration of Communication in the ISP</u> Based on review of the sample of ISPs, the following was noted: • 29 of 29 of the individuals for whom assessments were submitted had documented communication needs. ISPs were available for review for 27 of these. Each of the ISPs submitted and reviewed was current within the last 12 months. Five of these did not have sign-in sheets attached to the copy. • In 2 of 22 current ISPs (9%) reviewed that had sign-in sheets for individuals with communication needs, an SLP attended the annual meeting. An SLP attended two other meetings, but was assigned for dysphagia and mealtimes rather than communication. • In 7 of 9 current ISPs (67%) reviewed for individuals with AAC, AAC was referenced (Individual #410, Individual #298, Individual #33, Individual #190, Individual #447, Individual #402, Individual #128), though how these were used by the individual was not described. In two ISPs, there was no reference to AAC (Individual #68 and Individual #271). Individual #298 was described as having a communication book, but AAC list indicated that he also had an Express One. • 18 of 27 ISPs reviewed (63%) included a description of how the individual communicated. Most of these did not include how they used their AAC system (if he or she had one). Most of the descriptions were minimal and did not provide a functional description of how the individual communicated or ways staff could effectively communicate with him or her. In a number of cases, the only description was included in the psychology assessment section of the ISP, as there was no communication assessment available. This functional description should be an aspect of the ISP that describes the individual as a person in a holistic manner rather than merely as a reported finding in the assessments. • 0 of 27 ISPs reviewed (0%) contained skill acquisition programs related to communication skills developed by the SLP. Individual #128 had an action step to be encouraged to use her AAC device. Individual #190 had an action step to be trained to use her Dynavox. Some contained training objectives related to communication developed through the day program, but with no clear contribution or supports provided by the SLP. Many of these were not focused	Noncompliance

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		on meaningful, functional communication skills for the individual. • Also see section S regarding the absence of any communication SAPs in the sample of individuals who's SAPs were reviewed. <u>AAC Systems</u> It was reported that 39 individuals at LSSLC were provided one or more types of AAC, including: communication book (6), Big Mack switch (8), communication lapboard (5), Communication Builder (2), talking photo album (3), Dynavox (11), Express One (5), Talking Watch (1), individual poster (1), spec switch with talking icon (2), and ADDvox7 (2). Through grants awarded to the facility and a local fundraiser, a number of other devices had been ordered, including iPads. There were 239 individuals identified as Priority 1 and 2 who could potentially benefit from AAC. The majority of these individuals were nonverbal or presented with limited verbal skills. Another 62 individuals were identified as Priority 3, some of whom would also require AAC systems to augment or enhance their existing communication skills. It was of concern that AAC had been provided to only 39 individuals. This amounted to only 13% of those identified by the facility to be of highest priorities for communication supports, many of whom would require AAC. One individual with AAC (Individual #294) was not included in the Master Plan and, as such, was not assigned a priority level. There were a number of general use devices throughout the facility. Communication books were developed and placed in meeting rooms to assist with potential communication issues that might occur during an ISP meeting, for example. The meaningfulness and function of the devices appeared to be very appropriate and many were noted to be in use or specific training was occurring to promote use through direct interventions. The clinicians appeared to understand the application and integration of AAC as there were very excellent supports in place, however, more individuals would benefit from AAC and this should be provided in a timely manner. <u>Direct/Indirect Communication Interventions:</u> Generally accepted professional standards of practice for documentation by the SLP related to communication interventions include the following: • Current communication assessment identifying the need for intervention with rationale. • Measurable objectives related to functional individual outcomes included in the ISP. • Routine IPN or other SAP documentation contained information regarding whether the individual showed progress with the stated goal. • Routine IPN or other SAP documentation described the benefit of device and/or	

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		goal to the individual. • Routine IPN or other SAP documentation reported the consistency of implementation. • Routine IPN or other SAP documentation identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. • Termination of the intervention was well justified and clearly documented in a timely manner. Communication-related interventions were listed as provided for 26 individuals. Four intervention sessions were observed during this onsite review (Individual #425, Individual #248, Individual #506, and Individual #126). These sessions were implemented by the SLPA and supervised by the SLP. • The interventions were very functional, each involving training to make simple requests with an AAC device. The monitoring team was impressed with the structure and quality of these. Communication assessments were submitted for six of the individuals listed as receiving communication interventions (Individual #126, Individual #190, Individual #447, Individual #375, Individual #298, and Individual #410). Only four of these had a current communication assessment. It would be expected that any individual who was provided with communication supports and services, particularly direct therapy, would receive an annual assessment or update if a comprehensive assessment had been previously completed. ISPs were submitted for five of these six individuals (no ISP was submitted for Individual #375, though the meeting had been held on 9/7/12). These were reviewed to determine if these interventions were integrated into the annual plan. Comments are below: • Individual #126 (6/6/12): Direct therapy was a recommendation approved by the IDT, however, was not included as a service objective in an action plan. It appeared that this was intended to be diagnostic in nature. When an appropriate AAC system was identified for him, funding efforts would be initiated. Further therapy would be provided pending delivery of the new device. This recommendation should translate to an action plan and there should be routine documentation related to Individual #126's responses, clinical findings, and estimation of time frames required. His comprehensive assessment was dated 8/30/12, nearly three months later. An ISPA should have been held to integrate the findings and recommendations into the plan. There was no evidence of this in his individual record. • Individual #190 (6/6/12): There was no evidence of a recommendation for	

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		direct communication intervention in the assessment dated 10/21/08 nor was there a training objective related to direct therapy in her ISP, though a service objective for training on her Dynavox was listed. This required a clear learning objective for skill acquisition rather than as a service to be provided. She had not had a communication assessment in four years. It would be expected that an individual engaged in direct services would be provided an annual assessment. • Individual #410 (2/8/12): Direct therapy was a recommendation approved by the IDT, however, was not included as a service objective in an action plan. It appeared that this was intended to be diagnostic in nature. The intervention was planned for 15 to 30 minutes, six times weekly. When an appropriate AAC system was identified for him, funding efforts would be initiated and a ISPA would be held per the evaluation. Further therapy would be pending delivery of the new device. This recommendation should be translated into an action plan and there should be routine documentation related to Individual #410's responses, clinical findings, and estimation of time frames required. • Individual #298 (8/21/12): Direct therapy was not a recommendation in the ISP, though psychology recommended continued use of his communication devices to minimize challenging behavior. There were no communication SAPs developed by the IDT. • Individual #447 (6/15/12): Diagnostic therapy and communication-related SAPs were recommended per a comprehensive communication evaluation dated 3/9/12. There were no training objectives or service objective related to communication other than "Individual #447 will functionally operate a Big Mack or other voice output switch." This was a broad outcome and was not measurable. Upon completion of the assessment in March 2012, an ISPA should have been held. The facility intended to begin providing interim assessment updates for individuals who received communication supports. Documentation related to the communication interventions described above was reviewed for the two individuals included in the sample selected by the monitoring team and for whom individual records were submitted (Individual #447 and Individual #298). • Individual #298: There were only two IPNs noted in the individual record. The first was dated 7/27/12. There were no measurable objectives for the overall diagnostic therapy or even for the session on that day. This note did not document any specific data that could be used to track Individual #298's progress. The other note, dated 10/4/12, merely documented a service provided related maintenance of his communication book and lapboard. It was not possible to determine if he was participating in active direct therapy.	

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		• Individual #447: There were a small number of IPNs in the individual record related to communication interventions. Prior to 3/29/12, there were four notes that addressed a pending assessment. The IPN on 3/29/12 was a March 2012 monthly summary that reported the IDT had approved diagnostic therapy on 3/15/12, and seven other statements related to reasons why Individual #447 had not been seen for therapy during that month. There was no evidence that he had participated even one time that month. There were no subsequent notes until 4/20/12 when it was documented that talking icons were added to his lap tray for use to request help or a Coke. The SLP stated that she would leave them attached and check on them on Monday. There were no further IPNs related to communication through 10/29/12. There was no evidence of follow-up on the effectiveness of the talking icons. Additional documentation was requested for individuals participating in direct therapy including Individual #592, Individual #352, Individual #425, Individual #542, and Individual #285. • Individual #285: He had a current communication assessment dated 2/22/12. An SAP was recommended related to a communication program developed by the SLP. An ISPA was held on 3/26/12 to integrate this into his ISP. This was not within the timeframe of 30 days after the assessment. There was no evidence of an update for his ISP held on 6/21/12. Documentation was on a communication skills SAP progress note form. • Individual #542: There was no communication assessment submitted. A progress note written on 2/16/12 indicated that the SLP was beginning programming with his communication builder. A note dated 4/16/12 indicated that his last speech evaluation had been on 12/10/10 and that none of the recommendations had been implemented since that time. There was no evidence of the rationale for beginning programming in February 2012 and no rationale for not providing a current assessment. His ISP was dated 1/2/12 and the action plan indicated that he would continue a service objective to learn to use his communication builder. This type of program should not be a service objective, but rather an SAP with measurable objectives integrated into the ISP. • Individual #352: There was no communication assessment submitted. There were a couple of ISPAs to add communication programming to her ISP. There was documentation via IPNs related to these. There was only one SAP progress note written for July 2012. On 8/14/12, an ISPA was held to discontinue therapy due to the implementation of a new SAP for DSP implementation. There was insufficient rationale documented for discontinuing this intervention. • Individual #425: There was no communication assessment submitted. There was no SAP in his ISP dated 6/25/12. Communication skills SAP progress notes,	

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		however, were submitted for September 2012 and October 2012. There were three measurable objectives, but no rationale for this intervention. • Individual #592: There was no communication assessment submitted. There was no SAP in his ISP dated 1/30/12/12. A communication skills SAP progress note was submitted for October 2012. There were three measurable objectives, but no rationale for this intervention. The therapists are commended for their overall efforts to provide effective communication supports and services. The therapists may consider "backing into" assessments by initiating therapy (documented via a progress note), conducting an ISPA to integrate a SAP into the ISP, and providing consistent and effective documentation of progress toward specific measurable objectives, including the elements outlined above. The information gleaned from this process will provide a great deal of data for a communication assessment to be completed more on the backside of this process. This will only be effective, however, if the documentation is thorough and consistent. Indirect communication supports were provided for a number of individuals in the manner of monitoring of communication AAC devices. This was accomplished through PNMP monitoring completed by the PNMPCs. There was no evidence of effectiveness monitoring conducted and documented by the therapy clinicians. This requires assessment and analysis and cannot be completed by a non-licensed paraprofessional, such as and tech or PNMPC. The self- assessment reported that 375 monitoring tools for communication had been completed and reviewed. This number was much higher than the documentation submitted. The self-assessment further stated that 80% of the communication systems reviewed were functional and adaptable to a variety of settings. As stated above, this was a judgment of effectiveness and could not be completed by a non-licensed staff. Further discussion of monitoring follows in R4 below. <u>Competency-Based Training and Performance Check-offs</u> New employees participated in NEO classroom training prior to their assignment in the homes. The content was limited to general information about AAC, but there was no evidence of hands-on learning with the devices (though this was reportedly added). There was no content related to communication strategies for staff roles as communication partners. The schedule submitted outlined that two hours were allotted for deaf awareness and hearing aid training with no other time slot identified for communication or AAC. This amount of time was sorely inadequate to familiarize staff with AAC systems and their use, teach the necessary skills, provide opportunities for active practice of the skills, and teach strategies for effective communication partners. Three to four hours is the minimal time needed to ensure that staff can have the adequate time to absorb the information presented, practice the application of concepts learned, and demonstrate competency. A communication module of annual retraining	

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		had been added to the existing curriculum. Additional training for the Active Treatment Coordinators was provided by an SLP related how to use and apply AAC. This was initiated as it had been observed that staff typically tended to use the AAC devices for programming only rather than as means to communicate throughout the day and across settings. Specific eating and communication-related re-training had been provided in Castle Pines in June 2012 that included pre- and post-testing. This was not skills-based competency, but was a multiple choice and true/false test. The curriculum was not submitted, so it was not known if there were active practice learning opportunities for the staff participants. Other training related to use of communication posters and the Express One device were offered on multiple occasions for Homes 557A and B and 559A and B. Much of the interaction of staff with individuals observed by the monitoring team was specific to a task, with little other interactions that were meaningful. Sometimes, there was a tremendous amount of staff talking to/at the individuals during activities, but without appearing to understand how to facilitate better interaction, engagement, and participation with the individuals. Therapy clinician involvement in the programming sites was initiated in May 2012 and should continue, ideally in an expanded manner. The following should be considered: • Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities (using assistive technology where appropriate) should continue to be a priority. This will only be possible when the clinicians are sufficiently available to routinely model, train, and coach direct support staff and to assist in the development of activities across environments and contexts. • SLPs should participate in co-designing written programs and providing formal training. Implementation should be collaborative with demonstration in real time activities. Basic and individualized communication strategies should be outlined in assessments. These simple strategies or the ability to incorporate assistive technology will not be naturally intuitive for direct support professionals. They will require modeling and coaching. • Group and individual activities should be routinely co-directed by speech clinicians and DSPs in the homes, work, and day program environments, so that the clinicians can model how to appropriately use these strategies during the activities to expand and enhance staff's partnering skills as well as to expand and enhance active participation of the individuals via communication. • Also, further collaboration with OT and PT in this capacity will further promote functional and meaningful activities for individuals.	

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		This provision continued to be in noncompliance. The clinicians had effective knowledge and skills to conduct appropriate assessments and to establish appropriate communication supports and AAC systems. ISPs, however, lacked adequate descriptions of how individuals communicated and staff strategies for use as communication partners. Integration of communication supports and services was not consistently evident. While the systems in place for individuals were generally excellent, as functional and adaptable communication systems, there were just too few provided. The number of individuals participating in direct therapy was improved since the previous review, but documentation was inconsistent and did not meet generally accepted professional standards of care. Expanded staff supports for the implementation of communication programs and AAC systems is needed.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	<u>Monitoring System</u> Monitoring of communication supports was provided (and documented) with the PNMP Compliance Monitoring form. These were used to evaluate staff knowledge regarding the required supports, the presence and condition of the supportive equipment, and the appropriate implementation of the supports. The frequency of this monitoring was not made clear to the monitoring team, but should be based on prioritized communication needs. The self-assessment reported that 375 monitoring forms related to communication had been completed and reviewed. Completed monitoring forms were requested related to communication for the month prior to the onsite review. Forty-four forms for 18 individuals were submitted. These numbers were different from the findings in the self-assessment. Findings of the forms that were submitted indicated noncompliance in three key areas: • The equipment was present, working and utilized: 18% • Plan was performed as written: 25% • Staff was not trained on the plan: 75% Moreover, the monitoring forms did not reflect any action taken to address these items. In fact, 21 of the forms reported that "staff were not trained" as the only error, resulting in an overall score of 90%, and thereby found to be "in compliance." Instead, these items should be identified as a system problem and a specific action plan implemented to remedy this. At the time of this review, the previous role of the PNMPCs was changed due to inconsistencies in their findings with those of the therapy clinicians. By report, compliance was found to be much higher by the PNMPCs and was believed to be	Noncompliance

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		inaccurate. By report, the clinicians identified more issues related to staff compliance and, as such, the concerns noted above are likely even more significant. Monitoring findings were not documented in the individual record or integrated with the ISP review process. The SLPs did not reference these findings in their annual assessments or outline the necessary frequency of monitoring needed. Monitoring of communication programs and systems should be based on level of need 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. Evaluation of the frequency and consistency of implementation of communication supports and programs was another key indicator that was not reported. A tracking log for communication monitoring conducted from 1/30/12 to 4/30/12 and 10/1/12 to 10/31/12 was submitted and reflected very limited compliance monitoring conducted during those periods. For example, only six individuals had been monitored once in the three-month period. Thirty monitoring forms were completed for only 19 individuals in October 2012. Some of these individuals were monitored numerous times, others only once, and the majority of individuals at LSSLC had not been monitored at all. This provision continued to be in noncompliance. There did not appear to be a system of routine monitoring conducted to ensure appropriateness of the communication supports provided and that they were implemented correctly and consistently. The existing system of compliance monitoring was in transition as the role of the PNMPCs had changed and a revised system was not yet in place.	

Recommendations:

1. Ensure that factors related to community placement are addressed for each individual that, minimally identify what specific supports and services would be needed for the individual when living in the community (R2).

2. Develop a system to conduct assessment audits to establish and maintain competency, form the basis for peer review and drive training and continuing education for the speech clinicians (R2).

3. Evidence of discussion of the use of a Communication Dictionary as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who were nonverbal should be addressed in the communication assessment and reviewed routinely throughout the year (R2).

4. Develop guidelines and training for QDDPs as to how to integrate communication-related information into the ISP (R3).

5. Develop guidelines for documentation of communication supports and services to improve content and consistency (R4).

6. Evaluate NEO and other communication training to ensure that adequate time is allotted to ensure effective opportunities for presentation of content and opportunities for participants to practice skills required to implement communication programs and to be effective communication partners in the individuals' natural environments (R3).

7. Monitoring of communication supports and services should be based on need. This should address the consistency of implementation and the effectiveness of these, in addition to condition of any AAC devices or systems (R4).

