United States v. State of Texas

Monitoring Team Report

Lufkin State Supported Living Center

Dates of Onsite Review: July 8 –12, 2013

Date of Report: September 13, 2013

Submitted By:	Alan Harchik, Ph.D., BCBA-D Monitor
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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 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 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, supported the work of the monitoring team, was available and responsive to all questions and concerns, and set the overall tone for the week, which was to learn as much as possible about what was required by the Settlement Agreement. The new Settlement Agreement Coordinator, Dawn Stoltz, did a great job, before, during, and after the onsite review. She helped ensure that the monitoring team was able to conduct its activities as needed.

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, including frequent questions about what it would take to come into substantial compliance. It is hoped that some of these ideas and suggestions, as well as those in this report, will assist LSSLC in doing so.

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

<u>Restraint</u>

- There were 342 restraints used for crisis intervention involving 22 individuals between 12/1/12 and 5/31/13. The number of restraint incidents had increased significantly since the last review. Two of the three individuals with the highest number of restraints were indeed new admissions during the past six months.
- A log of all restraints provided by the facility included 157 instances of dental/medical restraint from 11/1/12 through 5/31/13 including mechanical (mittens), physical holds, and chemical restraints.
- Overall, the facility made good progress towards meeting compliance with requirements for documenting and reviewing restraint incidents for crisis intervention. The facility needs to focus on documenting protective medical restraints in compliance with the state policy, and ensuring that IDTs are engaging in adequate discussion regarding the least restrictive, most appropriate supports to prevent injury to an individual.

Abuse, Neglect, and Incident Management

- There were five confirmed cases of physical abuse and were three confirmed cases of neglect. There were 24 allegations of physical abuse, one allegation of exploitation, two allegations of sexual abuse, and 24 allegations of neglect. An additional 51 other serious incidents were investigated by the facility.
- There were 1547 injuries reported between 12/1/12 and 5/31/13. These included 27 serious injuries resulting in fractures or sutures. Injury trends were being generated by individual and made available to IDTs for access on the shared drive.
- Teams were not meeting and revising supports, then continuing to adequately monitor supports to verify implementation and efficacy.
- Minimal progress had been made in adequately following up on incidents by addressing factors contributing to the large number of incidents and injuries at the facility. See section D4 below regarding the actions and work done at LSSLC regarding injuries and falls, but the process was in the initial stages and adequate action plans and follow-up to action plans to track outcomes were not yet occurring.

Quality Assurance

- The QA program at LSSLC focused on the development of indicators for each of the 20 Settlement Agreement provisions, the creation of a risk threshold process, and addressing many DADS regulatory findings. The QA program also initiated a new CAPs process.
- When a Settlement Agreement provision was presented to QAQI Council, there was no consistent format to what or how they presented. There was no QA report.
- The facility's QA work on section D represented good coordination between departments, unit directors, and the QA department. Data were collected and analyzed. Actions were taken based upon the data.
- The CAPs program was new. Four CAPs with 37 action plans were created. Management reported on activity periodically at QAQI Council. The system was new and not yet complete.

Integrated Protections, Services, Treatment, and Support

- Since the last monitoring visit, IDTs implemented the newest ISP and risk identification process. Additionally, a data tracking system was implemented to track the submission of assessments prior to the annual ISP meeting and QDDP and QA staff were completing a monthly sample of Settlement Agreement Monitoring Tools to assess compliance with the requirements of section F.
- There was progress evident with the new ISP process. At three ISP meetings and two pre-ISP meetings observed by the monitoring team, progress had been made towards integrating the risk identification process into the ISP process. At the ISPs observed, rather than being two separate discussions held within the same meeting (as had been observed in

the past), the risk discussion was to some degree woven into the discussion regarding the individual's preferences, daily schedule, and support needs.

- IDTs should focus on developing action plans that expand on preferences by providing opportunities to learn new skills and explore new activities in the least restrictive setting. Recommendations from assessments should be integrated into all supports and services. All team members need to ensure that supports are monitored for consistent implementation and adequacy. Data collected during monitoring should be used to revise supports when there is regression or lack of progress.

Integrated Clinical Services

- The facility continued to make progress with improved integration. The integration policy was revised to include statements for nursing and dental. Some processes, such as the Dental Desensitization Workgroup, demonstrated continued progress, as did the integration of neurology and psychiatry. The primary care providers continued to have minimal involvement with the annual ISPs and the review of PNMPs.
- The consultation follow-up and tracking processes did not make any substantial gains in spite of multiple tracking systems. Primary providers were reviewing consults in a timely manner based on the documentation on the consultation forms but most were not following the guidelines for IPN documentation, and assessing the need for referral to the IDT.

Minimum Common Elements of Clinical Care

- The facility's QA nurse served as the lead for this provision item. He explained that each department was responsible for tracking assessments, which were also entered into a centralized database. The facility had addressed the timeliness of the scheduled annual assessments. The timeliness of quarterly assessments was not addressed nor was any aspect of the interval assessments.
- Improvement was seen in the diagnostic formulation for psychiatric assessments. The medical providers generally utilized ICD nomenclature and the diagnoses were consistent with the signs and symptoms of illness.
- The facility focused its efforts on Provisions H1 and H2. The development of the risk thresholds policy had the ability to impact the progress seen in the provision items H3-H6, however, the policy was newly implemented at the time of the compliance review and therefore no significant impact on the progress of the provision was observed.
- The facility developed a detailed policy for addressing this provision. It addressed every provision item and was a good start in describing the activities that were needed to move towards substantial compliance. A policy from state office was needed to provide additional guidance to the facility.

At-Risk Individuals

- Some progress had been made on meeting substantial compliance to ensure individuals were accurately assessed and action plans were in place to address risks.
- The monitoring team had a chance to observe three teams hold meetings utilizing the new format. Progress was observed towards integrating the risk discussion in relation to each individual's preferences, strengths, and daily schedule. However, IDTs were not yet using the IHCP to track the completion of assessments and document resulting recommendations. The process to ensure timely completion and implementation of action plans needs to be refined to meet substantial compliance with section I.
- Teams were reviewing supports following a change in status, but failing to ensure that assessments were completed and recommendations were implemented. Plans should be implemented immediately when individuals are at risk for harm, and then monitored for efficacy.

Psychiatric Care and Services

- Psychiatry services at LSSLC made progress towards substantial compliance. The facility was found to be in substantial compliance with six of the 15 items. Over half of the individuals residing at the facility received psychopharmacologic intervention (193 of 347, 55%). The facility had identified a lead psychiatrist.
- There were marked improvements in psychiatric documentation precipitated by peer review and inclusion of prompts for dictation. Most impressive was the scheduling change with a consistent day and time identified for ISP meetings allowing for psychiatric attendance at 92% of ISP meetings.
- 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.
- The monitoring team observed four psychiatric clinics, and one Neuro-Psychiatry clinic. There was participation in the discussion and collaboration between the disciplines (psychiatry, psychology, nursing, QDDP, direct care staff, and the individual).
- A review of psychiatric documentation revealed improvements with the justification of diagnoses and identification of nonpharmacological interventions.
- There were improvements reported in the psychiatric participation in the development of the PBSP.

Psychological Care and Services

- LSSLC made many improvements since the last onsite review. These improvements resulted in substantial compliance in four new items (K5, K6, K7 and K11). Additionally, LSSLC maintained substantial compliance on the two items (K2 and K3) that were in substantial compliance since the last review.
- Improvements included an increase in psychologists who are, or are working towards being, board certified behavior analysts (BCBAs). There was expansion of data collection reliability and inter-observer agreement data to all PBSPs

and improvements in the number and comprehensiveness of full psychological assessments and functional assessments. There were improvements in counseling services, PBSPs, and treatment integrity data.

- LSSLC needs to work on a data system is flexible enough to incorporate the most appropriate measure of an individual's target and replacement/alternative behaviors, demonstrate that minimal frequencies and levels of data collection reliability and IOA are achieved, and ensure that current data are available and graphed at interdisciplinary meetings to ensure that data based decisions are made. When an individual is not making expecting progress, the progress note should indicate that some activity (e.g., retraining of staff, modification of PBSP) occurred. LSSLC should also expand counseling services, ensure that PBSPs are implemented within 14 days of receiving consent, expand treatment integrity to all PBSPs, and ensure that all psychologists are using the same methodology to collect and calculate treatment integrity. Lastly, every staff assigned to work with an individual, including float/relief staff, needs to be trained in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter.