8. 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).

9. Continued staff training and modeling are indicated to ensure appropriate and consistent implementation of recommended AAC systems (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 #466, Individual #31, Individual #479, Individual #4, Individual #368, Individual #43, Individual #36, Individual #298, Individual #488, Individual #549, Individual #262, Individual #121, Individual #540, Individual #431, Individual #252, Individual #311, Individual #134, Individual #562, Individual #117 o Skill Acquisition Plans (SAPs) for: • Individual #131, Individual #549, Individual #262, Individual #121, Individual #540, Individual #431, Individual #252, Individual #311, Individual #134, Individual #562, Individual #117, Individual #34 o Reviews of SAP progress for: • Individual #549, Individual #262, Individual #121, Individual #540, Individual #431, Individual #252, Individual #311, Individual #134, Individual #562, Individual #117 o Functional Skills Assessment (FSA) for: • Individual #549, Individual #431, Individual #252 o Personal Focus Assessment (PFA) for: • Individual #549, Individual #431, Individual #252, Individual #117 o Vocational assessments for: • Individual #549, Individual #431, Individual #252, Individual #117 o Positive Assessment of Living Skills (PALS) for: • Individual #117 o Dental desensitization plans for: • Individual #34 o Section S Self-Assessment, 10/22/12 o Section S Action plans, 10/22/12 o A list skill training provided in the community, undated o Graphs IOA and data reliability from 11/11 to 8/12 o Medical and Dental Desensitization Pilot Plan, undated o Key Performance Indicator (KPI): Active Treatment/Active Engagement, dated October, 2012 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 who were eligible for educational services, including their assigned school and hours of attendance, 10/25/12 o IEPs, progress notes, and ISPs for • Individual #305, Individual #477, Individual #402

	o MOU between LISD and LSSLC, 8/20/12 o LISD classroom schedule and educational topics for LSSLC on campus classroom o Description of the summer camp program 2012 o Summer camp 2012 attendance information <u>Interviews and Meetings Held</u>: o Luz Carver, QDDP Coordinator and LSSLC Liaison to LISD o Delaina Dearing, RTT IV o Suzanne McWorter, QDDP Coordinator Assistant o Robin McKnight, M.A., Supervising Psychologist and Behavior Analyst I o Lisa Curington, Director of Employment and Day Services o Mary Gill, Assistant to Ms. Carver <u>Observations Conducted</u>: o Dental /medical desensitization meeting o SAP implementation for: • Individual #310, Individual #471, Individual #542 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. o LISD classroom on the LSSLC campus o Pre-ISP meeting for Individual #410
	Facility Self-Assessment: Overall, LSSLC's self-assessment included some relevant activities in the "activities engaged in" sections that were the same as those found in the monitoring team's report. The monitoring team believes, however, to most useful, the self-assessment should include activities that are identical to those the monitoring team assesses as indicated in this report. For example, S1 of the self-assessment included a review of the necessary elements of SAPs and engagement, which are topics that are included in the monitoring team's review of S1. Not all activities described in the self-assessment, however, were consistent with what the monitoring team reviewed. For example, S1 of the monitoring team's report also addressed the need for a clear rationale, a plan for generalization and maintenance, a review of the training methodology, and desensitization plans, which were not addressed in the facility's self-assessment. The monitoring team suggests 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, and the monitoring team's report. 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 facility's 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 suggests that the facility establish, and focus its 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 no items of this provision of the Settlement Agreement were found to be in substantial compliance, there were improvements since the last review. These included: • Increase in the number of SAPs that included an acceptable plan for maintenance and generalization (S1) • Continuous progress in pretreatment sedation reduction (S1) • Established improved engagement as key performance indicator for the facility (S1) • Increase in the percentage of SAPs reviewed that showed progress (S1) • Increasing activities to support the educational services for individuals by the local ISD (S1) The monitoring team suggest that the facility focus on the following over the next six months: • Ensure that each SAP contains a rationale for its selection that is specific enough for the reader to determine that it was practical and functional for that individual (S1). • Ensure that each SAP has a plan for maintenance and generalization that is consistent with the definitions below (S1) • Track engagement across all treatment areas, review trends, establish acceptable levels of engagement in each treatment area (S1) • Document how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans (S2) • Ensure that measures of skill training in the community are accurate, 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)

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision required an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at LSSLC. As discussed in detail below, more work needs to be done at the facility to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance with this provision. <u>Skill Acquisition Programming</u> 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/preference. The monitoring team reviewed 46 SAPs across 12 individuals. In three of the SAPs reviewed, no rationale was provided (i.e., Individual #562's SAP of applying lotion, washing hair, and making her bed). In 20 of the 43 SAPs reviewed with a rationale (47%), the rationale appeared to be based on a clear need and/or preference. This represented a slight decrease from the last review when 52% of the rationales reviewed appeared to be based on a clear need and/or preference. Examples of acceptable rationales were: • The rationale for individual #262's SAP of playing the stick bells indicated that she had an interest in listening to music, and this SAP would enable her to make her own music. • The rationale for Individual #117's SAP of choosing a community outing was that participating in more community outings would provide opportunities for him to increase his socialization and promote greater integration in his community. On the other hand, the following is an example of a rationale that was judged to not be specific enough for the reader to determine if it was practical and functional for the individual:	Noncompliance

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		• The rationale for Individual #311's SAP of pointing to his name on documents was he "will need to know how to spot his name on documents." LSSLC should ensure that each SAP rationale is specific enough for the reader to understand that the SAP was practical and functional for that individual. Once identified, skill acquisition plans need to contain some minimal components to be most effective. The field of applied behavior analysis has identified several components of skill acquisition plans that are generally acknowledged to be necessary for meaningful learning and skill development. These include: • A plan based on a task analysis • Behavioral objectives • Operational definitions of target behaviors • Description of teaching behaviors • Sufficient trials for learning to occur • Relevant discriminative stimuli • Specific instructions • Opportunity for the target behavior to occur • Specific consequences for correct response • Specific consequences for incorrect response • Plan for maintenance and generalization, and • Documentation methodology The SAP training sheets contained all of the above components. As discussed in the last report, the maintenance and generalization plans, however, did not consistently reflect the processes of maintenance and generalization. A generalization plan should describe how the facility plans to ensure that the behavior occurs in appropriate situations and circumstances outside of the specific training situation. A maintenance plan should explain how the facility would increase the likelihood that the newly acquired behavior will continue to occur following the end of formal training. Overall, 16 of the 46 SAPs reviewed (35%) included a plan for generalization that was consistent with the above definition, and three (7%) included a plan for maintenance that was consistent with the above definition. These represented improvements from the last report when no SAPs contained acceptable generalization plans and 5% contained an acceptable plan for maintenance. An example of a good generalization plan was: • The plan for generalization in Individual #121's music SAP stated that he will listen to music at home and in the community.	

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		An example of an unacceptable plan for generalization was: • The plan for generalization (it was combined with maintenance) for Individual #262's social skills SAP stated that she "…will meet criterion for one month and maintenance for three consecutive months to ensure she has learned the skill." An example of a good maintenance plan was: • The plan for maintenance in Individual #252's money management SAP stated that he continue to state the amount of money needed to buy an item (after the SAP had been achieved). An example of an unacceptable maintenance plan was: • The plan for maintenance in Individual #311's community SAP which stated he, "…will show progress for one month and show maintenance for two consecutive months to ensure adequate understanding of the training objective." Sixteen SAPs reviewed combined the maintenance and generalization plans into one plan. Since maintenance and generalization are different processes, they typically cannot be addressed in the same plan. It is recommended that all SAPs contain generalization and maintenance plans that are consistent with the above definitions. It is also recommended that the facility ensure that all generalization and maintenance plans be written as plans (i.e., include how maintenance and generalization will be accomplished). As suggested in the last report, the facility attempted to expand the methodology for training of SAPs to forward (e.g., Individual #549) and backward chaining (e.g., Individual #34). It was not clear, however, from reading the task analysis or training instructions, or observations of SAPs being implemented (see S3), that the SAPs that identified the instructional method as backward training actually represented the correct use of backward chaining (i.e., guide the individual through the initial steps of the task analysis, and start training with the last steps of the task). It is recommended that the facility staff ensure that they are correctly using forward and backward chaining, and continue to attempt to expand the range of training methodologies. The monitoring team was encouraged by LSSLC's continued use of the SAP peer review meeting (i.e., a weekly interdisciplinary meeting where selected SAPs are reviewed to ensure they contain all of the above components), however, it appeared that a significant barrier to more rapid progress in SAP development is the absence of expertise in the writing of SAPs. Compliance with this aspect of S1 requires expertise in the design of skill acquisition plans and various training methodologies; a skill that is often found in professionals with a special education background, or certified applied behavior analysts.	

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		The facility attempted to address this by adding a certified behavior analyst (BCBA) from the psychology department to the SAP peer review committee. Although the QDDP coordinator (the chairperson of the committee) indicated that this addition had been helpful in designing effective SAPs and training methodology, the monitoring team believe that a full time individual with expertise in SAP develop and training methodology will be necessary in a facility the size of LSSLC. It is suggested that the facility consider acquiring (either through the hiring of new employee or enrolling a current employee in the BCBA program describe in section K) an individual with training and expertise in developing effective skill acquisition plans. <u>Desensitization skill acquisition</u> The facility continued to make progress in this area. Desensitization plans designed to teach individuals to tolerate medical and/or dental procedures were developed by the psychology department. As discussed in previous reports, the psychology department had recently developed an assessment procedure to determine if refusals to participate in dental exams were primarily due to general noncompliance, or due to fear of dental procedures. A treatment plan based on the results of the assessment (i.e., a compliance program or systematic desensitization plan) was then developed. The facility also continued to use its newly developed simulated dental clinic to gradually introduce individuals to the sights and sounds of the dental clinic. The interdisciplinary team that reviewed these plans and other interventions to decrease the use sedating medication for routine dental/medical procedures, discussed in the last report, continued to meet regularly. A list of dental desensitization plans developed indicated that the majority of plans were informal plans designed to increase compliance and that one desensitization plan was developed since the last onsite review. A review of that dental desensitization plan written since the last review indicated that it appeared clinically sound, however, it did not include all of the components identified as necessary for a SAP (see detailed description of those components above). It is recommended that dental compliance and dental desensitization plans be incorporated into the new SAP format. Outcome data (including the use of sedating medications) from desensitization plans, and the percentage of individuals referred from dentistry with treatment plans, will be reviewed in more detail in future site visits. LSSLC was continuing to make good progress in this area. <u>Replacement/Alternative behaviors from PBSPs as skill acquisition</u> As discussed in the last report, LSSLC included replacement/alternative behaviors in each PBSP. The training of replacement behaviors that require the acquisition of a new	

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		skill should be incorporated into the facility's general training objective methodology, and conform to the standards of all skill acquisition programs listed above. Communication and language skill acquisition No SAPs for of the 12 individuals reviewed (0%) had skill acquisition programs targeting the enhancement or establishment of communication and language skills. This represented a decrease in the number of communication SAPs at the facility from the last review when 5% of the SAPs reviewed had skill acquisition programs targeting the enhancement or establishment of communication and language skills. It is recommended that the facility expand the number of communication SAPs for individuals with communication needs (also see section R). Service objective programming 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 section F for a review and discussion of service objectives). Engagement in Activities 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 at the facility was measured by the monitoring team in multiple locations, and across multiple days and times of the day. Engagement was measured simply by scanning the setting and observing all individuals and staff, and then noting the number of individuals who were engaged at that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. Specific engagement information for each home and day program is listed in the table below. LSSLC continues to attempt to improve individual engagement. In addition to continuing the efforts documented in the last report, the facility recently included engagement as a Key Performance Indicator (KPI). As a part of this initiative, efforts will be focused on two homes (561A and 524) that have consistently demonstrated the lowest engagement at the facility. The efforts to improve engagement in these homes will focus on the collection of baseline data, development of robust active treatment schedules, re-training of staff, and increasing the presence of supervisory, ATC, and administrative staff in the two trial homes. The monitoring team is eager to learn of the results of these efforts in	

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		the next onsite review. The monitoring team consistently observed staff attempting to engage individuals in active treatment at LSSLC. As found in past reviews, the ability to maintain individuals' attention and participation in the activities, however, varied widely across treatment areas. For example, in the Building 510 day program, the staff consistently engaged individuals in several lively small group discussions. In this treatment area, the monitoring team also noted participation of a variety of staff (e.g., QDDPs) encouraging individual engagement. Staff and individuals both appeared to be fully engaged in the activities. On the other hand, in other treatment areas, staff and individuals appeared less enthusiastic with the process of active treatment. Finally, the monitoring team noted a general increase in the quality of individual engagement and an increase of presence of supervisory and active treatment coordinators on the second day relative to the first day of the review of engagement in day and residential treatment sites. The table below documents this variability across settings. The average engagement level across the facility was 48%, about the same as that found in the last review (i.e., 47%). An engagement level of 75% is a typical target in a facility like LSSLC, indicating that the engagement of the individuals at LSSLC continued to have room to improve. The QDDP coordinator assistant indicated that the facility had recently modified the operational definitions of engagement. It is recommended that the facility track engagement across all treatment areas, review trends, establish acceptable levels of engagement in each treatment area, and attempt to achieve those levels (S1). <u>Engagement Observations</u>: Location / Engaged / Staff-to-individual ratio 506 — 1/7 — 3:7 506 — 2/11 — 3:11 520 A — 2/3 — 2:3 520 B — 1/1 — 2:1 561 B — 2/4 — 1:4 561 B — 4/5 — 2:5 561 B — 3/3 — 1:3 561 B — 1/4 — 1:4 561 B — 1/3 — 2:3 557 A — 3/5 — 1:5 549 B — 4/10 — 4:10 549 B — 3/4 — 1:4	

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549 B	0/2	0:2
549 B	3/4	2:4
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
Large Workshop	5/17	4:17
Large Workshop	3/10	3:10
510	3/6	2:6
510	2/3	1:3
510	6/8	3:8
510	4/4	2:4
Rec/Music/A and C	2/3	2:3
560	1/5	1:5
560	0/5	1:5
549 D	1/6	1:6

Educational Services

There was continued progress in the work of the LSSLC public school liaison and her staff in supporting the individuals at LSSLC to receive educational services to which they were entitled. Twenty-two individuals were students; 12 were at the LISD high school, five were at the LISD middle school, and five were assigned to the LISD classroom on the LSSLC campus. This compared with 26, 16, three, and seven individuals, at the time of the last review, respectively.

LSSLC and the Lufkin Independent School District (LISD) continued to have a good working relationship. An MOU was recently signed that memorialized many of the responsibilities of the ISD and the facility. Frequent communication was reported to occur by the LSSLC liaison. Moreover, LISD teachers were reportedly on the LSSLC campus regularly. Since the incident in which a student became seriously ill at school and later died, LISD nurses were now more involved in communication with LSSLC nurses and a written procedure was in place.

The number of times students were returned from school to the facility continued to be monitored and data on the frequency was being graphed by the LSSLC liaison and her staff. Data were being included in presentations to the QAQI Council. This was good to see.