Medical Care

- Over the period of three years, the monitoring team has seen improvement in the provision of medical services, most obvious in documentation of assessments, documentation of labs and diagnostics, completion of certain cancer screenings, and annual medical assessments.
- Even so, the monitoring team encountered poor clinical outcomes for many individuals due, perhaps in part, to the advancing age and declining health of many individuals. However, there were outcomes that were clearly linked to inadequate systems and the failure to implement appropriate corrective actions for recognized systems issues.
- The medical staff did not appear to have any reliable means, such as use of a spreadsheet, for tracking consults and diagnostics independently. There were examples in which labs and diagnostics were not ordered, consults were not obtained, and consultant recommendations were not implemented by the primary providers. Individuals with refractory seizure disorder generally were not referred to an epileptologist.
- Most individuals received routine preventive services and compliance with most cancer screenings was improving. There continued to be problems related to neurological care. Collaboration between psychiatry and neurology was improving.
- The external medical reviews were completed, but basic clinical outcome metrics were still not utilized. Mortality reviews continued to be completed and corrective actions were generated. The corrective actions focused primarily on nursing issues. This was likely due to the lack of an objective medical review.
- LSSLC did not address the need to develop a medical quality program. The requirement to develop and implement policies and procedures to guide medical care remained an outstanding need.

Nursing Care

- Improvements were seen since the last onsite review. The Nursing Department had experienced significant turnover in Nursing Leadership and Specialty Nursing Positions since the last review, including the CNE, Hospital Liaison, Infirmary Nurse, and Infection Control Nurse. The Immunization, Employee Health, and Wound Skin Nurse positions were also vacated and remained vacant.
- Implementation of new/revised policies had a direct impact on the quality of nursing assessments and plans of care. In addition, the Integrated Risk Rating Form (IRRF) was revised in May 2013. Thus, with many policy and protocol changes, the facility had not had enough time to assess and evaluate progress.
- There remained the need for continued progress in having a consistent method for implementing quality nursing assessments and developing sufficient health care plans, as well as understanding health risks and risk factors.
- The Nurse Educator maintained an excellent tracking system for training to ensure that nurses receive all required trainings. Nursing care must be demonstrated through actual clinical practice sufficient to address the health status of individuals.
- There were improvements found in practices of medication administration. There remained the need to further develop safe medication practice systems that ensure medication errors are harder to make, and that medication errors that do occur are buffered in order to have the least impact upon the individual.

Pharmacy Services and Safe Medication Practices

- The lack of a full time clinical pharmacist, involved in all aspects of the delivery of pharmacy services, was evident. These are discussed in the various sections of this report. The clinical services director will need to ensure that the administrative duties of the department are fully executed.
- The pharmacists were documenting the communication with providers, but most communication appeared to occur with nursing staff. The resolution of problems was also not always documented. The facility had not properly implemented all of the Intelligent Alerts.
- The facility made good progress in completion of the QDRRs. The MOSES and DISCUS evaluations were completed by nursing staff. There was no evidence that the information was used by the primary providers nor was it reviewed by the neurologists. Reporting of ADRs was scant and for those ADRs reported, the forms were usually not thoroughly completed. Many suspected ADRs were identified in the QDRRs and other documents, but no ADR form was completed. The facility completed three DUEs in a timely manner. The content was adequate, but for the most part, the medical staff was not present and follow-up related to deficiencies was inconsistent.
- Medication variances continued to be under-reported. The accuracy of the information was also in question because assignment of the correct discipline and severity level for many variances seemed incorrect.

Physical and Nutritional Management

- Progress was made towards substantial compliance O. The PNMT was fully staffed, and attendance at the meetings was generally consistent. All seemed well qualified and committed to the process and success of the PNMT. The assessments reviewed had not been completed in a timely manner from the date of referral, but once initiated, were completed promptly. The content was often weak. The meeting observed by the monitoring team was organized. Team members concisely and efficiently presented data for analysis and review
- Mealtimes and position and alignment were notably improved in Lone Pine and Woodland Crossing.
- A system of effectiveness monitoring was not well established.
- The therapists were encouraged to more objectively evaluate individuals for protective equipment. There were a large number of helmets and gait belts, for example.
- There continued to see implementation errors and failure to update PNMPs/dining plans to represent recent changes, and others that required clarifications.

Physical and Occupational Therapy

- There was continued progress towards substantial compliance. There were improvements in assessment content related to 48% of the elements; and at least six of the elements were present in more than 80% of the assessments. Most, however, were consistently well below 80%. The majority of the assessments were completed after the ISP.
- The assessments focused on the clinical aspects of health and safety, but had rather limited focus on skill acquisition or motor skill improvements. There were some notable exceptions, particularly with an increase noted in OT services and direct therapy overall. Documentation should consistently review the individual's status related to the objectives and this should drive the continuation or termination of services.
- Though improvements were evident, the OT/PT supports and services were not consistently integrated into the ISPs.

Dental Services

- Dental clinic made progress in several areas since the last review. Clinic continued to be conducted daily. Several individuals were seen in their homes as part of the Dental Outreach Program. Generally, the review of records and documents indicated that most individuals were receiving basic dental services. The monitoring team observed the treatment of individuals in clinic as well as treatment provided in the homes through the Dental Outreach Program.
- The facility provided endodontic treatment onsite due to newly purchased equipment. More advanced services were provided by a local oral surgeon.
- The facility made considerable progress in the reduction of failed appointments. Individuals who refused dental services were referred for assessment by psychology.

Communication

- There was continued progress toward substantial compliance. The majority of the assessments were not completed 10 working days prior to the ISP and many assessments were not completed at all.
- The content aspect of assessments reflected progress with 100% of the assessments containing at least 50% of the elements and a majority containing at least 60%. Improvements from the previous review were noted in 82% of the elements.
- The therapists are commended for the impressive quantity of direct services they provided on a weekly basis. Integration of communication into the ISP and real time coaching and modeling for staff are also keys to effective functional implementation.
- Maintaining equipment already provided to individuals was reported as an ongoing and costly problem.

Habilitation, Training, Education, and Skill Acquisition Programs

- There were improvements since the last review, such as the QIDP Coordinator Assistant enrolled in coursework to become a board certified behavior analyst. The facility modified the SAP format and made improvements in the quality of SAPs, individual engagement, pretreatment sedation reduction, and in the documentation of how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans.
- The facility needs to ensure that each SAP contains a rationale for its selection, and contains a plan for maintenance and generalization. Engagement should be tracked across all treatment areas, trends reviewed, and acceptable levels of engagement determined for each treatment area. Also, measures of skill training in the community need to be accurate.

Most Integrated Setting Practices

- LSSLC continued to make progress. The number of individuals who were placed and who were in the referral and placement process increased since the last review. 16 individuals had been placed in the community since the last onsite review. 19 individuals were referred for placement since the last onsite review. 14 individuals were on the active referral list.
- Professionals' determinations regarding most integrated settings were included in only some of the annual ISP assessments. An adequate living options discussion, however, was only evident in about half of the written and observed ISPs. Obstacles to referral and to transition were not adequately identified in the ISPs and plans to address these obstacles were not explicitly developed.
- CLDPs were created for every individual referred and ongoing activities occurred following referral. IDTs were very active in the transition planning and placement process. There were two individually thoughtfully-designed transition plans. Discharge assessments were not developed with the individual's new home, day, and employment environments in mind. The lists of pre- and post-move supports had greatly improved.
- A quality assurance program did not exist. The annual obstacles report and community placement reports were submitted.
- Post move monitoring was occurring as required. It was done thoroughly and the PMM identified numerous areas that needed follow-up. She ensured that follow-up occurred by involving the IDT as needed. Substantial compliance was maintained for both provisions of T2.

Guardianship and Consent

- The facility had not yet developed an adequate assessment process for determining the need for guardianship.
- IDTs were not holding adequate discussion at the annual IDT meeting to determine if individuals had the ability to make decisions and give informed consent.
- A priority list of those in need of a guardian had been developed, and the facility was moving forward with procuring guardianship for individuals with a prioritized need.

Recordkeeping Practices

- LSSLC made good progress. Sixteen of 16 (100%) individuals' records reviewed included an active record, individual notebook, and master record. For each active record, more than 90% of required documents were present, current, and substantially in compliance with the requirements of appendix D of the Settlement Agreement.
- Individual notebooks continued to be used for all individuals. Staff were very aware of the individual notebooks. A master record in the new format existed for every individual. They now contained a note to describe the status of any missing document.

- Five reviews (audits) were conducted in each of the previous six months, for a total of 30. They were done in a consistent manner and were neatly and clearly documented. A new audit tool was developed at LSSLC. The record clerks continued to conduct the audits. The facility had a good system of conducting the audits, follow-up, and documentation of the findings.
- Consistency across record clerks remained a problem that questioned both the validity and reliability of the findings of the audits.
- For V4, the URCs worked to address all six components. They documented how each was being addressed.

Status of Compliance with the Settlement Agreement

<table>
<tr><th>SECTION C: Protection from Harm-Restraints</th><th></th></tr>
<tr><td>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.</td><td>
Steps Taken to Assess Compliance:

<u>Documents Reviewed</u>:
o LSSLC Policy: Use of Restraints 001.1 revised 5/21/13
o LSSLC Self-Assessment
o LSSLC Provision Action Information Log
o LSSLC Section C Presentation Book
o Restraint Trend Analysis Reports for the past two quarters
o Sample of IMRT Minutes from the past six months
o List of all restraint by Individual in the past six months
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 LSSLC “Do Not Restrain” list
o List of individuals with crisis intervention plans
o List of individuals with desensitization plans
o Dental support plan data for:
• Individual #101, Individual #34, Individual #131, Individual #286, Individual #387, Individual #450, Individual #586, Individual #520, Individual #519, Individual #360, Individual #294, Individual #20, Individual #301, and Individual #110.
o Restraint Reduction Committee meeting minutes for past six months
o Sample #C.2, training transcripts for 24 LSSLC employees
o Sample #C.3, documentation for medical restraint and ISP for:
• Individual #189, Individual #151, Individual #500, Individual #14, Individual #309, Individual #262, Individual #216, Individual #477, Individual 370, and Individual #27.
o ISPs, PBSPs, Crisis Intervention Plans (when applicable), and ISPAs for:
• Individual #522, Individual #410, Individual #20, Individual #176, Individual #401, and Individual #380.
o A sample (#C.1) of restraint documentation for crisis intervention including:
<table>
<tr><th>Individual</th><th>Date</th><th>Type</th></tr>
<tr><td>#522</td><td>5/19/13@8:37 pm</td><td>Physical</td></tr>
<tr><td>#522</td><td>5/19/13@8:15 pm</td><td>Physical</td></tr>
<tr><td>#522</td><td>5/19/13@8:02 pm</td><td>Chemical</td></tr>
<tr><td>#522</td><td>5/19/13@7:17pm</td><td>Physical</td></tr>
<tr><td>#522</td><td>5/19/13@7:00 pm</td><td>Physical</td></tr>
</table>
</td></tr>
</table>

#522	5/18/13@9:21 pm	Chemical
#522	5/18/13@9:10 pm	Physical
#522	5/18/13@8:53 pm	Physical
#522	5/18/13@8:23 pm	Physical
#522	5/18/13@8:04 pm	Physical
#410	5/7/13@5:24 pm	Physical
#410	5/1/13@2:11 pm	Physical
#410	5/1/13@1:46 pm	Physical
#410	4/29/13@1:20 pm	Physical
#410	4/23/13@5:15 pm	Physical
#410	4/23/13@5:00 pm	Physical
#20	5/14/13@6:09 pm	Physical
#20	5/10/13@3:37 pm	Physical
#20	5/3/13@6:27 pm	Physical
#20	4/6/13@5:30 pm	Physical
#20	4/4/13@5:40 pm	Physical
#20	3/6/13@7:41 pm	Physical
#176	5/20/13@10:45 am	Physical
#176	5/20/13@10:30 am	Physical
#176	5/20/13@10:15 am	Physical
#401	4/20/13@8:55 am	Physical
#401	4/20/13@8:25 am	Physical
#380	3/12/13@6:50 pm	Physical

Interviews and Meetings Held:

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

Observations Conducted:

- Observations at residences and day programs
- Incident Management Review Team Meeting 7/9/13 and 7/11/13
- ISP preparation meeting for Individual #116 and Individual #185
- Annual IDT Meeting for Individual #192 and Individual #207
- Lone Pine Unit Meeting 7/9/13

	Facility Self-Assessment: LSSLC submitted its self-assessment. The self-assessment was updated on 6/27/13. 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 reviewed all crisis intervention restraints from 12/1/12 through 5/15/13 to assess compliance with each provision. Additional activities similar to those engaged in by the monitoring team were completed along with the review of restraint documentation. For instance, to assess compliance with C1, the facility also reviewed the facility policy and restraint training curricula, video reviews of restraints, and completed the state monitoring tool for a sample of 32 restraints. The facility reviewed crisis intervention restraints for compliance with C1, but did not include any review of the use of helmets. The facility self-assessment commented on the overall compliance rating for each provision item based on assessment findings. The facility assigned a self-rating of substantial compliance to C1, C2, and C3. C4, C5, C6, C7, and C8 were self-rated as noncompliant. The monitoring team found compliance with C3, C5, C6, and C8. Data gathered by the facility for C8 indicated substantial compliance, though the facility rated this provision as being out of compliance.
	Summary of Monitor's Assessment: Based on information provided by the facility, there were 342 restraints used for crisis intervention involving 22 individuals between 12/1/12 and 5/31/13. The number of restraint incidents had increased significantly since the last onsite review when it was reported that there had been 213 restraints during the review period. The facility attributed the increase in restraints to new admissions into the facility. Two of the three individuals with the highest number of restraints were indeed new admissions during the past six months. These two individuals accounted for 128 of the 347 restraints used for crisis intervention. However, there was still an increase in restraint incidents if those 128 restraints were not included in the total number of restraints. A log of all restraints provided by the facility included 157 instances of dental/medical restraint from 11/1/12 through 5/31/13 including mechanical (mittens), physical holds, and chemical restraints. The monitoring team looked at a sample of the latest restraints to evaluate progress towards meeting compliance with the requirements of section C. Overall, the facility made good progress towards meeting compliance with requirements for documenting and reviewing restraint incidents for crisis intervention. The facility needs to focus on • Continuing to develop desensitization strategies to address the use of chemical pre-sedation for

	routine appointments; • Documenting protective medical restraints in compliance with the state policy; and • Ensuring that IDTs are engaging in adequate discussion regarding the least restrictive, most appropriate supports to prevent injury to an individual.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	<u>Prone Restraint</u> a. Based on facility policy review, prone restraint was prohibited. b. Based on review of other documentation (list of restraints) prone restraint was not identified. 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 restraints for six individuals, representing 8% of restraint records over the last six-month period and 24% of the individuals involved in restraints. The sample included 26 physical restraints and two chemical restraints. Sample #C.1 included the three individuals with the greatest number of restraints, as well as three individuals who were subject to some of the most recent application of restraints. c. Based on a review of the restraint records for individuals in Sample #C.1 involving six individuals, zero (0%) showed use of prone restraint. <u>Other Restraint Requirements</u> e. Based on document review, the <u>facility</u> and <u>state</u> policies state that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample #C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: • f. In 28 of the 28 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. • g. For the 28 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 28 (100%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• h. In 26 of the records (93%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. o The restraint checklists for Individual #410 dated 5/1/13 at 2:11 pm and 1:46 pm indicated that only PMAB protection skills were attempted prior to restraint. • i. Facility policies identified a list of approved restraints. • j. Based on the review of 28 restraints, involving six individuals, 28 (100%) were approved restraints. k. In 19 of these records (68%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. • Individual #410 continued to have a high number of behavioral incidents leading to restraint (six in this sample). ISPAs did not document thorough discussion regarding treatment options recommended by IDT members or results of recommended assessments. During the onsite review, staff reported that the team had discussed the possibility that his behavior leading to restraint may be associated with seizure activity. The psychiatrist recommended a comprehensive neurological evaluation. There was no documentation that the recommended evaluation had been completed or if completed that any recommendations from the assessment were used in planning. • The restraint documentation for three restraints in the sample involving Individual #176 did not describe what triggered the behavior that led to restraint. It was not possible to determine whether or not those restraints were used in the absence or as an alternative to treatment. l. Of the 1 restraint reviewed that was considered to be PMR-SIB by the facility, 1 was reviewed by the monitoring team (Sample C.7). Of these, 1 (100%) followed state policy regarding the use, management, and review of PMR. The facility reported that there was only one protective mechanical restraint in use to prevent self-injurious behavior. Individual #192 was wearing a helmet to address SIB. A plan was developed to address attempts to fade the use of restraint, level of supervision while in restraint, schedule of restraint use and release, application and maintenance of the restraint, and documentation.	