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		LSSLC demonstrated actions to incorporate the LISD IEP into the individual's ISP and home life at the facility. For example, during the pre-ISP meeting for Individual #410, the IDT talked about including a math skills action plan in his ISP that would, thereby, be integrated with what was occurring at LISD. Further, in each of the ISPs reviewed, there were comments about the integration of the IEP and the ISP (a small section of the ISP was specifically devoted to this). The monitoring team, however, could not determine if LISD progress reports were regularly reviewed by the QDDP and the IDT. The LSSLC liaison reported that the progress reports get sent to the record clerk and the QDDP can see it in the active record. For next review, the facility should demonstrate how the LISD progress reports are reviewed by the IDT (a special ISPA meeting would not be required, unless there were specific concerns that required the IDT to meet). Individuals are entitled to a commensurate school day and LSSLC had worked with LISD to accomplish this for 16 of the 17 students who attended LISD programs in town. They were, however, working with the LISD to develop a commensurate day for the one other individual (Individual #475). The five students who attended the LSSLC on campus LISD classroom were also entitled to a commensurate school day. Even though LISD offered this classroom, attendance was often low. For example, during one observation by the monitoring team, three individuals were scheduled to be there, but only one was present. This was mentioned in the previous report and the monitoring team again recommends that attendance be tracked and charted. Many of the educational activities observed by the monitoring team did not appear to be appropriately challenging, functional, or age appropriate. The monitoring team recommends that the facility collaborate with the classroom teacher and the LISD special education director to find ways to make the classroom activities more age appropriate, functional, and perhaps thereby more inviting to these students. This may lead to better attendance and ultimately to attending school in town with the other students. LSSLC continued to raise the question of extended school year, when appropriate. The facility staff, however, took matters into their own hands by developing a "Summer Camp" for all of the students for three months over the past summer. The liaison reported that it was a great success. It was a full day program, with outdoor activities in the morning, and classroom-based special activities every afternoon. The monitoring team was impressed by this initiative. In the past, at times, an LSSLC psychologist was assigned to work with the LISD staff. The	

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		LSSLC liaison reported that a graduate intern who worked under the supervision of the facility's director of psychology, was filling this role, and very successfully. This seemed like a reasonable way for LSSLC to provide this additional support to its student.	
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. This item was rated as being in noncompliance because, at the time of the onsite review, it was not clear that assessments were consistently used to develop SAPs. At the time of the onsite review, the facility was completing the transition from the use of the Positive Adaptive Living Survey (PALS) for the assessment of individual skills to the Functional Skills Assessment (FSA). The LSSLC also used a vocational assessment, and the personal focus assessment (PFA) to assess preferences. The monitoring team reviewed three FSAs (Individual #117 still had a PALS rather than a FSA), four PFAs, and four vocational assessments. The FSA appeared to be an improvement over the PALS in that it provided more information (e.g., necessary prompt level to complete the skill) regarding individual's skills. No assessment tool, however, is going to consistently capture all the important underlying conditions that can affect skill deficits and, therefore, the development of an effective SAP. Therefore, to guide the selection of meaningful skills to be trained, assessment tools often need to be individualized. The FSA may identify the prompt level necessary for an individual to dress himself, but to be useful for developing SAPs, one may need to consider additional factors, such as context, necessary accommodations, motivation, etc. For example, the prompt level necessary for getting dressed may be dependent on the task immediately following getting dressed (i.e., is it a preferred or non-preferred task), and/or the type of clothes to be donned, whether the individual chooses them or not, etc. Similarly, surveys of preference can be very helpful in identifying preferences and reinforcers, however, there are considerable data that demonstrate that it is sometimes necessary to conduct systematic (i.e., experimental) preference and reinforcement assessments to identify meaningful preferences and potent reinforcers. There was no documentation of the use of individualization of assessment tools to identify SAPs. Additionally, review of ISPs and assessments did not consistently document how assessments impacted the development of programs. The following were typical: • Individual #431's had a SAP to brush teeth for three minutes, however, his FSA indicated that he was independent in toothbrushing. There was no comment in	Noncompliance

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		his FSA that he could brush his teeth, but doesn't or that he not did not brush long enough. This appeared to be a good example of how assessments need to be individualized to be most useful to identify SAPs. • Individual #252 had a vocational SAP to remain at his workstation for up to three hours per day, however, his vocational assessment stated that he was able to work four to six hours a day. There was no explanation in his vocational assessment or ISP of why his assessment indicated he had a skill that was being trained in a SAP. • Individual #549 had a medication SAP, but no mention in her ISP of any assessment results (e.g., FSA or PSA) that suggested that this was a practical SAP for her. Finally, Individual #549's FSA was not complete in that it did not have completed summary sections or recommendations section. The facility should ensure that assessments are consistently used and documented to select individual skill acquisition plans.	
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 needs to demonstrate that data based decisions concerning the continuation, revision, or discontinuation of SAPs consistently occurs, and that SAPs are consistently implemented with integrity, before this item is rated as in substantial compliance. QDDPs at LSSLC summarized SAP data monthly and presented those data at quarterly meetings. At the time of the onsite review, the facility was beginning to transition to monthly meetings. The QDDPs graphed SAP outcome data to improve data based decisions regarding the continuation, modification, or discontinuation of SAPs. Ten quarterly reviews were reviewed to determine compliance with this provision item. The data from two (i.e., Individual #311, and Individual #262) of those reviews included	Noncompliance

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		less than three data points and, therefore, trends could not be identified, and those data were not included in this review. The remaining 39 SAPs across eight individuals indicated SAP progress or the achievement of sustained high levels (i.e., above 90%) of SAP performance in 21 or 54% of SAPs reviewed. This represented an increase from the last review when 44% of SAPs reviewed showed progress. Additionally, there was some evidence of data based decisions concerning the discontinuation of SAPs (e.g., Individual #540's SAP of manipulating a joystick, Individual 117's SAP of making coffee). There were, however, several examples of SAPs where it appeared the individual achieved the objective stated in the SAP, but continued working on the old SAP without an explanation (e.g., Individual #252's SAP of locating his birthday on a calendar, Individual #431's identifying the items that did not belong, Individual #134's SAP of putting appropriate amount of food on his spoon). Additionally, there was no action documented for 18 SAPs reviewed that showed no progress. It is recommended that data based decisions be documented for the continuation, modification, or discontinuation of all SAPs at LSSLC. The monitoring team noted that many of the reviews used different formats. As the facility is transiting to the new monthly review format, it is suggested that a standardized review format may be helpful in ensuring that data based decisions are used. As during the last review, the implementation of SAPs was observed by the monitoring team to evaluate if they were implemented as written. The results were mixed: • Individual #542's SAP of turning on the radio appeared to be conducted as written, and staff were able to explain how to implement the plan. • Individual #310's SAP of handwashing was referred to as backward chaining, that is, guiding through early steps and training on steps one at a time from the last (e.g., throwing the used paper towel in the trash) to the first (e.g., turn on the water). Backward chaining can be a very effective training methodology for SAPs that have several steps and the steps naturally follow each other (e.g., handwashing). The SAP observed by the monitoring team, however, was not implemented as backward chaining. • When reviewing day programs, the monitoring team asked if anyone was planning to conduct SAPs at the 510 building. The response was that there were several SAPs scheduled at that time, but none of the SAP data sheets were available, so they could not conduct any skill acquisition programming that morning. • Record reviews (see section V) indicated that some data were missing from SAPs. This was considered to be an error by the URCs because staff who implemented SAPs were supposed to make a notation as to why a SAP was not	

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		implemented on any day on which it was supposed to be implemented (i.e., similar to what is required on MARs). The only way to ensure that SAPs are implemented and documented 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.	
	(b) Include to the degree practicable training opportunities in community settings.	As discussed in the last review, the majority of individuals at LSSLC participated in various recreational activities in the community, and the facility appeared to be providing training opportunities in the community. In order to achieve substantial compliance with this provision item, the facility now needs to ensure that measures of skill training in the community are accurate, establish acceptable levels of recreational and training activities in the community, and demonstrate the that those levels are consistently achieved. The facility was tracking the training of SAP objectives in the community. The QDDP coordinator indicated that her review of those data led her to question the accuracy of skill acquisition data in the community, and she was in the process of reviewing them more closely. It is recommended that the facility ensure that the data are accurate, 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 review, one individual (i.e., Individual #252) at LSSLC had supported employment in the community. This was a decrease from the last report when three individuals were reported to have supported employment.	Noncompliance

Recommendations:

1. Ensure that each SAP rationale is specific enough for the reader to understand that the SAP was practical and functional for that individual (S1).
2. It is recommended that all SAPs contain generalization and maintenance plans that are consistent with the above definitions. It is also recommended that the facility ensure that all generalization and maintenance plans, be written as plans (i.e., include how maintenance and generalization will be accomplished) (S1).
3. Ensure that the SAP training methodologies (e.g., backward chaining) are used correctly (S1).
4. Dental compliance and dental desensitization plans should be written in the new SAP format (S1).

5. It is recommended that the facility expand the number of communication SAPs for individuals with communication needs (also see section R) (S1).

6. Track engagement across all treatment areas, review trends, establish acceptable levels of engagement in each treatment area, and attempt to achieve those levels (S1).

7. Ensure and demonstrate that LISD school progress reports are reviewed by the QDDP/IDT (S1).

8. Consider working with the LISD classroom teacher and special education director to improve the activities for students in the classroom that is on campus at LSSLC, and track the attendance of those students who are assigned to this classroom (S1).

9. Ensure that assessments are consistently used and documented to select individual skill acquisition plans (S2).

10. Data based decisions should be documented for the continuation, modification, or discontinuation of all SAPs at LSSLC (S3).

11. Develop a plan to collect and graph integrity data to ensure that SAPs are conducted as written (S3).

12. Ensure that the training in the community data are accurate, 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: <u>Documents Reviewed</u>: 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, March 2012 • Email from state office on 3/7/12 to APCs asking for submission of any comments on draft policy be submitted to state office by 3/16/12 o LSSLC facility-specific policies regarding most integrated setting practices • Client Management-38, Most Integrated Setting Procedures, 9/20/11 o LSSLC organizational chart, 10/9/12 o LSSLC policy lists, October 2012 o List of typical meetings that occurred at LSSLC, undated, likely October 2012 o LSSLC Self-Assessment, 10/22/12 o LSSLC Action Plans, 10/17/12 o LSSLC Provision Action Information, most recent entries 10/19/12 o LSSLC Most Integrated Setting Practices Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 10/29/12 o Community Placement Report, last six months, 5/1/12 through 10/31/12 o List of individuals who were placed since last onsite review (7 individuals) o List of individuals who were referred for placement since the last review (15 individuals) o List of individuals who were referred <u>and</u> placed since the last review (1 individual) o List of total active referrals (18 individuals), as of 11/2/12 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) • Those who requested placement, but not referred due to LAR preference (2 individuals) o List of individuals who were not referred solely due to LAR preference (38 individuals) o List of rescinded referrals (3 individuals) • ISPA notes regarding each rescinding • Special Review Team minutes for each rescinding (none required because the rescinding was due to LAR preference for all 3) o List of individuals returned to facility after community placement and related ISPA documentation (0 individuals returned during this period) 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 (9 of 18 individuals who moved since 10/1/11, i.e., 1 year since placement)

	o List of individuals who died after moving from the facility to the community since 7/1/09 (2 individuals, 0 since the last review) o List of individuals discharged from SSLC under alternate discharge procedures and related documentation (1 individuals) o Graphs of most integrated setting related data, October 2011 through September 2012 o APC weekly reports • Statewide weekly enrollment report (none, none requested by monitoring team) • Detailed referral and placement report for senior management (5, 8/14/12-10/30/12) o Job descriptions for APC, PMM, and transition specialists o Training session on person centered thinking, APC and new PMM attended, 10/16/12 o Variety of documents regarding education of individuals, LARs, family, and staff: • Provider Fair, July 2012 ▪ Announcements, attendance sheets, evaluation information, and summaries • Community tours, 5/29/12 through 10/25/12 (8 for 19 individuals) ▪ ISPA notes (10) • Meetings with local LA (2), 7/26/12, 10/16/12 • New employee orientation (none) • Orientation to new post move monitor and two new transition specialists, 9/19/12 • Sessions with facility staff: (none) • Self-advocacy meeting (none) • Family association meetings (none) • Facility newsletter, information on admission and placement (none) • CLOIP and Permanency Plan tracking sheets, April 2012 through September 2012 o Description of how the facility assessed an individual for placement (from state policy) 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), obstacles were not included, undated o List of individuals who had a CLDP completed since the last review (7 individuals) o Completed checklists used by APC regarding submission of assessments for CLDP that were <u>not</u> within the CLDP, and completed checklists (6 examples) o DADS central office written feedback on CLDPs (none) o For the three statewide monitoring tools for section T: (Living options-15, CLDP-3, Post move monitoring-2, and 3 inter-rater reliability tools) o State obstacles report and LSSLC addendum, October 2011 o PMM tracking sheet, undated o Transition T4 materials for: • Individual #57 o ISPs and assessments in the older styles for: • Individual #490, Individual #43, Individual #310, Individual #245, Individual #288 o ISPAs regarding living options discussions for: • Individual #482, Individual #151, Individual #490 o ISPs in the October 2012 style for:

	• (none) o CLDPs for: • Individual #162, Individual #166, Individual #29, Individual #253, Individual #103, Individual #114, Individual #394 o Draft CLDP for: • (none) o In-process CLDPs for: • Individual #490, Individual #569, Individual #177 o Pre-move site review checklists (P), post move monitoring checklists (7-, 45-, and/or 90-day reviews), and ISPA documentation of any IDT meetings that occurred after each review, conducted since last onsite review for: • Individual #426: 90 • Individual #498: 45, 90 • Individual #525: 45, 90 • Individual #394: P, 7, 45, 90, post-90 • Individual #114: P, 7, 45, 90 • Individual #103: P, 7, 45, 90 • Individual #253: P, 7, 45, 90 • Individual #29: P, 7, 45 • Individual #166: P, 7, 45 • Individual #162: P, 7 <u>Interviews and Meetings Held</u>: o Lisa Pounds Heath, Admissions and Placement Coordinator o Mary Martin Ramsey, Post Move Monitor o Cynthia Thigpen, Amanda Huckabee, Transition Specialists o Community provider agency: D&S Residential, Longview, TX, Vicky Champion house manager, Kimberly Palmer and Beverly Neighbors, administrators o Monitoring team CLDP review meeting for Individual #162 <u>Observations Conducted</u>: o CLDP Meeting for: • (none) o CLDP assessment review meeting for: (none) o ISP Meeting for: • Individual #465, Individual #433 o ISP preparation meeting for: • Individual #410 o Community group home visit for: • Individual #162 o Senior management meeting, referral review, 10/30/12

	o Self-advocacy meeting, 11/1/12
	Facility Self-Assessment The APC had further developed what was presented last time by including a wider variety of activities in the self-assessment. Further, they were numbered and each activity had a corresponding numbered item describing the results of each activity. In that regard, she made progress in that she was trying to look at actual activities and outcomes for each provision item. The monitoring team and the APC spoke at length about the self-assessment during the onsite review. The self-assessment, however, focused almost exclusively on the results of a small sample of statewide self-monitoring tools. As noted throughout this report and in previous reports, there were many problems with these tools. Therefore, basing the self-assessment on an invalid tool means that the results of the self-assessment are likely to be (and often were) incorrect. The APC, therefore, needs to develop tools that are valid and that also line up with the content of what is in the monitoring team's report. This should not be difficult to do. She should go through the report and make an outline of everything that the monitoring team comments upon in each provision item. The APC reported that state office was creating a tool for self-monitoring the CLDP and post move monitoring process. If that new tool is valid and contains relevant items, it may help the self-assessment to be more valid, too. The self-assessment, however, should cover all of section T. Therefore, the new tool might be a part of, but not comprise the entire, self-assessment of section T. The monitoring team reviewed the self-assessment. Overall, it appeared that the APC put a lot of time into completing it. Unfortunately, it did not provide her with a lot of insight into the status of section T. Interestingly, the ratings of substantial compliance and noncompliance were the same as the monitoring team's. This, however, was not due to the conduct of a good self-assessment. It was due to the ratings being the same as given by the monitoring team last time. Further, the activities and outcomes upon which the APC self-rated each provision were not the same as what was looked at by the monitoring team. Therefore, the correlation in ratings was coincidental. For example, in T1a, the APC used the living options monitoring tool for item 1. A reading of section T1a in the monitoring report shows that there were many topics reviewed by the monitoring team that were not in the APC's tool. Moreover, some topics were the same, but were not evaluated for quality, such as whether the transfer was consistent with the determination of professionals. As noted in T1a (and T1b3), the monitoring team looks for determinations of professionals to be in three places: their assessments, during observed living options discussions, and in the written ISP. In T1b1, the statewide self-monitoring tools were again used. The monitoring team, in T1f below, reports that reliability appeared to be low between raters. There appeared to be confusion over when an item should be scored as no versus not applicable. It was also unclear as to how the raters determined whether

	individualized protections were provided. The monitoring team, however, did agree with the APC's finding that few ISPs identified and addressed obstacles to referral and placement. T1b2 should contain items for all nine of the topic areas described in the report (and in previous reports). Some of these items were addressed by the APC, but it would make more sense to have nine subsections, to line up with the subsections in the monitoring report. Similarly, in T1b3 in the report, four topic areas are addressed regarding occurrence and quality of living option discussions, but the self-assessment only commented upon whether a living options discussion occurred. In T1c, the APC self-rated substantial compliance, the same rating given by the monitoring team below, however, the APC did not look at all of the items that the monitoring looked at and reported on in section T1c. In T1d, the monitoring team also looks for whether the assessments adequately focused upon the individual moving to a new home and a new day/employment setting. The self-assessment looked at whether the assessments were completed within 45 days and whether they were comprehensive. It was not clear how the APC determined comprehensiveness, especially given that most of the assessments did not focus on the new settings. Similarly, for T1e, the monitoring team looks at the quality, breadth, and measurability of the ENE supports, not only whether there was a list of ENE supports. Overall, the APC did a nice job of self-assessing T2a. In addition to doing the self-assessment of the completion of the post move monitoring form, the self-assessment should include assessment of whether the proper form was used, if adequate follow-up was conducted by the PMM when needed, and if an ISPA meeting was held following each post move monitoring. The monitoring team recommends that a self-assessment for T2b (implementation of post move monitoring) be done, too. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the APC and believes that the facility was continuing to proceed in the right direction. An improved self-assessment will also lead to a better set of action plans.
	Summary of Monitor's Assessment LSSLC continued to make progress across all of section T. The specific numbers of individuals who were placed and who were in the referral and placement process remained low. The number of individuals placed was at an annual rate of less than 4% (7 placements in the last six months). Approximately 5% of the individuals at the facility were on the active referral list (18 individuals). Fifteen of these 18, however, were referred in the last six months indicating that IDTs may be making more referrals than in the past. The list of individuals not referred solely due to LAR preference contained 38 names (11% of the census).