#	Provision	Assessment of Status	Compliance
		The facility, however, reported that at least 22 individuals were wearing helmets classified as protective medical restraints to reduce the risk of injury due to falls or seizures. Medical restraint plans had not been developed for individuals to ensure that the use of protective restraints were adequately monitored and safeguards were in place to reduce any additional risk involved with wearing the helmet, such as possible loss of peripheral vision and compromised skin integrity. Without adequate documentation of IDT discussion regarding the use of helmets, it was not possible to confirm that a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner or that they were not used in the absence of or as an alternative to treatment. IDTs need to review the use of all protective medical restraints and document that they are not being used in place of less restrictive supports and treatments. Teams should ensure that staff have instructions to address level of supervision while in restraint, schedule of restraint use and release, application and maintenance of the restraint, and documentation. The facility has made progress towards compliance with C1 regarding the documentation of restraints used for crisis intervention. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The facility will need to document that restraints are not being used in the absence of adequate programming and treatment.. 2. Plans 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.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The restraint records involving the six individuals in Sample #C.1 were reviewed. All individuals in the sample had Crisis Intervention Plans that defined the use of restraint. For the six individuals involved in physical restraint who had Crisis Intervention Plans, three of 26 (12%) restraint checklists included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Crisis Intervention Plan. Following the onsite review, the facility provided additional information regarding three of the restraints, such as clarifying entries on the restraint checklist that were illegible on the monitoring team's copy of the document. Thus, it may be that six of the 26 (23%) included sufficient documentation. • Restraint checklists that clearly indicated the individual was released when no longer a danger to themselves or others included: o Individual #176 on 5/20/13 at 10:15 o Individual #20 on 4/6/13 at 5:30 o Individual #410 on 4/29/13 at 1:20	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Documentation for 15 (58%) of 26 restraints in the sample indicated that the individual was released when quiet (designated by action code "6" on the restraint checklist). Quiet was not listed as criteria for release in any of the crisis intervention plans reviewed. Based on this review, the facility is not in compliance with C2. To regain substantial compliance for C2, staff will need to adequately document that individuals are released according to criteria in crisis intervention plans when there is a plan in place.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. a. Review of the facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: • Policies governing the use of restraint; • Approved verbal and redirection techniques; • Approved restraint techniques; and • Adequate supervision of any individual in restraint. Sample #C.2 was randomly selected from a current list of staff. b. 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: • 23 of the 24 (96%) had current training in RES0105 Restraint Prevention and Rules. • 18 of the 19 (95%) employees with current training who had been employed over one year had completed the RES0105 refresher training within 12 months of the previous training. 24 of the 24 (100%) had completed PMAB training within the past 12 months. • 19 of the 20 (95%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. c. In 26 of the records (93%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. • The restraint checklist for Individual #410 dated 5/1/13 at 1:46 pm and 2:11 pm did not document staff attempts at other interventions recommended in the PBSP.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Based on this review, the facility was in substantial compliance with training requirements.	
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.	a. Based on a review of 28 restraint records (Sample #C.1), in 28 (100%) there was evidence that documented that restraint was used as a crisis intervention. b. In review of Positive Behavior Support Plans, in three (100%), there was no evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint). c. In addition, facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention. d. In 28 of 28 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to the "Do Not Restrain" list maintained by the facility. e. Restraints from Sample #C.1 for Individual #522, Individual #410, and Individual #20 were reviewed. In 16 of 22 restraint records reviewed (73%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to the form used by the facility to document restraint considerations/restrictions. • Individual #410's physician noted possible tachycardia/atrial flutter was a contraindication for restraint. There was no evidence that the IDT discussed this concern. f. In 22 of 22 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis intervention plan. In reviewing 11 ISPs for individuals for whom restraint had been used for the completion of ~~(medical or)~~ dental work: • g. 11 (100%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent); • h. 11 (100%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint; and • i. 11 (100%) of the treatments or strategies developed to minimize or eliminate the need for restraint were implemented as scheduled. According to a list provided by the facility, 90 individuals had required the use of pretreatment sedation prior to medical appointments. The facility reported that 22 individuals had medical or dental desensitization plans in place (24%). Of these 22, the	Noncompliance

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		monitoring team reviewed 11. They were all dental plans. The plans included individualized strategies. Data were being collected and graphed regarding progress on plans. The facility now had a dental and medical desensitization work group. The group was focusing on dental refusals and anxiety related to going to the dental clinic for treatment. An assessment tool had been developed and a process had been implemented for psychology staff to develop desensitization strategies. Based on this review, the facility was not substantial compliance with C4. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Desensitization or other individualized strategies will need to be considered for all individuals who require the use of pretreatment sedation for routine medical and dental appointments. 2. Ensure that all IDTs are holding adequate discussion regarding the use of medical restraints. Plans 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.	
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	a. Review of facility training documentation showed that there was an adequate training curricula for restraint monitors on the application and assessment of restraint. b. This training was competency-based. Eighteen staff in the psychology department and five campus coordinators had been deemed competent to monitor restraints. c. Based on review of restraint records in Sample #C.1, eight staff who performed the duties of a restraint monitor (100%) successfully completed the training to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint. Based on a review of 28 restraint records (Sample #C.1), a face-to-face assessment was conducted: • d. In 28 out of 28 incidents of restraint (100%) by an adequately trained staff member. • e. In 28 out of 28 instances (100%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. • f. In 28 instances (100%), the documentation showed that an assessment was completed of the application of the restraint. • g. In 28 instances (100%), the documentation showed that an assessment was completed of the consequences of the restraint.	Substantial Compliance

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	justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	A sample of 0 records for which physicians had ordered alternative monitoring schedules was reviewed (none were submitted). • h. In ___ out of ___ (___%), the extraordinary circumstances necessitating the alternative monitoring were documented; and • i. In ___ out of ___ (___%), the alternative monitoring schedules were followed. Based on a review of 28 restraint records for restraints that occurred at the facility (Sample #C.1), there was documentation that a licensed health care professional: • j. Conducted monitoring at least every 30 minutes from the initiation of the restraint in 28 (100%) of the instance of restraint. • k. Monitored and documented vital signs in 28 (100%). • l. Monitored and documented mental status in 28 (100%). Based on documentation provided by the facility, 0 restraints had occurred off the grounds of the facility in the last six months. A sample of N/A was reviewed (Sample #C.5). A licensed health care professional: • m. Conducted monitoring within 30 minutes of the individual's return to the facility in __ out of ___ (__%). • n. Monitored and documented vital signs in ___ (___%). • o. Monitored and documented mental status in ___ (___%). Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. For these individuals, p. In 10 out of 10 (100%), the physician specified the schedule of monitoring required or specified facility policy regarding this was followed; and • q. In zero out of zero (N/A), the physician specified the type of monitoring required if it was different than the facility policy. • r. In 10 out of 10 of the medical restraints (100%), appropriate monitoring was completed either as required by the Settlement Agreement, facility policy, or as the physician prescribed. Based on this review, the facility was in substantial compliance with this provision.	
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	A sample (Sample #C.1) of 28 Restraint Checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each of the required elements: • a. In 28 (100%), continuous one-to-one supervision was provided; • b. In 28 (100%), the date and time restraint was begun; • c. In 28 (100%), the location of the restraint; • d. In 25 (89%), information about what happened before, including what was	Substantial Compliance

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	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.	happening prior to the change in the behavior that led to the use of restraint. The restraint documentation for three restraints in the sample involving Individual #176 did not describe what triggered the behavior that led to restraint. The narrative portion just stated, "individual was physically aggressive towards staff." • e. In 28 (100%), the actions taken by staff prior to the use of restraint to permit adequate review per C.8. • f. In 28 (100%), the specific reasons for the use of the restraint • g. In 28 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; • h. In 28 (100%), the names of staff involved in the restraint episode; • Observations of the individual and actions taken by staff while the individual was in restraint, including: o i. In 28 (100%), the observations documented every 15 minutes and at release (at release for physical or mechanical restraints of any duration). The longest restraint in the sample was 15 minutes. o j. In ___ (____%) of those restraints that lasted more than 15 minutes, the specific behaviors of the individual that required continuing restraint; and (there were none) o k. In ___ (____%), the care provided by staff during restraint lasting more than 30 minutes, including opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan (there were none). • l. In 28 (100%), the level of supervision provided during the restraint episode; • m. In 30 (100%), the date and time the individual was released from restraint; and • n. In 28 (100%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. o. In a sample of 28 records (Sample #C.1), restraint debriefing forms had been completed for 28 (100%). p. A sample of 10 individuals subject to medical restraint was reviewed (Sample #C.3), and in 10 (100%), there was evidence that the monitoring had been completed as required by the physician's order.	

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		Sample #C.4 was a subsample of the two chemical restraints included in Sample #C.1. q. In two (100%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional 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. Based on this review, the facility was in substantial compliance with the requirements of 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 11 individuals were placed in restraint more than three times in a rolling 30-day period. This represented an increase from last review when eight individuals were placed in restraint more than three times in a rolling 30-day period. Three of these individuals (i.e., Individual #301, Individual #20, and Individual #110) were reviewed (27%) 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 three individuals were reviewed. The results of this review are discussed below with regard to Sections C7a through C7g of the Settlement Agreement. In order to achieve substantial compliance with this provision item, the minutes from at least 85% of the individual ISPA meetings following more than three restraints in a rolling 30-day period should reflect a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them. All three of the ISPA minutes reviewed reflected a discussion of the individuals' adaptive skills, biological/medical status, and psychosocial factors. None of the 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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	(b) review possibly contributing environmental conditions;	This item was rated as being in noncompliance because one of the three ISPAs reviewed (33%) reflected a discussion of potential contributing environmental factors (e.g., noisy or crowded environments) and, for those hypothesized to potentially affect dangerous behavior, suggestions for modifying them to prevent the future probability of restraint. One (i.e., Individual #110) of the three ISPAs reviewed (33%) indicated that environmental conditions did not play a role in his restraints. The other two IPSAs identified potential contributing environmental conditions (e.g., an Easter party for Individual #301), however, no discussion of how these environmental factor could be addressed was provided.	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. This item was rated as in noncompliance, however, because the other two 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 was rated as being in noncompliance because only one (i.e., Individual #301) of the three ISPA meeting minutes reviewed (33%) reflected a discussion of variables potentially maintaining the behavior provoking restraints, and suggestions for modifying them to prevent the future probability of restraint. Individual #301's ISPA suggested that one of his restraints might be due to tooth pain. The ISPA also indicated that Individual #301 was referred to the dental clinic to evaluate his tooth. The other two ISPAs reviewed included a discussion indicating variables potentially maintaining the dangerous behavior that provoked restraint. Neither of the ISPAs, however, reflected a discussion of potential action to address these hypothesized variables maintaining the individual's dangerous behavior that provoked restraint. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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.	
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	All three individuals reviewed (100%) had a PBSP to address the behaviors provoking restraint. The following was found: • All three PBSPs reviewed (100%) specified the objectively defined behavior to be treated that led to the use of the restraint (see K9 for a discussion of operational definitions of target behaviors), • All three of the PBSPs reviewed (100%) specified the alternative, positive, and functional (when possible and practical) adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, and • All three of the PBSPs reviewed (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint • All three of the PBSPs reviewed (100%) contained interventions to weaken or reduce the behaviors that provoked restraint that was based on the functional assessment results. All three of the Individuals reviewed (100%) had a crisis intervention plan. The following was found: • For all three the type of restraint authorized was delineated, • For none of the three crisis intervention plans reviewed (0%) was the maximum duration of restraint authorized specified, • For all three the designated approved restraint situation was specified, and • For all three the criteria for terminating the use of the restraint were specified. In order to achieve substantial compliance with this provision item, LSSLC needs to ensure that at least 85% of crisis interventions plans contain the maximum duration of restraint authorized.	Noncompliance
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	For none of the individuals reviewed (0%) was there evidence that demonstrated that the PBSP was implemented with a high level of treatment integrity (see K10 for a more detailed discussion of treatment integrity at the facility).	Noncompliance

#	Provision	Assessment of Status	Compliance
	(g) as necessary, assess and revise the PBSP.	One (Individual #20) of the three ISPAs reviewed (33%) documented that the PBSPs would be modified following more than three restraints in a 30-day period. There was no evidence, however, in the ISPAs reviewed that the other two PBSPs were reviewed. In order to achieve substantial compliance with this provision item, 85% individuals who were placed in restraint more than three times in a rolling 30-day period, should have evidence of a review (in the ISPA), and revision when necessary, 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.	A sample of documentation related to 28 incidents of non-medical restraint was reviewed (Sample #C.1), this documentation showed that: • a. In 28 (100%), the review by the Unit IDT occurred within three business days of the restraint episode and this review was documented by signature on the Restraint Checklist and/or Debriefing Form. • b. In 28 (100%), the review by the IMRT occurred within three business days of the restraint episode and this review was documented by signature on the Restraint Checklist and/or Debriefing Form. • c. In 28 (100%), the circumstances under which the restraint was used was determined and is documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. • d. In 28 (100%), the review conducted by the restraint monitor was sufficient to determine if the application of restraint was justified; if the restraint was applied correctly; and to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. Based on this review, the facility was in substantial compliance with review requirements.	Substantial compliance

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 #002.4, dated 11/20/12 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021.2 dated 12/4/12 o LSSLC Policy: Investigation of Client Abuse, Neglect, and Exploitation dated 2/15/13 o LSSLC Policy: Incident Management dated 1/15/13 o QAQI Data Summary October 2012-December 2012 o Information used to educate individuals/LARs on identifying and reporting unusual incidents o Incident Management Review Committee meeting minutes for each Monday of the past six months o Training transcripts for 24 randomly selected employees o Acknowledgement to report abuse for 24 randomly selected employees o Acknowledgement to report abuse for all employees hired within the last 2 months o Training and background checks for the last three employees hired o List of DFPS investigators assigned to complete investigations at LSSLC (6) o Abuse/Neglect/Exploitation Trend Reports FY13 o Injury Trend Reports FY13 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 A sample of acknowledgement to self report criminal activity for 24 current employees o ISPs for: • Individual #502, Individual #151, Individual #369, Individual #110, Individual #306, Individual #235, Individual #238, Individual #145, Individual #258, and Individual #301. 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 incidents and injuries since 6/3/12 o List of all ANE allegations since 11/3/12 including case disposition o A list of all investigations completed by the facility in the last six months. o List of employees reassigned due to ANE allegations o List of staff who failed to report ANE, or failed to report in a timely manner o Documentation of employee disciplinary action taken with regards to the last three incidents of confirmed abuse or neglect. o Documentation from the following completed investigations, including follow-up:

Sample D.1	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#42734631	Sexual Abuse	Unconfirmed	5/4/13 9:14 am	5/4/13 7:00 pm	5/13/13
#42714959	Emotional/Verbal Abuse (2) Physical Abuse	Unconfirmed (2) Unconfirmed	4/16/13 4:07 pm	4/19/13 3:30 pm	4/26/13
#42712566	Physical Abuse	Unconfirmed	4/14/13 7:11 pm	4/15/13 1:00 pm	4/24/13
#42695134	Neglect Physical Abuse	Unconfirmed Unconfirmed	3/28/13 7:01 am	3/30/13 2:00 pm	4/7/13
#42692296	Physical Abuse	Inconclusive	3/25/13 8:26 pm	3/27/13 1:30 pm	4/14/13
#42684040	Neglect Physical Abuse	Unconfirmed Confirmed	3/17/13 9:37 pm	3/19/13 2:30 pm	4/3/13
#42684373	Neglect (3)	Confirmed (2) Unconfirmed (1)	3/18/13 11:32 am	3/18/13 5:00 pm	4/27/13
#42679977	Emotional/Verbal Abuse	Unconfirmed	3/12/13 1:46 pm	3/13/13 12:48 pm	3/22/13
#42678241	Neglect (2)	Other (1) Unconfirmed (1)	3/10/13 7:42 am	3/10/13 4:05 pm	3/20/13
#42658732	Physical Abuse	Unconfirmed	2/19/13 10:47 am	2/19/13 1:00 pm	3/1/13
#42658403	Neglect (2)	Inconclusive (2)	2/18/13 8:23 pm	2/19/13 4:20 pm	3/18/13
#42655065	Emotional/Verbal Abuse	Unconfirmed	2/14/13 3:37 pm	2/15/13 6:10 pm	2/22/13
#42651585	Neglect	Unconfirmed	2/11/13 7:03 pm	2/12/13 4:16 pm	2/21/13
#42640773	Emotional/Verbal Abuse (2) Physical Abuse	Unconfirmed Confirmed Confirmed	1/31/13 4:38 pm	2/1/13 9:20 am	2/10/13
#42724525	Neglect	Referred Back	4/25/13 9:03 am		4/30/13

Sample D.2	Type of Incident	Date/Time Incident Occurred			
#13-129	Serious Injury-Determined Cause	5/22/13 5:35 pm			
#13-127	Serious Injury-Determined Cause	5/21/13 8:55 am			
#13-126	Serious Injury-Determined Cause	5/20/13 1:20 pm			
#13-117	Theft	4/24/13 Unknown			
#13-103	Serious Injury-Determined Cause	3/18/13 4:45 pm			