	Of the 10 individuals who received post move monitoring, 7 (70%) ultimately transitioned very well and appeared to be having great lives. Some of these 7 individuals had difficulty during the first 90 days, but due, in large part, to the tenacity of the PMM and the involvement of the IDT, inadequately provided supports were improved and lifestyles benefited. Of the remaining 3, 2 (20%) were still having transition problems and 1 (10%) was not doing well. Nine of the 18 individuals placed in the past year had experienced one or more untoward events. As discussed with the APC, a simple review should be done for all of these cases to evaluate (e.g., root cause analysis type review) the placement and transition processes to see if anything might be done differently in the future. Note, however, that the problems for all 9 individuals were resolved successfully. The transition home, described in previous reports, was open again. Three women were living in the home, all of whom were at various points in the process for placement in the community. Overall, the home appeared to be running well. Overall, the provision of professionals' opinions regarding most integrated settings had improved. Many of the professionals who conducted the assessments included an explicit statement regarding their opinion about whether the individual could be supported in a less restrictive, more integrated setting. The APC reported that she was starting to address many of the nine activities regarding education of individuals, LARs, and facility staff regarding community living and most integrated setting options. Seven CLDPs were completed since the last review. Overall, the quality of the CLDPs had improved. Most of the improvement was seen in the two most recent of the CLDPs. IDT members continued to be very actively involved in the placement process once an individual was referred. The discharge assessments, however, need to focus upon the individual moving to a new residential and day setting. A CLDP meeting was not held during the week of the onsite review. Therefore, one could not be observed. There were some improvements in the identification of an adequate list of essential and nonessential (ENE) supports. Further improvement was needed. Staff training inservice ENE supports needed more detail. There also needed to be implementation of every important aspect of LSSLC plans (e.g., PBSP, PNMP, dining plans), not only a general statement that the PBSP and PNMP will be implemented. There needed to be clarity as to what the provider needed to do to show evidence that the support was being implemented. No special actions were taken after an individual was referred to ensure that skill acquisition programs were considered and developed based upon the individual's referral to the community. Some important supports might have been overlooked in some CLDPs. Note, however, that even though more work was needed, LSSLC continued to make progress in this area.

	Twenty-two post move monitorings for 10 individuals were completed. This was 100% of the post move monitoring that was required. All 22 (100%) were documented in the proper format, in line with Appendix C. For the most part, the post move monitoring report forms were completed correctly and thoroughly. The new PMM conducted the post move monitoring in a very professional manner, proceeding through all of the items, asking questions, and asking for documentation. She needs to, however, conduct more thorough interviews of each staff, and she needs to raise concerns about what she observes whenever warranted. There was no organized, easily explained quality assurance process as required by this provision. The APC, and other staff in the department, appeared to use the statewide self-monitoring tools regularly. The monitoring team's comments regarding these tools from previous monitoring reports in sections T1f and E remain applicable and should be reviewed by the APC.

#	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	LSSLC continued to make progress across all of section T. This was due, in large part to the leadership provided by the APC, Lisa Pounds Heath, and her experience with most integrated setting practices, knowledge of the facility's individuals and of the community system, and support for her new staff. Further, the APC responded to the comments, suggestions, and recommendations in the previous monitoring report. There was a new post move monitor, and in addition, the two new transition specialist positions were created and filled. The specific numbers of individuals who were placed and who were in the referral and placement process remained low. The number of individuals placed was at an annual rate of less than 4%. Approximately 5% of the individuals at the facility were on the active referral list. Below are some specific numbers and monitoring team comments regarding the referral and placement process. • 7 individuals were placed in the community since the last onsite review. This compared with 8, 13, 9, 8, and 5 individuals who had been placed during the periods preceding the previous reviews. o This continued a decreasing trend. • 15 individuals were referred for placement since the last onsite review. o This compared with 7 and 14 who were newly referred at the time of the previous reviews. o 1 of these 15 individuals were both referred and placed since the last onsite review. o This indicated that IDTs were continuing to make referrals (i.e., at an	Noncompliance

	disabilities.	annualized rate of 8% of the census). • 18 individuals were on the active referral list. This compared with 13, 17, 20, 25, and 17 individuals at the time of the previous reviews. o This indicated that the admissions and placement department had much work to do over the next six months o 2 of the 18 individuals were referred for more than 180 days. ▪ 0 of the 2 were referred more than one year ago. • 2 individuals were described as having requested placement, but were not referred. This compared with 8, 6, 6, and 9 individuals at the time of the previous reviews, respectively. o All 2 were not referred due to LAR preference. o LSSLC had a 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. o It was not reported to the monitoring team as to why the number of individuals had dropped, for example, whether some individuals no longer requested placement, or if the individuals who had requested placement were now on the referral list. • The list of individuals not being referred solely due to LAR preference contained 38 names (compared to 107, 6, 3, and 17 individuals at the time of the previous reviews, respectively). o The APC reported that the number was less than half of what was reported at the time of the last review because the QDDPs were doing a better job in maintaining this list. The monitoring believes, however, that many individuals who met criteria for being on this list were not (e.g., Individual #43, Individual #288). • The referrals of 3 individuals were rescinded since the last review. This compared to 3, 4, and 4 at the time of the previous reviews. o All 3 were due to LAR request. o Even so, as recommended in previous reports, 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 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. o Note that the new ISP process may result in an increase in referrals and, as a result, an increase in the number of rescinded referrals. If this occurs, it should not necessarily be viewed as an increase in failure by the facility. • 0 individuals were returned to the facility after community placement. This	

		compared with 0, 0, and 2 individuals at the time of the previous reviews. • 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, who had run away from their community placements, and/or had other untoward incidents were tracked and provided. These data were being obtained for at least a one-year period after moving. o 9 of the 18 individuals experienced one or more untoward events. o The APC created a spreadsheet listing all of the individuals placed in the past 12 months, with seven columns for indicating if any untoward events occurred. ▪ In addition, she provided a short narrative regarding each of the situations and how each one was resolved. All were resolved satisfactorily. o It was good to see that every situation was resolved successfully. However, a detailed review/root cause-type analysis should be conducted for every occurrence to assess the referral and placement process to determine if anything might have been done differently. In this way, processes can be improved and future problems avoided. ▪ For example, 3 of the 9 individuals were affected by the failure of the chosen provider. The APC might review this case to see if there were any indications that might be now be more evident in retrospect. • 0 individuals had died since being placed since the last onsite review. This compared with 0 at the time of the previous review. o A total of 2 individuals had died since 7/1/09, both in 2011. • 1 individual was discharged under alternate discharge procedures. This compared with 2 at the time of the previous review (see T4). As recommended in previous monitoring reports, the APC started graphs of the above bullets. This was good to see and should be useful to the APC in her review and presentations of her department's activities and progress. These data/graphs should be submitted and included as part of the facility's QA program (see sections E above and T1f below). The monitoring team suggests that APC create a full set of relevant graphs. A list of suggestions is provided below. The printouts can have more than one small graph on each page (e.g., three or four) to make the set of graphs easier to manage for the reader. • Number of individuals placed each month • Number of new referrals each month • Number of individuals on the active referral list as of the last day of each month • Number of individuals on the active referral list for more than 180 days, as of the	

		last day of each month • Pie chart showing the status of all of the active referrals (e.g., CLDP planned, move date set, exploring possible providers). • Number of individuals who have requested placement, but have not been referred, as of the last day of each month. • Percentage of individuals who have requested placement (who do not have an LAR), but have not been referred, for whom a placement appeal process has been completed, as of the last day of each month • Number of individuals not referred solely due to LAR preference as of the last day of each month • Number of individuals who had any untoward event happen after community placement each month • From T1b1 below: number of individuals whose ISPs identified obstacles to referral and placement, and whose ISPs identified strategies or actions to address these obstacles • From T1b2 below: number of individuals who went on a community provider tour each month The transition home, described in previous reports, was open again. Three women were living in the home, all of whom were at various points in the process for placement in the community. Overall, the home appeared to be running well. The facility reported that a review was conducted and the results of this review were sent to the monitoring team after the onsite review. This resulted in five actions to improve the functioning of the transition home. This was good to see and provided an example of positive outcomes that can come from a detailed review and analysis. <u>Other activities</u> None described. <u>Determinations of professionals</u> This aspect of 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 was discussed at length in previous monitoring reports. Primary responsibility for meeting this requirement belongs to the QDDPs and the professionals. Thus, the monitoring team looks for indications in each professional's assessment, during the conduct of the annual ISP meeting, and in the written ISP that is completed after the annual ISP meeting. LSSLC was transitioning to the newest iteration of the ISP process (see section F). As a	

		result, the monitoring team was limited in its ability to review professional determinations. During the week of the onsite review, the first new style annual ISP meetings were held (two). The monitoring team observed these meetings. The resultant written ISPs, however, were not completed (they were not due for 30 days after the meeting). As a result, the monitoring team used its observation of these two annual ISP meetings and one third-quarter ISP preparation meeting, and a review of a sample of ISP documents completed for four annual ISP meetings held in August 2012. The monitoring team understands that the content and processes used in the August 2012 written ISP meetings and documents were to be updated. Nevertheless, the monitoring team provides some comments below and in section T1b1 and T1b3. Overall, status regarding the provision of professionals' opinions had improved. First, for the written assessment updates that were attached to the ISPs, many of the professionals who conducted the assessments included an explicit statement regarding their opinion about whether the individual could be supported in a less restrictive, more integrated (i.e., community) setting. This continued to be the case for most, but not yet all, of the assessments. Typically, nursing, psychology, social work, medical, and habilitation provided an explicit statement. Residential services, vocational/day services, and active treatment services staff provided their opinions in only some of the assessment updates. Some professionals did not provide an explicit statement in any of the ISPs reviewed. Second, in the ISP meeting and ISP preparation meetings observed during the week of the onsite review, community living was discussed at various times during the meeting, and in some of the meetings, professionals were specifically asked to give their explicit opinions. Third, the monitoring team reviewed a sample of completed ISPs and found that there was discussion of living options in every one of them (see T1b3). Within the description, quotes from some professional members were included. In observations and reviews at LSSLC and the other SSLCs, the monitoring team has noted different "approaches" to way professionals give their determinations and opinions. The monitoring team recommends that the facility and state office consider providing more direction to the professionals, so that there is a consistent approach to this requirement. It may be that all three of these aspects of the professional's opinion should be addressed (that is the recommendation of the monitoring team). 1. A description of what supports that individual would need if he or she lived in the community. This, alone, was not really an adequate indication of the professional's opinion. 2. A statement of whether needed supports could be provided in the community,	

		based upon the professional's knowledge of available community supports. 3. A specific declarative statement regarding whether the professional believed the individual should be referred and whether the individual was likely to do well in the community. <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. The facility followed-up to the question raised during the previous monitoring review regarding LAR's questions about whether their loved one could return to LSSLC if a community placement did not work out, including adding it to the quarterly meeting agenda with the local LA (see T1b2 below). There now appeared to be more flexibility in ensuring LARs about this. Also, the QDDP coordinator followed-up on comments in the last report regarding training for QDDPs in handling these difficult placement discussions. As part of the newest ISP process, additional training was being provided to QDDPs. <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 written report each week. Second, once each week, she made a 15-30 minute presentation to senior management. She had further improved this reporting by adding a section regarding individuals at the facility who were likely to be, but were not yet, referred (five individuals at this time). The APC and monitoring team also talked about her reporting on the many successes that individuals have had since moving to the community.	
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 very soon. As noted in previous reports, on 5/16/11, the three monitoring teams submitted a number of comments related to the DADS draft policy for the state's consideration. It was anticipated that the state would address the monitoring teams' concerns in the revised version of the 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	Noncompliance

		will require updating of facility policies to make them in line with the new state policy. Further, at the parties' meetings in July 2012, the parties agreed that the rating for T1b would be based solely on the development of adequate state and facility policies. The sections T1b1 through T1b3 would be considered stand-alone provisions that required implementation independent of T1b or any of the other provision items under T1b. The state and facility had not yet finalized adequate policies related to most integrated setting practices, therefore, the facility remained out of compliance with this provision.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	The newest style ISP process had been brought to LSSLC, but was only implemented for the first time during the week of this onsite review. The new ISP was 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), the identification of individual obstacles (T1b1), and a thorough living options discussion and determination (T1b3). <u>Protections, Services, and Supports</u> The reader should see sections F and S of this report regarding the monitoring team's findings about the current status of ISPs and the IDT's ability to adequately identify the protections, services, and supports needed for each individual. Recently, DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was also found for these three provision items of section F: F1d, F2a1, and F2a3 The seven CLDPs reviewed by the monitoring team indicated that no special actions were taken after an individual was referred to ensure that skill acquisition programs were considered and developed based upon the individual's referral to the community. The monitoring team recommends that, upon referral, the APC and/or transition specialist seek out the IDT, and the active treatment coordinator to talk about what SAPs 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. • For individuals who have been referred, there might be an action plan (set of actions, SAPs) directly related to the individual's upcoming move. <u>Obstacles to Movement</u> Given that a new iteration of the ISP was just underway, the monitoring team's ability to comment on this aspect of this provision item was extremely limited. Going forward, the facility should ensure that obstacles to referral and to placement are appropriately identified and included in the new ISP (the ISP template format included this). Further,	Noncompliance

		there should be an action plan to address whatever obstacle or obstacles were identified. The monitoring team recommends that the next revision to the facility's self-monitoring tool for section T contain a determination of whether the ISP showed that the IDT identified obstacles to referral and placement, and if the ISP included a plan to overcome any identified obstacles. These data could then be incorporated into the data set described in T1a above.	
	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.	Below are the nine activity areas upon which the Monitors, DADS, and DOJ agreed would comprise the criteria required to meet this provision item. The solid and open bullets below provide detail as to what is required. LSSLC was engaging in some, but not all, of these activities. The APC reported (in the self-assessment and in her action plans) that she was starting to address six of the nine activities. It was good to see that the APC was attending to the details of this provision item. <u>1. 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>: There was some progress towards developing an individualized plan in that the newer ISPs described activities the individual and/or LAR would take over the upcoming year, such as visiting some community providers. All three of the above open bullets, however, were not included in any of the ISPs. This may require an additional prompt in the ISP or standard expectations about what is in an action plan for community living. Some ISPs had an action plan with activities and objectives that was titled "Transition to a less restrictive setting." This could be included in all ISPs and meet the requirement of the third open bullet above. <u>2. 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 APC made progress regarding the provider fair. The fair was held in July 2012. Data collected showed that 15 different providers attended, along with 5 LA staff. Further, 112 individuals and 104 staff attended, but only 2 family members attended. Evaluations were received from 54 attendees, mostly from LSSLC staff. Positive comments were about the providers and the high level of participation. Suggestions centered primarily on making it so that more family members would attend. The APC reported that she was considering holding two	Noncompliance

		provider fairs over the upcoming year. During the next onsite review, the APC should report on what she was planning for next year's provider fairs and how the data and responses received this year affected what is planned for next year. 3. Local MRA/LA • Regular SSLC meeting with local MRA/LA LSSLC status: The APC maintained a good working relationship with the local authority. Two meetings occurred since the last review. These were two quarterly meetings (July 2012, October 2012). The APC provided documentation regarding these meetings. The topics were very relevant to most integrated setting practices. 4. 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 LA CLOIP workers. 5. 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: The APC continued to struggle with creating a manageable system regarding tours of community providers. Since the last review, there were 8 tours for a total of 19 individuals. This compared with 23, 4, 39, and 40 individuals who had been on community tours during the six months prior to each of the previous monitoring reviews. ISPA information was provided for 10 of the 19 individuals and indicated a range of responses from interested and happy to non-responsive. The APC reported that she now planned to arrange tours by going from home to home at LSSLC, so that every individual could be considered for a tour. This seemed to be a good idea. The additional of the transition specialists may make this more likely to be successful. As the APC moves forward, she should consider the following: o The staff's report of the individual's experience needs to go the IDT, so that it can be used by the team for planning purposes o A tracking system is needed so that the APC knows if all individuals for whom a tour is appropriate indeed went on a tour. The facility staff should understand that a tour is an activity that every individual should have access	

		to, but it is not one that must occur for every individual because, for some, it may be counter-therapeutic. o Try to assess the effects of tours, such as whether tours result in referrals. 6. Visit friends who live in the community LSSLC status: LSSLC was not yet implementing this activity in any organized manner. 7. Education may be provided at • Self-advocacy meetings • House meetings for the individuals • Family association meetings or • Other locations as determined appropriate LSSLC status: The rights officer was new to his role and was working on improving attendance and participation. No other educational activities were described or reported. There were no weekly house meetings. 8. A plan for staff to learn more about community options • management staff • clinical staff • direct support professionals LSSLC status: There was no plan to address this item and no specific activities had occurred. The APC, however, reported that she trained and oriented the new post move monitor and the new transition specialists. The APC and PMM attended a session on person centered thinking in October 2012. The expectation for all new QDDPs to attend a community tour in their first six months, as described in the previous report, was beginning to occur. Four new QDDPs had toured community providers. 9. 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	This provision item required the facility to assess individuals for placement. The APC presented the state policy on most integrated settings and a list of all individuals at the facility along with their referral status.	Noncompliance

	individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	To meet substantial compliance with this provision item, the facility will need address the following four items to show that: • Professionals provided their determination regarding the appropriateness of referral for community placement in their annual written assessments. o Further progress was shown in that more professionals, more regularly, provided their explicit opinions. The facility should, however, address the points made above in T1b1 regarding the ways in which professionals should provide their determination and opinion. • The determinations of professionals were discussed at the annual ISP meeting, including a verbal statement by each professional member of the IDT during the meeting. o This was occurring at some, but not all of the living option discussions at LSSLC. • Living options for the individual were thoroughly discussed during the annual ISP meeting and, if appropriate, during the third quarter ISP preparation meeting. o This was more evident during this monitoring review than during previous reviews. Some detail is provided below. o For Individual #465, the IDT unanimously indicated that she could be supported successfully in the community, however, her LAR (who was not present at the meeting) refused to allow community referral to occur. The IDT members discussed this with the individual in an extremely thoughtful, caring, and sensitive manner. The IDT talked about taking small steps. The individual appeared satisfied with this living option discussion. o Similarly, Individual #433's LAR refused to allow community referral (or even exploration) even though the LAR was reported to not have had any direct contact with the individual in 15 years or so. The IDT agreed to initiate discussion with the LAR, so that the LAR could learn more about the individual's current lifestyle and frequent community outings. o For Individual #410, during his pre-ISP meeting, the IDT discussed working together with the LAR who was already, on her own, exploring possible providers near their own home. o Living options discussion also occurred in between regularly scheduled meetings and resulted in (or were held in order to make) community referrals (e.g., Individual #151, Individual #482, Individual #490). • 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 enough detail. o 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. o Some of the sampled ISPs used a template format; others used narrative statements.	
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 all seven CLDPs completed since the last review (100%). Two of these were completed right at the time of the previous review. The monitoring team, therefore, reviewed the other five of these seven CLDPs (71%). A set of in-process CLDPs was also reviewed. Across the five CLDPs, there were individuals ages 17 to 63, from different residential units at LSSLC, and with different levels of needs. Overall, the quality of the CLDPs had improved. Most of the improvement was seen in the two most recent of the five CLDPs, that is, the one completed in August 2012 and the one completed in September 2012. The other three were very similar to the ones described in the previous monitoring report (i.e., there was not much improvement seen in these). <u>Timeliness</u>: All of the CLDPs were developed in a timely manner. That is, activities related to transition and placement occurred at a good pace. There were good explanations when a few months elapsed between placement activities. Examples included addressing medical problems (Individual #29, Individual #162), obtaining behavioral stability (Individual #166), and exploring other possible day programs or group homes (Individual #103). Only one of the five had been on the referral list for more than 180 days. Further, as noted in T1a, only two of the 18 individuals on the referral list had been on the list for more than 180 days (and both were less than 30 days more than 180 days). This showed good efforts by the APC and her staff, and the IDTs in moving referrals along once they were made. <u>Initiation of the CLDP</u>: Rather than waiting until right before the individual moved, the CLDP document should be created at the time of referral. This occurred 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.	Substantial Compliance

		A sample of the in-process CLDPs were reviewed. They were for referrals that occurred approximately 30, 90, and 120 days. The APC entered all information into these CLDPs. The referrals with the most activity resulted in being the largest CLDPs. The APC expected that, with the help of the new transition specialists, in-process CLDPs would be more thoroughly developed. For the next onsite review, the monitoring team would appreciate a detailed presentation of the development and growth of the in-process CLDPs. IDT member participation: At LSSLC, IDT members continued to be very actively involved in the placement process once an individual was referred. This was evident in all five of the CLDPs reviewed. IDT members visited sites, had meaningful and thoughtful discussions about providers, and helped to make decisions regarding residential and day placements. Individual #162's CLDP indicated a good working relationship between LSSLC, the local authority, and the family. Individual #103 made a lot of progress in his two years at LSSLC. In fact, he was an example of an LSSLC success story, in terms of someone who was an emergency admission, was referred, and now was living in the community. Other ways that IDT member participation was evident were in ensuring Individual #253's mother could visit the sites before her son moved, supporting Individual #29 through a medical problem during her transition planning, working on Individual #166' behavior support plan, and supporting Individual #103 through exploring different group homes and day programs and then through cataract surgery before moving to the community. CLDP meeting prior to move: A CLDP meeting was not held during the week of the onsite review. Therefore, one could not be observed. The monitoring team would very much like to observe a CLDP meeting during the next onsite review. Based upon previous observations at LSSLC and at other facilities, the monitoring team recommends that that APC do some preparatory work with the individual and with the direct care staff prior to the CLDP meeting so that they know what to expect and so that they know what participation is expected from them. Post post-move monitoring IDT meetings: IDT meetings continued to occur after every post move monitoring visit, even if there were no problems. Please also see T2a.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community	Five of the seven 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.	Noncompliance

	living discharge plan and coordinating the community living discharge plan with provider staff.	Some comments regarding the actions in the CLDP are presented below. • The CLDPs identified the need for training for community provider staff. For example, the APC reported that Individual #162's new provider said that they had never received as thorough a training for an individual as they had received for her PBSP. This was great to hear. Overall, the CLDPs included good descriptions of the content of what was to be trained in many areas (e.g., PNMP, dining plans, PBSPs, skill training). To move forward with this aspect of this provision item, however, the APC should address the following: o All of 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. o The method of training was not indicated, such as didactic classroom, community provider staff shadowing facility staff, or demonstration of implementation of a plan in vivo, such as a PBSP or health care plan. o The training did not always that it was competency based. It should and it also needs to state how competency was to be assessed. • In addition to training, the CLDP should ensure that all activities that should be implemented are implemented, that is, supports for implementation after inservice training should be included in the list of required supports (see T1e). • Collaboration between the facility clinicians and the community clinicians (e.g., psychologists, psychiatrists, medical specialists) was not addressed. • The monitoring activities of the local authority, as well as the role of facility staff in the post-move monitoring and follow-up process were described in standardized sections of the CLDP. There were not, however, any action steps designed to ensure that the post move monitor worked together with the LA Service Coordinator to keep him or her informed of the status of essential and nonessential supports and/or any other important aspects of the individual's home and work life found by the PMM. • 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. The assigned staff person was now included, which was good to see. The completion of these activities also needs to be documented. DADS central office no longer conducted reviews of CLDPs at LSSLC. Although not a requirement for substantial compliance, these reviews had served to improve the quality of LSSLC CLDPs. It may be possible for the LSSLC transition specialists and the QA department to review a sample of CLDPs, too. To do so, some sort of tool will need needed, one that is better than the current tool being used to self-monitor CLDPs (see T1g).	

	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. To maintain substantial compliance, every CLDP ENE support needs to also include a date of required implementation, not only that it would be monitored during the 7-, 45-, and/or 90-day post move monitoring intervals. A specific date was not included in many of the CLDPs, only the date of the monitoring.	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.	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 two reviews, 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's tracking system also remained the same as it was at the time of the last review. That is, she recorded two dates for each assessment, the date the assessment update was written, and the date it was submitted to her. 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. Unfortunately, however, across the five CLDPs, changes to improve the quality of the assessments were not done as recommended in the previous report and changes in the way the IDT's discussions, deliberations, and recommendations were written into the CLDP were not done as recommended. Below is the status regarding each of the four bullets in the previous report. • The assessments need to focus upon the individual moving to a new residential and day setting. This was only slightly improved in the most recent two CLDPs. The monitoring team recommends that the APC read the comments in the previous report as she moves forward with raising the expectation for what is required to be in discharge assessments and updates. • The assessment summary section of the CLDP was also slightly improved in the two most recent CLDPs. More attention is needed to make those sections as succinct and informative as possible.	Substantial Compliance

		• The APC should ensure that all recommendations that result from assessments make it into the list of ENE supports, or if not, that a clear rationale is provided in the deliberations paragraphs. Well-written summaries and deliberations sections are required to make this easy for the APC and monitoring team to track. • The occurrence of typographical and proofreading errors had improved. LSSLC received substantial compliance at the time of the last review. The monitoring team has kept this rating, but the above improvements must be made if substantial compliance is to be maintained.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	LSSLC continued to make incremental progress in this provision item since the last onsite review. During the onsite review, the monitoring team met with the APC, her staff, and the IDT for Individual #162 for an open discussion regarding the CLDP, ENE supports, and the overall transition process. Positive aspects in the identification of an adequate list of essential and nonessential (ENE) supports were occurring, such as: • Individuals had between 35 and 40 ENE supports. That is, LSSLC and the providers were not hesitant to make as long a listing as they deemed necessary. The lists included a variety of medical and healthcare supports, as well as supports for improved independence and preferred activities. • There was continued progress in the inclusion of individualized ENE supports. For example: o For Individual #29, there were ENE supports for a box of sensory materials, stuffed animals, going on outings, and being outside. Further, she had supports for having a communication poster and training objectives. o For Individual #103, there were ENE supports for helping him when he was around unfamiliar people, interaction style of staff, chore participation, outings, favorite TV shows, and getting $3 per week. o For Individual #166, there were ENE supports for fishing, using her bathtub, and using a phone card. • There were some standard ENE supports in almost every CLDP. Given that there were also numerous individualized ENE supports, this continued to be acceptable and reasonable. • Leisure activities in the home were now listed as separate ENE supports from leisure activities in the community, as recommended in the previous report. • ENE supports continued to include some detail on what information needed to be brought to the new PCP (e.g., Individual #29, Individual #253). • Skill training objectives were carried forward in every CLDP. This was another	Noncompliance

		good improvement. • LSSLC had the local school district participate in Individual #162's CLDP (though see below). This was very good and likely helped her transition to her new school district. Improvements, however, continued to be needed. The APC and her staff should attend to these as they move forward towards substantial compliance. • Staff training inservice ENE supports need more detail, such as who is to be trained, how they are to be trained, if/how competency will be determined, how what was trained will be implemented, and how it will documented/evidenced so that the PMM can see it (T1c1). • Inservice ENE supports should not have all of the content detail in the table in the CLDP. Important topics/bullets should be listed, but not the three to five pages of content that were in the LSSLC CLDP ENE lists (this is repeated from the last monitoring report). Instead, there should be more detail about the training itself, as indicated in the above bulleted paragraph. • Any ENE support that calls for an inservice should have a corresponding ENE support for <u>implementation</u> of what was inserviced (also repeated from the last report). A rationale should be provided for any ENE inservice support that does not have a corresponding ENE support for implementation. • Implementation of every important <u>aspect</u> of LSSLC plans (e.g., PBSP, PNMP, dining plans) needs to be included in the list of ENE supports (i.e., not only a general statement that the PBSP and PNMP will be implemented). o For Individual #29, 10 bulleted items were listed under her PNMP. Each of these should have been in an ENE support. This was done for her adaptive equipment ENE support. Similarly, there were four bullets for regarding important aspects of her PBSP that were not all included within an ENE support. o For Individual #253, details regarding implementation of his PBSP were also not included within an ENE support. • There was an improvement in there being references to the use of positive reinforcement, schedules, incentives, and/or other motivating components to an individual's success. This was seen in the two most recent CLDPs. The wording of the ENE, however, was identical in both and did not provide any detail or direction to the provider, provider staff, or PMM regarding what it was that the LSSLC psychologist wanted to see occur. The monitoring team was concerned that this ENE support was going to become a standard item in every future ENE support list. Instead, it should be individualized. • There needs to be clarity as to what the provider needed to do to show evidence that the support was being implemented. One way to do so is to create a simple checklist that includes all ENE supports for which a checklist report would be	

		useful to the PMM. This could apply to the many aspects of PNMPs, PBSPs, dining plans, leisure time, community activities, house chore participation, and so forth. For example, a checklist would be appropriate for many of the ENE supports for Individual #103. Most providers have welcomed this suggestion from the facility. • The monitoring team's review of the CLDPs and accompanying documents indicated that some important supports might have been overlooked. Some of these are listed below. Note, however, that even though more work was needed, LSSLC continued to make progress in this area. o Individual #253: The IDT made a thoughtful decision to find a placement in Lufkin so that he could remain at the local district. There was, however, nothing in the ENE supports regarding his continuation at the school district, how the school district and the new provider would work together, and how they would address his history of serious problems when in school. Note that he only attended the public school for half days due to his behavior problems. The CLDP did not address his half-day attendance at all. Further, he had a need for language and communication support, but there was only an ENE for a speech evaluation, not for direct speech and language therapy as recommended in the discharge assessment. Moreover, there was an ENE for communication wall posters, but posters were not recommended in any of his assessments or documents. Perhaps this was a copy error from another individual's CLDP. Taking food was a major problem for him and a concern to the IDT because of the access to food in the group home. This was not specifically addressed with an ENE support. o Individual #29: Her serious problems with constipation did not appear adequately addressed by the ENE supports. The supports only referred to RN monitoring. Further, her histories of self-injurious behavior and pica were not directly addressed. The monitoring team suggests the APC (or transition specialist or PMM) do an ENE support self-assessment <u>prior</u> to finalization of the list of ENE supports. A suggested initial list of items for a self-assessment of ENE supports is bulleted below. The purpose is to help ensure that all of the appropriate ENE supports are included. Further improvement in the way the discharge assessments are done also help improve the list of ENE supports (T1d). • Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems. • All safety, medical, and supervision needs were addressed. • What was important to the individual was captured in the list of ENE supports. • The list of supports thoroughly addressed the individual's need/desire for	

		employment. Many individuals are excited to move to the community and do not fully understand that it may take months, if not longer, to find a job. This may have contributed to many problems at Individual #166' day program because of the failure to find her any employment opportunities. • Positive reinforcement, incentives, and/or other motivating components to an individual's success procedures were included in the list of ENE supports. • There were ENE supports for the provider's <u>implementation</u> of supports. That is, 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. • Topics included in training had a corresponding ENE support for implementation. • Any important support identified in the assessments or during the CLDP meetings that was not included in the list of ENE supports should have a rationale. • Every ENE support included a description of what the PMM should look for when doing post move monitoring (i.e., evidence). This provision item also requires that: • Essential supports that are identified are in place on the day of the move. A pre-move site review was conducted for all individuals. Each review indicated that each essential support was in place. • Each of the nonessential supports needs to have an implementation date. This was not the case for all of the ENE supports. Instead, dates of post move monitoring were given (also noted in T1c2, and also repeated from the previous monitoring report). • Although not required, the APC and IDTs should consider holding a meeting following every pre move site review.	
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.	LSSLC made some progress in this area in that there was a more organized (and described in a document) system for the completion of the three statewide self-monitoring tools that included the APC, PMM, and transition specialists. It included direct observation of living options discussions, CLDP meetings, and post move monitoring. The monitoring team reviewed all of the completed tools submitted (i.e., 15 living options reviews, 3 CLDP reviews, 2 post move monitoring reviews, and 3 tools completed to assess inter-rater agreement). Unfortunately, numerous problems were evident by this review, including: • There were no comments any (but one or two) of the completed tools • Almost every score was 100%	Noncompliance

		• Only one of the raters ever scored anything as a no • There was poor inter-rater agreement when one of the raters was the one who sometimes scored an item no • There was apparent confusion over when something should be scored no versus n/a • The content (items) did not look at what the monitoring team looked at • There was no indication if feedback was given to the QDDP, CLDP meeting leader, or post move monitor. These, and other, problems were noted during previous onsite reviews and in previous monitoring reports. DADS state office was well aware of these concerns and, as a result, was developing a new tool that would, according to the APC, encompass the entire process from referral through post move monitoring. This was good to hear and was urgently needed by the APC. Further, it would be in line with meeting the requirement of T1f (i.e., a quality assurance process to ensure that the CLDPs are developed and implemented). State office and the APC should consider creating a tool to also monitor the quality of all of the provision items of section T, too. The quality assurance process for section T needs to be planned out and included in the facility-specific policy for most integrated setting practices. The monitoring team recommends that this be a separate facility-specific policy. Further, the monitoring team suggests that a quality assurance process be more than just the (new) self-monitoring tool and include: • The statewide self-monitoring tool • Graphs of the outcomes of these tools • Graphs of the other outcomes noted throughout this report, especially in T1a • The provision T section of the QA report • Presentations to QAQI Council • Corrective actions and/or corrective action plans	
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	The same state and facility report that was discussed in the previous monitoring report was again submitted. It was an annual report. The new report was due sometime in October 2012. Because this was the same report, please refer to the previous monitoring report for discussion. The facility submitted a current listing of individuals who would have been referred by the IDT except for the preference of the LAR. The list had 38 names. This was a more accurate number than that which was reported during the last onsite review. This type of information will be useful when the APC completes the facility-specific portion of the next annual report.	Noncompliance