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
- Paula McHenry, QA Director
- Keith Bailey, Residential Director
- Todd Miller, Unit Director
- Rotley Tankersley, Unit Director
- Kenneth Self, Unit Director
- Mary Stovall, Unit Director

Observations Conducted:

- Observations at residences and day programs
- Incident Management Review Team Meeting 7/9/13 and 7/11/13
- ISP preparation meeting for Individual #116 and Individual #185
- Annual IDT Meeting for Individual #192 and Individual #207
- Lone Pine Unit Meeting 7/9/13
- Self-Advocacy 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 the requirements of the Settlement Agreement. One listed all of the action plans for each provision of the Settlement Agreement. The second document 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 D2b, the facility reviewed investigations to ensure that immediate protective actions were taken when an allegation was reported and reviewed the facility tracking log for reassignment of all alleged perpetrators. The facility's review of its own performance found compliance with 20 of 22 provisions of section D. The exceptions were D2i and D4. The monitoring team found the facility to be in substantial compliance with 18 of the 22 provision items. The monitoring team was unable to confirm compliance with the requirements that • Staff were to immediately report all serious incidents to the appropriate parties(D2a); • The facility was to audits of all serious or suspicious injuries for investigation (D2i); • The facility implemented action promptly and thoroughly, and tracked actions and the corresponding outcomes following unusual incidents (D3i). • Corrective action was taken to address trends of incidents and injuries (D4). The facility is to be commended for its continued focus on developing an adequate self-assessment process to monitor compliance with section D requirements.
	Summary of Monitor's Assessment: According to a list provided by LSSLC, DFPS conducted investigations involving 51 allegations at the facility between 11/1/12 and 5/4/13, including 24 allegations of physical abuse, one allegation of exploitation, two allegations of sexual abuse, and 24 allegations of neglect. Of the 51 allegations, there were five confirmed cases of physical abuse and three confirmed cases of neglect. An additional 51 other serious incidents were investigated by the facility. There were a total of 1547 injuries reported between 12/1/12 and 5/31/13. These 1547 injuries included 27 serious injuries resulting in fractures or sutures. Injury trends were being generated by individual and made available to IDTs for access on the shared drive. As noted in previous reviews, many of the serious injuries were preceded by similar incidents not adequately addressed. For example, Individual #151 sustained a serious injury from a fall on 5/22/13. She had seven other falls over the past year, two resulting

	in serious injury. Her PNMP in effect at the time of the most recent fall was not clear in what supports staff should be providing to protect her from injury. There was no indication that supports were being monitored to ensure that they were adequate to protect her from injury. Fourteen individuals had been identified by the facility as having had 10 or more falls between October 2012 and May 2013. Teams were not meeting and revising supports, then continuing to adequately monitor supports to verify implementation and efficacy. See section D4 below regarding the actions and work done at LSSLC regarding injuries and falls. Minimal progress had been made in adequately following up on incidents by addressing factors contributing to the large number of incidents and injuries at the facility. As discussed in D4, the QAQI Council was beginning to focus on developing action plans to address trends at the facility, but the process was in the initial stages and adequate action plans and follow-up to action plans to track outcomes was not yet occurring. While the incident management and quality assurance departments were beginning to focus on trends and systemic issues that contribute to incidents and injuries, it was not evident that IDTs were proactive in revising supports and monitoring implementation following incidents. Individuals at the facility remained at risk for harm due inadequate follow-up to incidents.

#	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		

#	Provision	Assessment of Status	Compliance
	incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	The 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. Although in the paragraphs that follow, the monitoring team has provided some figures with regard to allegations and incidents, it is essential to note that reviewing pure numbers provides very little meaningful information. For each of these categories, the facility would need to conduct analyses to determine causes, and to review carefully whether for incidents that were preventable, adequate action had been taken to prevent their recurrence. Determining the reasons or potential reasons for increases or decreases in numbers also is essential. Although the ultimate goal is to reduce the overall numbers of preventable incidents, care needs to be taken to ensure that the result of such efforts is not the underreporting of incidents. For an incident management system to work properly, full reporting of incidents is paramount, so that they can be reviewed, and appropriate actions taken. The facility's progress in analyzing data collected, and addressing issues identified is discussed in further detail with regard to section D4 of the Settlement Agreement. According to a list of all abuse, neglect, and exploitation investigations between 11/1/12 and 5/4/13 provided to the monitoring team, investigations of 51 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility. From these 51 allegations, there were: • 24 allegations of physical abuse including, o 5 confirmed; o 15 unconfirmed; and o 4 inconclusive. • 2 allegations of sexual abuse including o 2 unconfirmed. • 24 allegations of neglect including, o 3 confirmed; o 15 unconfirmed; o 1 inconclusive; and o 5 administrative referrals. • 1 allegations of exploitation including, o 1 unconfirmed.	Noncompliance

#	Provision	Assessment of Status	Compliance
		According to a list provided by the facility, there were 51 other investigations of serious incidents not involving abuse, neglect, or exploitation between 12/1/12 and 5/31/13. This included: o 26 serious injuries/determined cause, o 3 serious injuries from peer-to-peer aggression, o 0 serious injury/undetermined cause o 3 sexual incidents, o 0 unauthorized departures, o 5 deaths, o 1 suicide threat, o 1 encounters with law enforcement, and o 12 others unspecified. From all investigations since 12/1/12 reported by the facility, 20 investigations were selected for review. The 20 comprised two 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 (15 cases). • Sample #D.2 included investigations the facility completed related to serious incidents not reportable to DFPS (5 cases). Based on responses to questions about reporting, seven of eight (88%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for abuse, neglect, and/or exploitation. One direct support professional stated that he would notify his supervisor. Based on a review of the 15 investigative reports included in Sample #D.1: • 15 of 15 reports in the sample (100%) indicated that DFPS was notified within one hour of the incident or discovery of the incident. o In DFPS case #42684373, during a breach of supervision, Individual #488 removed his g-tube. He was transported to the hospital for replacement of the g-tube. Although the breach of supervision was documented in his IPN, attention was not given to this breach of supervision to prevent a similar incident from occurring until the incident ultimately led to his death three days later. The staff person that neglected his care was allowed to continue caring for him following the incident. • Eleven (73%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by	

#	Provision	Assessment of Status	Compliance
		DADS/Facility policy. o 11 of 15 (73%) indicated the facility director or designee was notified of the incident within one hour. ▪ The facility did not document notification for DFPS case #42695134. ▪ DFPS case #42734631 was reported to DFPS at 9:00 am on 5/4/13. The UIR documented notification of the director at 10:43 am. ▪ DFPS case #42684040 was reported to DFPS at 9:37 pm on 3/17/13. The facility director was notified on 3/18/13 at 1:00 am. ▪ DFPS case #42640773 was reported to DFPS at 4:38 pm on 1/31/13. The facility director was notified at 5:50 pm. o 15 of 15 (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. o 15 of 15 (100%) documented that the state office was notified as required. Based on a review of five investigation reports included in Sample #D.2: • Three (60%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. o UIR #13-127 was investigation of a serious injury. The director was not notified within an hour of diagnosis of a fractured clavicle. o UIR #13-117 was investigation of a theft reported at 3:00 pm on 4/24/13. The facility director was notified at 5:20 pm according to the UIR. This was not within an hour as required by state policy. • Five (100%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. The facility had a standardized reporting format. 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. Based on a review of 20 investigation reports included in Samples #D.1 and #D.2, 20 (100%) contained a copy of the report utilizing the required standardized format and were completed fully. New employees were required to sign an acknowledgement form regarding their obligations to report abuse and neglect. 80 of 81 (99%) new employees hired since 4/1/13 signed this form when hired. All employees were required to sign an acknowledgement form annually. A sample of this form was a random sample of 24	

#	Provision	Assessment of Status	Compliance
		employees at the facility. Twenty-four of 24 employees (100%) in the sample signed this form annually as required by state policy. The facility was not in substantial compliance with the requirements of D2a. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The facility should ensure that the facility director or designee is notified within one hour, as required by state policy, for all serious incidents.	
	(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 had 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. The monitoring team was provided with a log of employees who had been reassigned between 11/1/12 and 5/10/13. The log included the applicable investigation case number, date of reassignment, and the date the employee was returned to work. Based on a review of 15 investigation reports included in Sample D.1, in 13 out of 13 cases (100%) where an alleged perpetrator (AP) was known, it was documented that the AP was placed in no contact status immediately. All allegations were discussed in the daily IMRT meeting and protections were reviewed. In 13 out of 13 cases (100%), where there was a known alleged perpetrator, 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. The DADS UIR included a section for documenting immediate corrective action taken by the facility. Based on a review of the 15 investigation files in Sample D.1, 15 (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 changes in level of supervision when applicable. The facility was in substantial compliance with this provision.	Substantial Compliance
	(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	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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	documentation indicating completion of such training.	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. • 20 (100%) of 20 employees (employed over one year) with current training completed this training within 12 months of the date of previous training unless documentation indicated that the employee was on leave. • 24 (100%) employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • 19 (95%) of the 20 employees (employed over one year) with current training completed this training within 12 months of the date of previous training unless documentation indicated that the employee was on leave. The facility maintained compliance with the requirement for annual retraining according to the sample reviewed. The facility was in substantial compliance with this provision.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	According to facility policy, all staff were required to sign a statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation to DFPS immediately during pre-service and every 12 months thereafter after completing ABU0100 training. A sample of this form was reviewed for a random sample of 24 employees at the facility. 24 (100%) of 24 employees in the sample had a current signed acknowledgement form. A review of training curriculum provided to all employees at orientation and annually thereafter emphasized the employee's responsibility to report abuse, neglect, and exploitation. The facility reported that there were two cases where staff failed to report abuse or neglect as required. One staff person resigned and the second person was suspended for 10 days without pay. The monitoring team assigned a substantial compliance rating to this provision.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual	A review was conducted of the materials to be used to educate individuals, legally authorized representatives (LARs), or others significantly involved in the individual's life. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. 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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	A sample of 10 ISPs was reviewed for compliance with this provision. The sample ISPs were for Individual #502, Individual #151, Individual #369, Individual #110, Individual #306, Individual #235, Individual #238, Individual #145, Individual #258, and Individual #301. • Nine (90%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings. The exception was the ISP for Individual #151. 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. The facility was in substantial compliance with this item.	
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	A review was completed of the posting the facility used. It included a brief and easily understood statement of: • Individuals' rights, • Information about how to exercise such rights, and • Information about how to report violations of such rights. Observations by the monitoring team of all living units and day programs on campus showed that all of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. There was a human rights officer at the facility. Information was posted around campus identifying the human rights officer with his name, picture, and contact information. The HRO was actively involved in educating individuals about their rights through the facility's self-advocacy group. The facility remained in substantial compliance with this provision item.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	Documentation of investigations confirmed that DFPS routinely notified appropriate law enforcement agencies of any allegations that may involve criminal activity. DFPS investigative reports documented notifications.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Based on a review of 15 allegation investigations completed by DFPS (Sample #D.1), DFPS notified law enforcement and/or OIG of the allegation in 15 (100%), when appropriate. OIG investigated seven cases in the sample and criminal activity was substantiated in three of seven (43%) cases. The facility remained in substantial compliance with this provision item.	
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	The following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: • LSSLC 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. No names were submitted. Based on a review of investigation records (Sample #D.1), there were no concerns related to potential retaliation for reporting. The facility maintained substantial compliance with this item.	Substantial Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The facility had implemented an injury audit process to determine if all injuries that should have been reported for investigation were investigated. This included those injuries defined in DADS policy as "serious injuries" as well as non-serious injuries on parts of the body that might indicate potential abuse or neglect, or patterns of minor injuries both witnessed and discovered Reviews included a sample of Integrated Progress Notes, Home/Shift Logs, Observation Notes, and Campus Coordinator Logs to identify any incidents that should have resulted in completing a Client Injury Report, and a comparison to determine if incident reports were filed. The facility conducted audits at least quarterly, during the preceding six months. The audits conducted were sufficient to determine whether significant resident injuries had been reported for investigation.	Noncompliance

#	Provision	Assessment of Status	Compliance
		No significant injuries were identified by the audit that had not previously been investigated. The facility was in agreement that this was a new process and not yet sufficient for determining that all injuries were reported for investigation. Based on observations and interviews in two of the residences and a sample of completed injury audits, the facility's audit system was not adequate for ensuring that all discovered and/or suspicious injuries were reported for investigation. The monitoring team found injuries to individuals that were not documented or reported. The facility was not yet in substantial compliance with this provision item. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The facility should include a review of current injuries in the audit process to ensure that all injuries are being reported.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	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. Eight DFPS investigators were assigned to complete investigations at LSSLC. The training records for DFPS investigators were requested and submitted. • Of 8 DFPS investigators, 8 (100%) had completed the requirements for training regarding individuals with developmental disabilities.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		LSSLC had 14 employees designated to complete investigations. This included the IMC, Facility Investigators, and Campus Administrators. The training records for those designated to complete investigations were requested, 14 (100%) investigators had completed training on: • Abuse, Neglect, and Exploitation, • Unusual Incidents, and • Comprehensive Investigator Training. Facility investigators did not have supervisory duties, therefore, they would not be within the direct line of supervision of the alleged perpetrator.	
	(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. The facility incident management coordinator reported good cooperation between the facility incident management staff and DFPS.	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 15 investigations completed by DFPS (Sample #D.1), OIG investigated seven of the incidents. In the investigations completed by both OIG and DFPS, it appeared that there was adequate coordination to ensure that there was no interference with law enforcement's investigations. • There was no indication that the facility had interfered with any of the investigations by OIG in the sample reviewed. The facility was found to be in substantial compliance with this provision.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(d) Provide for the safeguarding of evidence.	The LSSLC policy on Abuse and Neglect mandated staff to take appropriate steps to preserve and/or secure physical evidence related to an allegation. Documentary evidence was to be secured to prevent alteration until the investigator collected it. Based on a review of the investigations completed by DFPS (Sample #D.1) and the facility (Sample #D.2): • There was no indication that evidence was not safeguarded during any of the investigations. Video 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 10 of 15 (75%) investigations. o 15 (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. • Thirteen of 15 (87%) were completed within 10 calendar days of the incident. Those not completed within 10 days included: o Case #42692296 was submitted on the 20th day (extension filed – OIG involvement). o Case #42684373 was submitted on the 40th day (extension filed- OIG involvement). • All 15 (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below in section D3f. • In seven of 15 (47%) DFPS investigations reviewed in Sample #D.1, 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 of being reported in five of five cases (100%).	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• Five of five (100%) indicated that the investigator completed a report within 10 days of notification of the incident. • Five (100%) included recommendations for follow-up action to address the incident.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	Based on the Monitoring Teams' review of DADS revised Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section VII.B, the policy was consistent with the Settlement Agreement requirements. The facility policy and procedures were consistent with the DADS policy with regard to the content of the investigation reports. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • In 15 out of 15 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. • The report utilized a standardized format that set forth explicitly and separately: o In 15 (100%), each unusual/serious incident or allegations of wrongdoing; o In 15 (100%), the name(s) of all witnesses; o In 15 (100%), the name(s) of all alleged victims and perpetrators; o In 15 (100%), the names of all persons interviewed during the investigation; o In 15 (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 15 (100%), all documents reviewed during the investigation; o In 15 (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. DFPS found in each case that prior case history of principals was reviewed and used or not used in the current investigation. Facility UIRs included a summary of previous similar investigations with a statement regarding the outcome of those investigations. o In 15 (100%), the investigator's findings; and o In 15(100%), the investigator's reasons for his/her conclusions.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Facility Investigations The following summarizes the results of the review of five facility investigations: • The report utilized a standardized format that set forth explicitly and separately: o In five (100%), each unusual/serious incident or allegations of wrongdoing; o In five (100%), the name(s) of all witnesses; o In five (100%), the name(s) of all alleged victims and perpetrators; o In five (100%), the names of all persons interviewed during the investigation; o In five (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 five (100%), all documents reviewed during the investigation; o In five (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o In five (100%), the investigator's findings; and • In five (100%), the investigator's reasons for his/her conclusions. • In five out of five investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. 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.	The facility policy and procedures required that staff supervising the investigations reviewed each report and other relevant documentation to ensure that: 1) the investigation is complete; and 2) the report is accurate, complete, and coherent. DFPS Investigations The following summarizes the results of the review of a sample of 15 DFPS investigations included in Sample #D.1: • In 15 (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. • The DFPS investigations in Sample D.1 met at least 90% compliance with the requirements of Section D.3.e (excluding timeliness requirements) and D.3.f; • The facility Incident Review Team (IRT) accepted all (100%) investigations in the sample. • The monitoring team did not note problems with regard to Sections D.3.e, and/or D.3.f for DFPS investigations in the sample.	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, • 15 (100%) DFPS investigations were reviewed by both the facility director and IMC following completion. • 13 (87%) were reviewed by the facility director and/or the Incident Management Coordinator within five working days of receipt of the completed investigation. o The IMC and director signed off on DFPS Case #42655065 on 3/6/13. The DFPS report indicated that the report was submitted to the facility on 2/21/13. o The IMC and director reviewed and approved DFPS case #42692296 on 4/23/13. DFPS completed their investigation on 4/14/13. Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations in samples #D.2: • In four out of five investigation files reviewed (80%), there was evidence that the supervisor had conducted a prompt review of the investigation report to determine whether or not the investigation was thorough and complete and that the report was accurate, complete, and coherent. o UIR #13-126 was completed on 5/20/13 and was not reviewed by the IMC Coordinator until 5/28/13. • The supervisor did not identified concerns in any of the investigations. • The monitoring team did not identify deficiencies in any of the investigations. 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. The facility was in substantial compliance with the requirement for review of all investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent.	
	(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 reviewed. A statement regarding review, recommendations, and follow-up was included on the review form. The facility-only investigations met the requirements outlined in Section D.3.f.	Substantial Compliance