	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.		
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	The monitoring team was given a document titled "Community Placement Report." It was dated for the six-month period, 5/1/12 through 10/31/12. Although not yet included, the facility and state's intention was to include, in future Community Placement Reports, a list of those individuals who would be referred by the 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.	Substantial Compliance

	services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool 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, 22 post move monitorings for 10 individuals were completed. This compared to 28 post move monitorings for 15 individuals at the time of the last review. This was 100% of the post move monitoring that was required to be completed. Twenty of the 22 (91%) occurred within the required timelines. One of the two that were late was only late by one day. The other late monitoring was two weeks late; it was handled by another SSLC (further supporting DADS standard that post move monitoring be conducted by the placing SSLC). The PMM visited both the residential and the day program sites, and for two of the individuals, she also visited the public school. This was great to see. The PMM maintained a spreadsheet that listed all of the individuals, the due date for each post move monitoring, and the date upon which the post move monitoring occurred. This was a useful tool and was improved from the last review. The monitoring team reviewed completed documentation for all 22 (100%) post move monitorings. Of these 22 monitorings, 12 were competed by the previous PMM Leigh Anne Hall, 9 by the new PMM Mary Martin Ramsey, and 1 by the Denton SSLC. Overall, the breadth and depth of post move monitoring expanded and improved across the past year for all of the SSLCs. Post move monitoring-related activities occurred across the transition and placement process. Consider that the following were now standard components of the process, and if done thoroughly, would regularly result in substantial compliance with T2a and T2b.	Substantial Compliance

		• PMM participates in CLDP meeting to ensure that each ENE support adequately defines the evidence to be kept by the provider to indicate that implementation occurred. • PMM conducts the pre move site review. • PMM conducts the 7, 45, and 90 day reviews with a high standard for correct implementation, support of high quality lifestyles, etc. • PMM participates in IDT meeting following each of the reviews. • PMM provides follow-up and continues to communicate with IDT, provider, APC, LA if ENE supports are not provided and/or if there are other concerns or problems. <u>Content of Review Tool</u>: All 22 (100%) post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement. For the most part, the post move monitoring report forms were completed correctly and thoroughly. Good information was included. Below are comments regarding the content of this set of 22 post move monitorings. • Overall, the reports indicated that the PMM were conducting post move monitoring as per the requirements and intentions of this provision item. • The monitoring team liked that the PMM completed the checklists in a cumulative format. This made it very easy for the reader to follow the individual through his or her first 90 days in the community. • Good detail was included in the evidence boxes for each of the ENE supports. This made it easy for the reader to understand more detail rather than merely checking the yes/no box. • Most of the reports included some summary subjective comments towards the end of the report regarding the PMM's overall opinion of the placement and the individual's happiness there. This was very helpful to, and appreciated by, the reader. These should continue. • The people who were interviewed and/or observed were listed on the first page of the report. • LAR/family satisfaction with the placement (question #9) and the individual's satisfaction (question #11) were explicitly stated in the comments section in every review. • The individual's psychiatric diagnoses, psychiatric medications, and medical conditions can be inserted right into the post move monitoring form. This should be standard practice. It will help the PMM to be more efficient when conducting interviews. • The PMM needs to ensure that staff training was done adequately. Some post move monitoring forms only noted that inservice sheets indicated training was	

done and that the staff was competent based on training provided. The PMM should provide more information about what she did to determine that the provider adequately trained staff and assessed their competency.

Of the 10 individuals who received post move monitoring that was reviewed by the monitoring team, 7 (70%) ultimately transitioned very well and appeared to be having great lives. Some of these 7 individuals had difficulty during the first 90 days, but due, in large part, to the tenacity of the PMM and the involvement of the IDT, inadequately provided supports were improved and lifestyles benefited as a result. It was good to see that many providers hung in there with their new admissions. Of the remaining 3, 2 (20%) were still having transition problems (Individual #166-behavior, Individual #394-health), and 1 (10%) was not doing well.

As discussed with the APC, a simple review should be done of all placements to find out if any serious incidents occurred for the period of one year following placement. This was being done by the APC and was a good improvement. The next step is for her to evaluate (e.g., root cause analysis type review) the placement and transition processes to see if anything might have been done differently. For example, this type of review should certainly be done for Individual #394, who's group home placement failed and he ended up in a nursing home (although he and his family appeared happy with the way this turned out, it was not the original intent of the IDT, and it was likely due in large part to the failure of his new community provider to do an adequate job in supporting him), and for Individual #29, who's provider continued to fail to provide all of the supports she required in an adequate manner.

<u>Use of Best Efforts to Ensure Supports Are Implemented:</u>
IDTs, the APC, and the TSs and PMM put a lot of effort into these placements. The PMM appeared to do a good job of following up when there were problems. Some examples are below:

- Dynavox at school, speech therapy, and being in pajamas at 5:30 p.m. (Individual #162). The PMM followed up the pajama time after questioning from the monitoring team. The provider responded that this was not typically the case. The PMM should feel empowered to ask for more evidence, such as documentation for the next two weeks about pajama time.
- DARS and employment, eyeglasses, cleaning of shower and tub, and missing documentation (Individual #166).
- Public school (Individual #253).
- Communication boards at day program (Individual #103).
- Constipation and diarrhea (Individual #114).
- Meaningful day activities, appearance and cleanliness of home and grounds, and hospital bed (Individual #394).

		o The PMM, during one visit, refused to leave the home until the provider brought over and installed a proper hospital bed for him. • The IDT remained involved, well after 90 days, when Individual #394 was placed in a nursing home, including visiting other potential community providers. Even so, there were items that warranted more follow-up and advocacy from the PMM: • Individual #166: She was reported to be bored at her day program and this was setting the occasion for behavior problems. Although DARS was contacted, the employment search process should be a high priority for the provider immediately. • Individual #29: Many aspects of her supports appeared to need more follow-up, that is, they were noted, but received little attention from the PMM and IDT: o Being prescribed Risperdal (an antipsychotic) for sleep problems. o Inability to accurately weigh her each week. o Not going on outings due to housemates and staffing. o Not going to church. IDT meetings were held following the post move monitoring visits. This was good to see. Documentation of these meetings was submitted for 20 of the 22 (91%) post move monitorings reviewed by the monitoring team. The monitoring team continued the rating of substantial compliance for this provision item by taking into account the thoroughness of post move monitoring done by the previous PMM (she completed half of the post move monitoring during this review period), the recency of the appointment of the new PMM, and the improvements seen in her post move monitoring over the first few months of her appointment.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before	The monitoring team accompanied the new PMM Mary Martin Ramsey on a 45-day post move monitoring visit to the home of Individual #162. This was the same home visited during the last onsite review, though this time for a different individual's post move monitoring. The monitoring team noted that many of the items raised during the last visit had been corrected. This was due to the previous PMM's efforts, as well as the responsiveness of the provider, as also documented in the post move monitoring reports that the PMM completed. The home was a simply decorated, clean, but overall plain home. Three women lived in the home. The provider was D&S. Provider staff present were the house manager and direct care staff member Vicky Champion, and two administrators, Kimberly Palmer and Beverly Neighbors. In addition to the PMM and these three D&S staff, also present was	Substantial Compliance

	the 90th day following the move date.	the APC, the two transition specialists, and the monitoring team. All in all, it was a larger than typical group. Even so, the new PMM conducted the post move monitoring in a very professional manner, proceeding through all of the items, asking questions, and asking for documentation. As a result, LSSLC maintained substantial compliance with this provision item. She went through the list of every ENE support. Some items had been put onto a checklist as recommended in previous reports. The monitoring team discussed various aspects of additional ENE supports for which a staff checklist could have been created to provide additional documentation of the provision of the support. The PMM looked at progress notes, schedules, and other documentation. She questioned the administrators and, to a lesser extent, the house manager. The PMM asked good questions about supports, for example, regarding daily temperatures, weekly nurse reviews, and the individual's hematologist appointment. One important aspect of post move monitoring is the interview of the staff. This is one way that the PMM can be confident in the staff's knowledge of important supports. The PMM will need to improve this aspect of her monitoring. First, the interview needs to be with the direct care staff person, not with the administrators. Second, it should be done, as much as possible, in a way that the staff being interviewed can fully attend to the questions. During this visit, the house manager and nurse were called over for questioning with all of the visitors observing. It was an extremely uncomfortable interaction for these staff. Third, every direct care staff member should be interviewed. If there is more than one staff member, the PMM should do a thorough interview of one staff and then a more abbreviated interview with all other staff. Another important aspect of post move monitoring is for the PMM to feel, and thereby act, empowered to address all concerns, even if they are not specific ENE supports or part of the list of questions in the monitoring tool. For example, at this home, all three women, all of whom were in their early 20s, were in their pajamas at 5:30. After discussion with the monitoring team, the PMM followed-up, but in the future, she should go ahead and address these types of issues right then and there. Even though these two aspects of post move monitoring needed improvement, the monitoring team has maintained a rating of substantial compliance given the recency of the PMM's appointment and the progress she had already shown in implementing post move monitoring thoroughly.	
T3	**Alleged Offenders -** The provisions of this Section T do not	This item does not receive a rating.	

	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.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency 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	One individual was discharged under this T4 provision. He was transferred to another SSLC. The discharge was done properly as per the requirements of this provision item as evidenced by documents submitted to the monitoring team.	Substantial Compliance

	the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.		

Recommendations:

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

2. Do a detailed review (i.e., root cause analysis) of each rescinded referral and any other untoward post move serious incidents to determine if anything different should be done in future transition planning to reduce the likelihood of these types of problems occurring (T1a, T2a).

3. Expand the current set of graphs, and include them in the facility's QA program (T1a, T1f).

4. Implement procedures so that professionals' opinions and determinations regarding community placement are in their annual assessments, in the ISP meeting discussion, and in the ISP document (T1a, T1b3).

5. The monitoring team has noted at least three different "approaches" to way professionals give their determinations and opinions. All three should be included. Provide more direction to the professionals, so that there is a consistent approach to this requirement (T1a, T1b3).

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

7. 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).

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

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

10. Ensure that there are thorough living options discussions and living option determinations. The living option determinations should include a clearly worded rationale for the decision made by the IDT as a whole (T1b3).

11. Prepare the individual and his or her direct support staff for actively participating in the CLDP meeting (T1c).

12. Provide more information on the training of provider staff (e.g., to whom, method, demonstration of competency) (T1c1).

13. Collaborate with community and provider clinicians, especially but not limited to the PBSPs (T1c1).

14. Document the completion of the day of move activities (T1c1).

15. Consider developing a self-assessment of the CLDPs (T1c1).

16. Every CLDP ENE support needs to also include a date of required implementation, not only that it would be monitored during the 7-, 45-, and/or 90-day post move monitoring intervals (T1c2).

17. Ensure assessments are for the upcoming move to new home and day/employment settings (T1d).

18. The assessment summary sections of the CLDP need to show recommendations from the professional as well as what recommendations the team determined should be in the list of ENE supports (T1d).

19. Ensure that all topics included in training have a corresponding ENE support for implementation (T1e).

20. Clearly describe the ways the PMM should evidence the occurrence of the implementation of supports by the provider (T1e).

21. Make sure a wide range of ENE supports are identified, and that no important aspects of the individual's life fail to have a corresponding ENE (T1e).

22. The monitoring team suggests the APC do an ENE support self-assessment prior to finalization of the list of ENE supports. A suggested initial list of items for a self-assessment of ENE supports is bulleted in T1e (T1e).

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

24. Develop new self-monitoring tools (T1f).

25. Ensure follow-up on all supports for which follow-up is needed (T2a).

26. Conduct thorough interviews of staff, and raise concerns about what she observes whenever warranted (T2b).

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o LSSLC Guardianship Policy dated 6/21/12 o ISPs for: • Individual #288, Individual #192, Individual #401, Individual #43, Individual #310, Individual #245, and Individual #412. o LSSLC Section U Presentation Book o A Sample of HRC Minutes o LSSLC Prioritized Guardianship/Advocate List o A list of individuals for whom guardianship had been obtained in the past six months. o Documentation of activities the facility had taken to obtain LARs or advocates for individuals Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Mike Ramsey, Incident Management Coordinator o Melissa Latham, Facility Investigator o Sylvia Middlebrook, Director of Psychology o Luz Carver, QDDP Coordinator o Royce Garrett, Director of Consumer and Family Relations o Steven Webb, Human Rights Officer Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 10/29/12 and 10/31/12 o ISPA regarding restraint for 10/29/12 o Oak Hill Morning Unit Meeting o Annual IDT Meeting for Individual #465 and Individual #433 o Human Rights Committee Meeting 10/31/12 o ISP preparation meeting for Individual #410 o Restraint Reduction Committee Meeting
	Facility Self-Assessment: LSSLC submitted its self-assessment. The self-assessment was updated on 10/22/12. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment, the results of these self-assessment activities, and a self-rating for each item.

	The facility self-assessment described criteria used to evaluate compliance for each item and details on specific findings. For example, for item U1, the self-assessment activities engaged in by the facility included a review of ISPs each month between April 2012 and August 2012 to determine if there was a discussion of giving and withdrawing informed consent and a review of all Rights Assessments updated during the same time period. The self-assessment focused on documentation being present, but failed to comment on the quality of that documentation. The facility was still trying to determine how to evaluate the quality of IDT discussions regarding guardianship. The Director of Consumer and Family Relations was aware of the need to further assess this process and was working with the Human Rights Officer to expand the audit process and provide additional guidance to IDTs. The facility self-rated U1 and U2 as not in compliance. The monitoring team agreed with the facility's compliance ratings for U1 and U2.
	Summary of Monitor's Assessment: The facility had appointed a new Human Rights Officer. The Consumer and Family Relations Director was now working closely with the HRO to develop a process to assess each individual's functional decision-making capacity and need for guardianship. The facility was aware that development of a good assessment process will be critical in moving ahead with the requirements of section U. Developing a meaningful assessment will be the first step towards ensuring that the priority list for guardianship is accurate, which is compliance with U1. Then U2 will be the next step which is procuring guardians for individuals assessed as high priority. The facility should coordinate its efforts with the state office. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. The facility had still not developed a priority list of individuals needing an LAR based on an adequate assessment process. IDTs continue to need training to determine each individual's functional capacity to render informed decisions. • 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. Once a priority list of those in need of a guardian has been developed, then the facility can move forward with procuring guardianship for individuals with a prioritized need.

#	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.	A prioritized list of individual lacking both functional capacity to render a decision and a LAR to render such a decision was still in place, though the facility still lacked a formalized assessment process that included adequate IDT discussion. A sample of ISPs and relevant assessments was reviewed, for Individual #288, Individual #192, Individual #401, Individual #43, Individual #310, Individual #245, and Individual #412. All ISPs in the sample documented a brief discussion on guardianship. None included an adequate discussion of the individual's ability to express their own wishes or make determinations regarding his or her own health or welfare. For example, • The ISPs for Individual #192 and #43 noted that the LARs had let guardianship expire. The team did not document discussion regarding either individual's ability to give informed consent or make decisions in any area. There was no action regarding what would be done to ensure that guardianship would be pursued. When individuals have been deemed incompetent by the court to make decisions and are without LARs, IDTs need to have a clear discussion and develop actions steps to ensure that a guardian is obtained to make decisions on the individual's behalf. The annual IDT meetings were observed for Individual #465 and Individual #433. Both individuals had guardians. Neither guardian attended the annual IDT meeting or provided significant input. • The IDT for Individual #465 did a nice job of including her in the discussion and planning for the upcoming year. The team encouraged her to voice her opinions and offered further explanation to her when she appeared to need more information regarding her choices. The team did not agree with the LAR's decision regarding living options. Action steps were developed to further educate the LAR on community living. • The IDT for Individual #433 agreed that she was unable to express her preference for living options. The IDT also acknowledged that her family (against community placement) was unable to make an informed decision due to lack of knowledge about community placement and lack of knowledge about their family member. The family had not had seen Individual #433 since 1997, but maintained guardianship. The team appropriately agreed to develop action steps to try to encourage the family to be more involved and provide further education on living options. The team should further discuss the need for an advocate that would be more actively involved in her life. IDTs were not yet holding thorough discussions regarding the need for guardianship and ability to make decisions and give informed consent. Priority for guardianship should be	Noncompliance

#	Provision	Assessment of Status	Compliance
		based on this discussion. The facility was not yet in compliance with this provision.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	The facility continued to make efforts to obtain LARs for individuals through contact and education with family members and community groups. Four individuals had been assigned new guardians since the last visit by the monitoring team. The facility did have some rights protections in place, including an independent assistant ombudsman housed at the facility, and a human rights officer employed by the facility. The facility continued to offer self-advocacy opportunities for individuals at the facility, including a self-advocacy group. There was a Human Rights Committee (HRC) at the facility that met to review all emergency restraints or restrictions, all behavior support plans and safety plans, and any other restriction of rights for individuals at LSSLC. The new Human Rights Officer had further expanded membership on the HRC to include an individual residing at the facility and additional facility staff. There was still very little discussion regarding requests submitted to the committee. In many cases, there was not enough information available for the committee to make an informed decision. For example, the committee was asked to approve using TIVA sedation for dental work on individuals without having information regarding individual's risk rating in relevant areas, a list of medication that the individual was currently taking, or any past history of an adverse reaction to sedation. Any information relevant to the risk of a restriction should be presented to the committee prior to consideration for approval. The monitoring team encourages the facility to continue to explore new ways to support the rights of individuals while working through the guardianship process.	Noncompliance

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 based on IDT recommendations (U1).
3. 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: <u>Documents Reviewed</u>: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o LSSLC recordkeeping-related policies: • Management of Protected Health Information, Adm-3, updated 8/20/12 o LSSLC organizational chart, 10/9/12 o LSSLC policy lists, October 2012 o List of typical meetings that occurred at LSSLC, undated, likely October 2012 o LSSLC Self-Assessment, 10/22/12 o LSSLC Action Plans, 10/17/12 o LSSLC Provision Action Information, most recent entries 10/19/12 o LSSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 10/29/12 o List of all staff responsible for management of unified records o Tables of contents for the active record updated and individual notebooks 9/7/12, and the master records 3/10/12 o List of other binders or books used by staff to record data (there were none) o Description of the LSSLC shared drive o An 18-page spreadsheet that listed every LSSLC facility-specific policy and also showed the status of state policies for each provision of the Settlement Agreement, undated, probably October 2012 o Description of how staff are trained on policies, October 2012 o Data regarding training on state and facility-specific policies (none) o Email regarding state office expectations for facility-specific policies, from central office SSLC assistant commissioner, Chris Adams, 2/15/12 o New tool for end of month document transfers from individual notebooks to active records o Blank tools used by the URC and clerks, 9/7/12 o List of individuals whose unified record was audited by the URC or clerks, April 2012 through October 2012 o Completed unified record audit tools for 10 individuals, August 2012 and September 2012 • Active record and individual notebook • Statewide self-monitoring tool • Master record • Findings list • V4 questionnaire (8 of 10) • Emails showing notification of responsible person (7 of 10) o V4 questionnaire for 3 additional individuals o Audit tracking system, 4/9/12 to 9/5/12

	o One page with two graphs, April 2012 to September 2012 o One paragraph description of how LSSLC addresses section V4, 9/27/12 o A nicely organized packet of information showing documentation of actions taken in response to comments and recommendations in the previous monitoring report, a total of 21 actions were documented across the four provision items of section V. o Record clerk inservices, 5/23/12, 6/14/12, 9/11/12 o Review of active records and/or individual notebooks of: • Individual #366, Individual #363, Individual #13, Individual #592, Individual #371, Individual #47, Individual #518, Individual #1, Individual #177, Individual #482, Individual #465, Individual #410 o Review of master records of: • Individual #312, Individual #110, Individual #100 <u>Interviews and Meetings Held</u>: o Stormy Tullos and Terri Fatheree, Unified Records Coordinators o Paula McHenry, Director of Quality Assurance o Various staff, including Doris Morris, record clerk; Leticia Oliphant, RTT; Kathy Bennett, DSP; Sharon Shankle, HM; Felinda Redd, DSP. <u>Observations Conducted</u>: o Master records storage area o Records storage areas in residences o Section V presentation by QA director to QAQI Council, 10/30/12
	Facility Self-Assessment LSSLC continued to use the self-assessment format it developed for the last review. The Quality Assurance Director and the Unified Records Coordinators (URCs) had further developed what they presented last time by including additional activities and outcomes. In that regard, they made progress in that they were trying to look at actual activities and outcomes for each provision item. This time, the improvement included an attempt to look at the types of things looked at by the monitoring team. To that end there were many activities listed in the "activities engaged in" section that were more in line with the monitoring team's report than ever before. Even so, all of what the monitoring team looked at was not yet in the self-assessment. Further, there was some duplication of items in V1 and V3. The monitoring team, looked at specific items in each of the four provision items of this provision. That is, processes and outcomes did not count in the determination of substantial compliance for more than one provision. For V4, they reported on all six of the aspects that are described in the monitoring report. This showed additional progress. In the report below, within the six components of V4, the monitoring team's report notes what was reported in the self-assessment and what other items need to be self-assessed.

	The facility self-rated itself as being in noncompliance with provisions V1, V2, and V3, and being in substantial compliance with V4. The monitoring team rated all four provisions to be in noncompliance, however, continued progress was noted in all four provision items.
	Summary of Monitor's Assessment: LSSLC continued to make good progress in all four of the items of provision V. This was due to the hard work of the veteran unified record coordinator (URC) Stormy Tullos, the new URC Terri Fatheree, and the group of competent unit record clerks. The URCs conducted regular meetings and trainings with the record clerks to help ensure they were knowledgeable about filing and about criteria for their audits. The recordkeeping staff also maintained good relationships with the facility's many service disciplines and departments. The active records continued to be in good shape. The quality of entries in the observation notes, physician orders, and IPNs had improved. Gaps in the entries were addressed. There were, however, some missing, misfiled, and/or incorrectly filed documents. The URCs also need to address some questions about the active record table of contents. LSSLC continued to use individual notebooks. Staff appeared comfortable and knowledgeable about the individual notebooks. Improvements had been made to the individual notebooks and how they were managed. The URCs continued to create appropriate master records. They reported that more than 60% were completed. The master records were organized, consistent across records, and easy to use. Still to be resolved was what to do when non-optional documents could not be located or obtained. A detailed 18-page spreadsheet listed every policy at LSSLC and had 11 columns of relevant information. The facility must also ensure that the policies are implemented and that staff who should be trained on the policies have been trained on the policies. Continued progress was made in the quality and management of the monthly process for the review of five unified records, including addressing the recommendations and comments made in the previous monitoring report. The QA department was going to conduct inter-rater agreement checks, but this was not yet happening. Is was needed, especially given the finding that there were differences in average scoring across the set of record clerks who conducted these audits. The URCs re-initiated graphic summaries of data from their department's activities. The graphs were simple and easy to understand.

	The facility showed progress in V4 by taking first steps to assess, and possibly address, the six activities in this provision item.

#	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 continued to make good progress in all four of the items of provision V. This was due to the hard work of the veteran unified record coordinator (URC) Stormy Tullos, the new URC Terri Fatheree, and the group of competent unit record clerks. Moreover, recordkeeping activities were being overseen by the new QA director. The URCs, QA director, and the record clerks took very seriously the comments, suggestions, and recommendations in the previous monitoring report. This also contributed to their progress. The recordkeeping staff submitted a packet of documents to show their responses to 21 different items noted in the previous monitoring report. The packet was extremely well organized and easy for the monitoring team to follow. In addition, once an activity met its goal, it was re-evaluated by the URCs. For example, for the past year or so, on the last day of the month, the record clerks went into the homes during the overnight shift to oversee and assist with the transfer of documents from the individual notebooks into the active records. This had improved this process and was no longer necessary. The URCs discontinued the practice and were piloting a new way of ensuring the document transfer occurred correctly. Implementation, however, was not yet approved by residential management. The URCs conducted regular meetings and trainings with the record clerks to help ensure they were knowledgeable about filing and about criteria for their audits. This was evidenced by various emails and documentation of meetings and inservices. This was all very good to see. As noted in V3 below, however, more training will be necessary to obtain (and demonstrate) good inter-rater agreement across the record clerks. The recordkeeping staff also maintained good relationships with the facility's many service disciplines and departments. This was also a reason why the recordkeeping staff were able to get their jobs done and establish good unified records. During a meeting of the RN case managers, a question came up regarding the proper filing of the dental pretreatment sedation signature form. The monitoring team suggested that the RN case manager supervisor talk with the URCs about how to do this in the best way possible. All managers should be aware that the URCs are available for consultation and problem solving. The recordkeeping staff also showed that they communicated with other facilities, DADS state office, and the LSSLC residential director's office. That office directly supervised (and monitored) the record clerks' performance, too. This included an overnight shift rounds done by Genna Lewis of the residential director's office.	Noncompliance

#	Provision	Assessment of Status	Compliance
		State policy remained the same since the last review. The one facility-specific policy, Adm-3, was updated slightly on 8/20/12. The facility policy spreadsheet (see V2), however, did not have this new date, it still noted 3/11/11. In addition to updating this policy, the QA director planned to develop a list of forms used at the facility and a policy regarding forms and documents (as recommended in the previous report). <u>Active records</u> The active records continued to be in good shape. The monitoring team reviewed active records in each of the four units at the facility. Improvements noted in the previous report were continued (but are not detailed again here). The facility had a high standard and expectation for the quality of the active record (see V3). Improvements were noted in the following areas, as recommended in the previous report. • The quality of entries in the observation notes, physician orders, and IPNs had improved. o However, improvements in nursing entries were still needed, as described in section M1 of this report. • Gaps in the entries were addressed. The facility established a standard that there should be no blank lines. This was evidenced by the monitoring team's review of active records, and in numerous emails in May 2012 between the facility's URC, medical department, and facility director, as well as with the state office discipline lead for recordkeeping and state office medical services coordinator. Further, the URC then conducted an inservice (5/23/12) with the record clerks, so that they were clear on this standard, with examples of what was, and what was not, considered to be a gap in the entries. • The listing of medical consultations was improved. A new spreadsheet now also indicated that the consultation actually occurred (the previous listing was for all consultations scheduled, even if some had been cancelled or re-scheduled). • The table of contents guidelines were improved. The URCs added an asterisk to consents, a family contact log, and a tab for quarterly medical reviews. • There were also some questions regarding whether an IPN entry could be typed. For example, in Individual #518's IPNs, there was a typed entry by OTPT on 10/10/12. The page was inserted correctly, was written succinctly, and placed in a way that did not disrupt the flow of the IPNs. The Settlement Agreement, Appendix D, and the monitoring team do not have a requirement regarding typed versus handwritten IPN entries. They do, however, require that IPNs be written and entered in a way that is easy to understand and that follows the facility's policy and directives.	

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		Even so, there continued to be a need for further improvement in the active records as found in the facility's own audits (V3) and self-assessment, in the monitoring team's review of a sample of unified records, and during the monitoring team's detailed review of Individual #366's active record with the URCs. • There were some missing, misfiled, and/or incorrectly filed documents. For example, Individual #205's FSA and PFA were filed in Individual #177's active record. • The PALS and PFA for Individual #47 were old and out of date and his integrated risk rating form and risk action plan were stapled on the bottom, opposite of the binder rings, making it impossible to look at the document without having to open the binder rings and take the documents out. • Observation notes included client injury reports and fall assessments inserted behind the observation notes. Although this was on the LSSLC active record table of contents, this seemed to be an odd way to include this information because their presence would not be readily evident to users of the active record. The URCs should consider adding a tab, or a sub-tab, for these. • Some data were missing from SAPs (Individual #518, Individual #366). This was considered to be an error by the URCs because staff who implemented SAPs were supposed to make a notation as to why a SAP was not implemented on any day on which it was supposed to be implemented (i.e., similar to what is required on MARs). The monitoring team was pleased to see how seriously the URCs took these missing data. It also demonstrated how far the unified records had progressed since the baseline review. • Thinning records (so that there was not an overly excess amount of paper in the active record and in the individual notebook) was one of the most frequently cited errors. • Overall, the active record for Individual #366 was in good shape. Below, however, are some errors identified by the monitoring team. These were discussed at length with the URCs. The URCs said that they would expect each of these to be counted as an error during an audit. o The new DG1 form, 10/12/11, did not have signatures, however, this turned out to be an old version. The new version requires a signature. o Her trust fund consent was not in the active record. The URCs thought it might be in the master record. That turned out to be the case and a copy was sent to be inserted into the active record. o The FSA was overdue/outdated. o An ISP quarterly was missing. Instead of the first quarter from the current year, it was the first quarter's from a previous year. This was corrected by the record clerk once she was notified. o The Community Resource tab appeared in both volume 1 and volume 2.	

#	Provision	Assessment of Status	Compliance
		The URCs also need to address some questions about the active record table of contents. • Reiss screen: if the individual hasn't had a psychiatric evaluation, a Reiss is required. More detail/direction in the table of contents comments might be helpful. For example, Individual #366 had a Reiss on 4/27/10 (according to a list submitted to the monitoring team for the October 2011 onsite review), so it should have been in the active record. Perhaps a list of individuals who have had a Reiss screen completed can be obtained from psychiatry or psychology for the record clerks to refer to when they are doing the unified records audit (i.e., similar to how they were doing the list of medical consultations). • HRC referral: might be asterisked. • Rights addendum: might be asterisked. • PNMT (and maybe PNMP, too) should be asterisked. <u>Individual notebooks</u> LSSLC continued to use individual notebooks. Staff appeared comfortable and knowledgeable about the individual notebooks. For example, Sharon Shankle, a house manager, said that the individual notebooks were very handy with lots of information for staff. Leticia Oliphant, an RTT staff said that the individual notebooks were fine and good to use. In the Castle Pine day program building, Kathy Bennett, a DSP floater staff, had an individual notebook open on the table. She told the monitoring team that she was a floater and was reading about the men whom she did not know (she had a group of five individuals, a few of whom were new to her). Some improvements had been made to the individual notebooks and how they were managed. First, a competency check off sheet for PNMP for DSPs was added. Second, some newer harder covered binders were ordered because the older version, although lighter, was not very durable. Third, the residential director's office occasionally monitored the individual notebooks, too). As also noted in section K and in V4, data in the individual notebooks were recorded up to date for most individuals observed by the monitoring team. This was an improvement from the last onsite review. Observation notes appeared appropriate and were moved from the individual notebook into the active record in a timely manner. This was done at the end of the month. Other binders/logs: The facility reported that there were no other binders or logs used to record data regarding the individuals.	

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		Master records The URCs continued to create appropriate master records. They reported that more than 60% were completed, that is, there was continued progress since the last review. A sample of master records examined by the monitoring team were organized, consistent across records, and easy to use. The master record storage area was also organized, though the old folders remained on the shelves. The URCs planned to remove these older files once all of the master records were created. This was reasonable. • Still to be resolved was what to do when non-optional master record documents could not be located or obtained. The URCs should develop a procedure for adding a note, or a page with notes, in the master record indicating what was done to obtain the missing documents and if there was nothing further that could be done. If the notes indicate that a document could not be obtained, future audits of the master record would no longer need to continue to mark those items as missing. • Even though many master records were not yet in the appropriate format, the URCs and record clerks conducted an audit for the items required to be in the master record as part of their monthly set of audits. Shared drive The shared drive was described to the monitoring team. The recordkeeping department and the quality assurance department reported that there were no items in the shared drive that were not in the unified record as a hard copy. Overflow files Overflow files were managed in the same satisfactory manner as during the previous onsite review, that is, one year was stored in the record clerk's office. Two additional years were stored in the 510 building, and anything older than three years was stored at an offsite facility.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	The QA director re-built the facility's list of policies. That is, she created a detailed 18-page spreadsheet that listed every policy at LSSLC and had 11 columns of relevant information, such as the policy name and number, any corresponding state office policy, whether the facility policy related to a Settlement Agreement, and its most recent revision date. The spreadsheet was a good way to have of all of the facility's policies listed in one document. It would benefit, however, from having headings to divide it up. Also, all policies that are relevant to a single (or multiple) Settlement Agreement provision should be noted. This appeared to be the case for some, but not all of the facility policies on the list.	Noncompliance

#	Provision	Assessment of Status	Compliance
		That is, facility policies that were related to Settlement Agreement provisions were not identified as such. Examples included Dental/Medical Sedation, Adverse Drug Reaction Reporting, Clinical Death Review Committee, Administrative Death Review Committee, Infection Control Committee, Administration Morning Meeting Council, Use of Restraints, Community Activities, Individual Supervision, Placement Appeals, Oral Hygiene Procedure, and Restraint Procedure. Identifying that these facility policies are related to Settlement Agreement provisions is not a factor in the monitoring team's rating of substantial compliance, but would likely help tie together the facility's list of policies with the provision items of the Settlement Agreement, thereby increasing the likelihood of the policies contributing to the achievement of substantial compliance. Similarly, the monitoring team requests that the facility make a supplemental spreadsheet that lists each Settlement Agreement provision in alphabetical order and then shows every one of the facility's policies that are related to the provision. This will make it easier for the QA director to self-assess provision V2, make it easier for the monitoring team to understand and be aware of all Settlement Agreement-related policies, and help all facility staff understand the relationship between facility policies, state office policies, and the Settlement Agreement. Further, details from the assistant commissioner's 2/15/12 email were incorporated into the QA director's V2 spreadsheet. Not all state policies were in place yet, though continued progress was evident. In addition to having relevant policies, the facility must also ensure that the policies are implemented and that staff who should be trained on the policies have been trained on the policies. To that end, for the next onsite review, the facility should specify, for the state and facility policies for each provision of the Settlement Agreement, regarding training: • For each policy, what categories of staff need to be trained. • For each policy, o what type/method of training is needed (e.g., classroom training, review of materials, competency demonstration), o who will be responsible for certifying that staff who need to be trained have successfully completed the training, and o documentation necessary to confirm that training occurred. -- (Some of this responsibility may be with the Competency Training Department or accomplished in collaboration with the Competency Training Department.)	

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		• Timeframes for when training needs 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). Some trainings occur only once, while others require annual refreshers. • A system to track which staff completed which training. • Data on the number of staff who are supposed to receive training on each and every policy and the number of staff who did receive training on each of these policies. Then, a percentage can be calculated. A table could be created (or this information could be in columns added to the current spreadsheet) that showed every state and facility-related policy. For example, it might be that 100 employees were required to have training on the state and facility restraint policies and 90 were trained at the time of the onsite review. A simple table could show columns for the number of staff required to be trained (e.g., 100), the number who's training was current (e.g., 90), and the resulting percentage (e.g., 90%). Each row of the table could be a state or facility-specific policy.	
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.	Continued progress was made in the quality and management of the monthly process for the review of five unified records, including addressing the recommendations and comments made in the previous monitoring report. This was due to the efforts of the URCs, the QA director, and the record clerks. Moreover, staff throughout the facility were responsive when notified by the recordkeeping staff about any errors found in the records and any needed corrections. All of the reviews were done in a fairly consistent manner and were neatly and clearly documented. The review consisted of the following activities: • Completion of the table of contents review of each of the three pieces of the unified record • Completion of the statewide self-monitoring tool • A listing of all needed corrections • Email notifications to staff who needed to make corrections to errors • Completion of the V4 questionnaire At LSSLC, the record clerks conducted the monthly audits. There were five record clerks. Each one conducted one audit each month (of an individual who's unified record was managed by another record clerk). Clerks were reported to now have their own computers, which greatly facilitated their efficiency in completing these audits. A modified sampling procedure was used in that one individual from the caseload of each clerk was chosen each month, and the same individual never had his or her unified record chosen more than once in any 24-month period.	Noncompliance

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		In addition, the QA department was going to conduct inter-rater agreement checks on two of the five audits each month. This was not yet happening and, therefore, inter-rater agreement data were not available. The monitoring team spoke with the URCs and QA director about possible problems with not having the URCs conduct any audits. The monitoring team pointed out the importance of the URCs being "in" the actual records regularly, and about possible unintentional scoring bias by the record clerks. Many of the unified record reviews identified very few errors, even though the facility self-assessment and the monitoring team identified errors. The record clerks varied in their scoring. This indicated that more work was needed to regarding ensuring that the audits are done with high reliability (inter-rater agreement). One would expect for their to be a range in scores, but the monitoring team's finding that one rater had the highest four scores, and another rater had the three lowest scores indicated that more work was necessary. Below is the monitoring team's summary of the audits for August 2012 and September 2012. Auditor Average # # of items needing correction A 15.0 13, 16, 4, 18, 4, 35 B 8.2 10, 6, 9, 3, 13 C 7.5 13, 2 D 6.3 5, 4, 10 E 4.8 3, 7, 2, 7 F 2.8 2, 3, 6, 3, 2, 1 G 2.5 0, 1, 3, 0, 3, 8 H 2.0 2 I 1.7 1, 1, 3 For all errors found, emails were sent to the responsible person that clearly stated what was needed to be corrected and the date that the clerk would check to see if the correction was made. The emails were professionally written and were in a pleasant tone. The clerks then followed up to see if corrections were made after one week, after one month, and after two months. The percent of corrections was calculated by the URCs; it was the status for all needed corrections. An audit tracking system was created to track and document follow-up. It was a very	

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		good data report and was easy to understand. All of the columns of information were useful to the rater, the URCs, the QA director, and the monitoring team. It indicated the rater's name, the individual, each of the errors, the staff person who was notified about the needed corrections, the status of each error through the three follow-up checks (though all three were seldom needed because corrections usually happened within the first week), and the date the correction occurred. The URCs re-initiated graphic summaries of data from their department's activities. In mid-September 2012, the URCs met with the facility's data analyst to create a first set of graphs. Two graphs were presented to the monitoring team (and to QAQI Council). One showed the total number of errors found each month. The other was the percentage of items that were corrected. The graphs were simple and easy to understand. The URCs should be sure to analyze (and explain) their graphs. The graph of the number of errors was ascending. The reader could interpret this as being due to a worsening of the quality of the unified records. When asked by the monitoring team, however, the URCs explained that the record clerks were getting better at identifying errors (though see the table above). The percentage of errors corrected showed a stable high percentage (90% or more) being corrected within the two month period). The monitoring team has three additional comments regarding graphing of recordkeeping data: • Additional graphs of the number of errors might be created for: o Each record clerk's caseload (i.e., one audit per month) o Each record clerk's audits that she conducts (i.e., also one audit per month) • Not all items can be corrected, such as an illegible IPN. The URCs might pull these out of the calculation of percentage of errors corrected. For example, a rating of 95% might mean that 100% of all errors that could be corrected were corrected, but that 5% of the errors found could not be corrected. • The monitoring team also recommends that the URCs create a table that shows the type of errors that were being made. The URCs can create their own categories, such as missing signatures, out of date documents, illegible entry, problems with signature or credential, misfiled document, etc. Similarly, they might note the number of errors that were from the active record versus the individual notebook versus the master record. This information could then help them to focus training efforts, if needed. These graphs should be included in the QA program's data inventory, QA matrix, and QA report.	

#	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.	During the previous review, and in the previous monitoring report, the monitoring team detailed the activities that the facility was expected to engage in to demonstrate substantial compliance with provision item V4. The facility showed progress in this provision by taking first steps to assess, and possibly address, the six activities in this provision item. For instance, in the facility self-assessment, the QA director and URC reported the following, based upon the 36 unified record audits that were conducted from April 2012 through September 2012. 1. The active record was available and referenced at meetings and that individual notebooks and master records were available when needed. 2. Individual notebooks were being used, and ISPs were current. 3. [Only] 14 progress notes and two SAPs were missing from the individual notebooks. 4. Only one progress note had no data recorded. 5. IPNs were being fully used to make care, medical treatment, intervention, and training decisions. 6. 15 interview tools were more detailed and another 15 were not detailed enough. Below, the six areas of this provision item are again presented, with some comments regarding LSSLC's status on each. <u>1. Records are accessible to staff, clinicians, and others</u> LSSLC was self-assessing this as part of the monthly audit. It was not clear, however, how a determination was made by the auditor. The monitoring team observed that: • Direct support staff reported that the individual notebooks were easy to use and readily accessible. • Records were maintained in the home areas where medical clinicians had access. The clinical pharmacist noted some problems with accessing records for completion of QDRRs, but there was an action plan in place to address this. • Psychiatrists did not report any challenges in access or availability of records. • Some nursing staff reported that complete records and/or portions of records were often missing, and their whereabouts unknown, especially during morning and afternoon hours. This resulted in delayed follow-up to physicians' orders and/or missed information. For example, Individual #174's 9/26/12 nursing assessment noted that the results of his 9/3/12 KUB and 9/19/12 chest x-ray to rule out possible complications of vomiting were "not found on the chart," and although the results were requested, they were not received. • There were a number of late entries noted in the IPNs by the habilitation therapists due to difficulties accessing the individual records. • ISPs were not routinely filed in the unified record within 30 days of	Noncompliance

#	Provision	Assessment of Status	Compliance
		development. The facility attributed this to a high turnover rate among QDDPs. 2. Data are filed in the record timely and accurately LSSLC was somewhat assessing this during the monthly audits, that is, when the URC indicated whether a document was in the record, up to date, and in the right place. The information from these reviews, however, should be used to satisfy this requirement, too. • The monitoring team's review of a sample of unified records and the monthly unified record audits indicated that some documents were not filed in a timely or accurate manner. • Interestingly, some QDRRs were filed very timely, but even for the psychiatrist had reviewed and signed. • Documentation of habilitation therapy interventions were completed on SAP forms, yet filed in the Habilitation Therapy section of the active record rather than in the IPNs for ready access by all team members. In most cases the SAPs were not contained in the ISP or integrated via an ISPA. • As noted in section F, assessment results were not always documented and available to IDTs when making determinations regarding supports and risk status. 3. Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure) LSSLC was not yet self-assessing this. The monitoring team, however, observed that: • For most individuals observed throughout the LSSLC campus, data regarding their PBSPs were recorded right up to the time of the observation. The percentage observed by the monitoring team had increased sharply since the last onsite review. This was due to the efforts of the psychologists and the unit directors and their staff. • During one observation at 10:45 am by the monitoring team, BSP data had not been recorded for about two hours. The DSP, Leticia Oliphant, however, asked the monitoring team if she could have the individual notebook because she needed to update the data sheets because the individuals had just returned from their morning work break. This was good to see. • Individual #592 was reported to have exhibited a problem behavior earlier in the morning. When the monitoring checked his observation notes, a note had already been appropriately written and entered. • There were blank/missing entries in more than half of the 22 individuals' health status information, such as vital signs, weekly weight, etc. • Data collected was predominately related to implementation of interventions, rather than specific data related to measurable outcomes outlined in the action plans and objectives of the ISP.	

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		4. IPNs indicate the use of the record in making these decisions (not only that there are entries made) LSSLC appeared to be, but wasn't really, self-assessing this. The monitoring team observed: • The record clerks reviewed IPNs to check for integration of departments while doing the five monthly reviews. Specific criteria, however, should be determined for this. • Physician legibility made it difficult to read many of their entries. • Psychiatrists routinely documented use of the record and review of record documentation. • There was little evidence that nurses' consistently reviewed individuals' records to make care/treatment/training decisions to address acute changes in individuals' health status. Rather, nurses' were much more likely to make care, treatment, and training decisions based upon reports from direct care staff members and their observations/descriptions of changes in individuals' health status. • The IPNs failed to reveal that nurses consistently incorporated a review of the individual's history and/or prior illnesses and /or injuries and prior assessments as part of their evaluation and/or when they made care, treatment, and training decisions. • The majority of IPN entries made by Habilitation Therapies described actions taken by clinicians, but status updates, progress or intervention plans were less often documented in the IPNs. • The facility was attempting to enter relevant data on risk rating forms prior to risk discussions. Having this information for all team members will be beneficial for the IDT in making treatment decisions. As noted in section F and I, all relevant assessments were not available or reviewed prior to completing the risk rating form. 5. Staff surveyed/asked indicate how the unified record is used as per this provision item • Interviews were conducted as part of each monthly unified record audit. Good information was provided by the interviewees regarding their use of the unified record. o There was, however, no summary or interpretation of these interviews. • The RN case managers engaged in a detailed discussion during their meeting regarding how best to file pretreatment sedation documentation in the active record. • Some physicians reported that the record was cumbersome to use, particularly the IPNS. • When a random sample of nurses were asked about how they used the	

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		individuals' record to make decisions, they reported that during their quarterly and annual assessments and during the completion of audit/monitoring tools they reviewed the individuals' records and made decisions regarding whether or not individuals received care in accordance with the Settlement Agreement and Health Care Guidelines. <u>6. 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> The monitoring team found the following: • The active record was available at the ISP for Individual #465 and the Pre-ISP meeting for Individual #410. IDT members referred to the unified records to provide information in regards to data needed to assess risks. • At one of the annual ISP meetings, the nurse in attendance was reviewing them. The nurse, however, had a limited understanding of the individual's medical challenges. As a result, information was poorly presented to the IDT, and while the record was present, the meeting required the presence of a physician to guide the discussion with regard to specific medical issues that the individual was experiencing. • During the PNMT meeting there were no individual records available. For example, when the monitoring team had questions about the individual's weight, the team did not have this information available, even an for an individual who's primary reason for PNMT review was related to weight loss. • The HRC did not utilize information contained in the unified record when evaluating risks prior to approving restrictions. For example, the committee members approved the use of TIVA sedation for dental treatment for several individuals without reviewing current medications or risk ratings. This kind of information should be considered when weighing risk of treatment prior to approval.	

Recommendations:

1. Ensure all management and clinicians know that the recordkeeping staff is available for consultation and problem solving regarding the unified record (V1).

2. Continue to address missing, misfiled, out of date, and/or un-thinned (not yet purged) documents in the active record, especially regarding (though not limited to) nursing entries (see detail in M1) (V1).

3. Consider a tab or sub-tab for injuries and falls that were currently inserted behind the observation notes in the active record (V1).

4. Address questions/topics raised in this monitoring report about the active record table of contents (V1).

5. The URCs should develop a procedure for adding a note, or a page with notes, in the master record indicating what was done to obtain the missing documents and if there was nothing further that could be done (V1).

6. For the facility policies spreadsheet, (a) consider adding headings to divide up the lengthy list, and (b) put a notation by all facility policies that relate to a Settlement Agreement provision (V2).

7. Consider the monitoring team's request for a supplemental spreadsheet that lists each Settlement Agreement provision in alphabetical order and then shows every one of the facility's policies that are related to the provision (V2).

8. Create state policies for all remaining provisions of the Settlement Agreement (V2).

9. Create a process for the implementation and training of relevant staff on state and facility-specific policies (V2).

10. Provide data on the number of staff who were supposed to be trained on every Settlement Agreement-related state and facility-specific policy, and the actual number of staff who were trained (V2).

11. Conduct inter-rater agreement checks on some of the audits each month. Calculate data on the results of these checks and implement procedures to improve inter-rater agreement when it falls below a set criteria (V3).

12. Analyze the recordkeeping graphs (V3).

13. Consider creating graphs of the number of errors for (a) each record clerk's caseload (i.e., one audit per month), and (b) each record clerk's audits that she conducts (i.e., also one audit per month) (V3).

14. Create a table that shows the type of errors that were being made (V3).

15. 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
APAAP	Alkaline Phosphatase Anti Alkaline Phosphatase
APC	Admissions and Placement Coordinator
APL	Active Problem List
APEN	Aspiration Pneumonia Enteral Nutrition
APES	Annual Psychological Evaluations

APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
ARB	Angiotensin Receptor Blocker
ARD	Admissions, Review, and Dismissal
ARDS	Acute respiratory distress syndrome
AROM	Active Range of Motion
ASA	Aspirin
ASAP	As Soon As Possible
ASHA	American Speech and Hearing Association
AST	Aspartate Aminotransferase
AT	Assistive Technology
ATP	Active Treatment Provider
AUD	Audiology
AV	Alleged Victim
BBS	Bilateral Breath Sounds
BC	Board Certified
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BID	Twice a Day
BLE	Bilateral/Both Lower Extremities
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
BSPC	Behavior Support Plan Committee
BPRS	Brief Psychiatric Rating Scale
BTC	Behavior Therapy Committee
BUE	Bilateral/Both Upper Extremities
BUN	Blood Urea Nitrogen
C&S	Culture and Sensitivity
CA	Campus Administrator
CAL	Calcium
CANRS	Client Abuse and Neglect Registry System

CAP	Corrective Action Plan
CBC	Complete Blood Count
CBC	Criminal Background Check
CBZ	Carbamazepine
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
CIP	Crisis Intervention Plan
CIR	Client Injury Report
CKD	Chronic Kidney Disease
CL	Chlorine
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CM	Case Manager
CMA	Certified Medication Aide
CMax	Concentration Maximum
CME	Continuing Medical Education
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
DNP	Doctor of Nursing Practice
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
ERC	Employee Reassignment Center
FAAA	Fellow, American Academy of Audiology
FAST	Functional Analysis Screening Tool
FBI	Federal Bureau of Investigation
FBS	Fasting Blood Sugar
FDA	Food and Drug Administration
FFAD	Face to Face Assessment Debriefing
FLACC	Face, Legs, Activity, Cry, Console-ability
FLP	Fasting Lipid Profile
FMLA	Family Medical Leave Act
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
GIFT	General Integrated Functional Training
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
IHCP	Integrated Health Care 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
IPSD	Integrated Psychosocial Diagnostic Formulation
IRR	Integrated Risk Rating
IRRF	Integrated Risk Rating Form
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IT	Information Technology
ITB	Intrathecal Baclofen
IV	Intravenous
JD	Juris Doctor
K	Potassium
KCL	Potassium Chloride
KG	Kilogram
KPI	Key Performance Indicators
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
LOI	Level of Involvement
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
ORIF	Open Reduction Internal Fixation
OT	Occupational Therapy
OTD	Occupational Therapist, Doctorate
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P	Pulse
PA	Physician Assistant
P&T	Pharmacy and Therapeutics
PAD	Peripheral Artery Disease
PAI	Provision Action Information
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
PDR	Physicians Desk Reference
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
PM	Physical Management
PMAB	Physical Management of Aggressive Behavior
PMM	Post Move Monitor
PMRP	Protective Mechanical Restraint Plan
PMRQ	Psychiatric Medication Review Quarterly
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	Personal Skills Assessment
PSA	Prostate Specific Antigen
PSAS	Physical and Sexual Abuse Survivor

PSI	Preferences and Strength Inventory
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
RML	Right Middle Lobe
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
SIS	Second Injury Syndrome
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SOB	Shortness of Breath
SOTP	Sex Offender Treatment Program
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
ST	Speech Therapy
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
TCA	Texas Code Annotated
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
TSHA	Texas Speech and Hearing Association
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
UT	University of Texas
UTHSCSA	University of Texas Health Science Center at San Antonio
UTI	Urinary Tract Infection
VFSS	Videofluoroscopic Swallowing Study
VIT	Vitamin
VNS	Vagus nerve stimulation
VOD	Voice Output Device
VPA	Valproic Acid
VRE	Vancomycin Resistant Enterococci
VS	Vital Signs
WBC	White Blood Count
WFL	Within Functional Limits
WISD	Water Valley Independent School District
WNL	Within Normal Limits
WS	Worksheet
WT	Weight
XR	Extended Release
YO	Year Old