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	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	The facility policy and procedures required disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence to be taken promptly and thoroughly. The IMRT considered and accepted or provided a reason for not accepting recommendations in the DFPS or UIR reports. In addition, the policy and procedures did specify the facility system for tracking and documenting such actions and the corresponding outcomes. The facility had implemented a tracking log to document completion of all recommendations from investigations. A subsample of investigations was reviewed to confirm that appropriate disciplinary action was taken following the investigation when warranted. This sample included DFPS cases #42540773, #42658403, #42678241, #42684373, #42684040, facility investigations #13-129 and #13-126. For four out of five of the investigations reviewed in which disciplinary action was warranted (80%), prompt and adequate disciplinary action had been taken and documented. • In DFPS Case #42640773, the investigator returned a confirmed allegation of physical abuse and a confirmed allegation of emotional/verbal abuse against the AP. Video surveillance corroborated the finding. The AP received a three day suspension for her actions. This did not support the facility's policy of zero tolerance for abuse and neglect. Based on a review of a subsample of investigations (listed above) for which recommendations for programmatic action were made, the following was found: • For four out of six of the investigations reviewed (67%), prompt and thorough programmatic action had been taken and documented. o In DFPS case #42658403, the investigator recommended a PNMT assessment for Individual #76 to be completed by 4/26/13. The assessment was not completed until 5/14/13. At that time, the therapist recommended changes in his PNMP. There was no documentation of follow-up to ensure that his PNMP was revised and staff were trained on the changes. o In UIR #13-129, the investigator recommended a change in Individual #151's PNMP following a fall resulting in a serious injury. The IDT met on 5/23/13 and recommended a change in her PNMP. A request for Individual #151's current ISP and supports yielded an outdated PNMP that did not include changes requested by the IDT. There was no evidence that the revised PNMP had been implemented.	Noncompliance

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		• The facility was in the beginning stages of developing a system to confirm that expected outcomes were achieved following recommendations from investigations (e.g., based on retraining, staff had passed a competency test or during interview could provide relevant information; observation of a change in physical environment; observation or documentation review to confirm a change in practice; behavioral data showing a change in behavior; etc.). To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The facility needs to ensure adequate following up on all recommendations, documenting follow-up action, and monitoring outcomes of the action for investigations.	
	(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
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 fully implemented the statewide system to collect data on unusual incidents and investigations. For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending 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 investigation. Over the past two quarters, the facility's trend analyses: ▪ Were conducted at least quarterly; and • Addressed the minimum data elements. • A narrative description/explanation of the results and conclusions was generated; and • Recommendations for corrective actions were made to address some trends identified.	Noncompliance

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		Based on a review of trend reports, IMRT minutes, and QAQI Council minutes, when a negative pattern or trend was identified, adequate corrective action plans were not developed. As appropriate, corrective action plans were not fully developed to address both specific individuals and systemic issues. The trend reports and minutes did not show that corrective action plans were implemented and tracked to completion. The report and minutes did not review, as appropriate, the effectiveness of previous corrective actions. As appropriate, corrective action plans should be developed in response to the trends and data analysis. The plans should identify the strategies the facility intends to implement to reduce the risk of similar events occurring in the future for specific individuals, as well as at a systemic level. Each corrective action plan should identify: a. Changes to be implemented to reduce risk or a referral to another group to develop such a plan, such as a referral for an IDT meeting, or review by PNMT. Such changes should be expected to correct the identified issue. When referrals are made to other groups, a process should be in place to ensure the IMRT and/or QAQI Council review/approve the resulting plan, and will be provided follow-up information; b. Who is responsible for implementation and when the action will be implemented, including any pilot testing. Timeframes should be reasonable based on the seriousness of the issue and the time necessary for the action to be completed; and c. The method for assessing the effectiveness and sustainability of the actions. The QA department was focusing on incidents and injuries at the facility. A particular focus had been placed on addressing the high incidence of injuries to individuals with a more intensive look at the number of falls resulting in injury. Trend data showed that there had been 258 falls with injuries at the facility between October 2012 and May 2013. Fourteen individuals at the facility had 10 or more falls during this period. Corrective action plans were developed by the QA/QI Council in February 2013 to address falls with an outcome of reducing falls by 20%. While some of the action steps had dates assigned for completion, others did not.	

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		At the QAQI Council meeting observed during the week of the onsite visit, the committee reviewed data regarding falls, but did not comment on the status of all action steps developed to address falls. Unit managers commented on action taken at the unit level to reduce the number of falls in each unit, but this information was not being formally gathered and reviewed to monitor efficacy. Additionally, the facility had recently implemented a threshold identification process. According to the guidelines developed by the facility, the process was a quality improvement system for identifying and reviewing incidents, health-related episodes, and associated risk indicator data on an individual and aggregate basis and ensuring follow-up activities as appropriate. The quality assurance department was responsible for monitoring established risk thresholds for risk indicators and communicating that information to the IDT, PNMT, and/or BSC. At the time of the onsite review, • A database was in place to track identified incidents and health related episodes. • The QA department was notifying IDTs when a risk threshold was reached by an individual. • Aggregate data were distributed and reviewed by the unit managers and QA/QI council. • QA staff was monitoring follow-up by the IDT It was not evident that IDTs were aggressively addressing risk factors by developing measurable action steps, assigning dates and responsibility for team members to complete action steps, and then following up to monitor and/or revise action steps when appropriate. For example, the QA department had identified that Individual #305 was at high risk for falls when data showed a trend of five falls in a three-month period. The five falls occurred after he had sustained a serious head injury due to a fall on 1/31/13. The IDT met to review his risk for falls on 5/20/13. The IDT determined that the falls were caused by seizure activity and tripping over his socks that had fallen down. The team made recommendations including: • Continue to follow BSP; • Routine 15 minute checks due to seizures; • Put shoes on immediately upon waking; • Wear a helmet at all times; and • Psychiatrist to review medications. The QA department reviewed the ISPA to ensure that the team met, but did not comment on the quality of the incident review or lack of measurable outcomes.	

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		Individual #305's IDT met numerous times following his serious injury on 1/31/13. Supports were developed by the team, but data indicated that he fell at least five more times over the next five-month period. Supports were not revised when it was noted that he continued to fall. The IDT noted that his seizure activity had increased and recommended a neurological assessment on 5/23/13. There was no documentation to show that the assessment occurred or if it did occur that the team met to discuss the assessment and follow-up on any recommendations made by the neurologist. It was not evident that trends were being addressed with adequate changes in supports when needed. To move forward, the facility will need to ensure that as risk are identified and • Measurable outcomes and action steps are developed; • Specific staff are assigned to monitor implementation; and • A date is set to review efficacy of the plan and make revisions when needed. The facility had made significant progress in identifying incident trends at the facility. Using trend data to develop supports is a new process for the IDTs. IDTs at LSSLC are still learning how to best use this information to develop and implement supports. IDTs need to aggressively address trends in injuries and implement protections to reduce these incidents and injuries.	
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	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.	Substantial Compliance

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	indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	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 FY13, criminal background checks were submitted for all applicants. There were no applicants who failed the background check in the hiring process and therefore was 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.	

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, dated 1/26/12 o LSSLC facility-specific policies: • Quality Assurance, Adm-14, 10/15/12, slightly revised 5/21/13 • QAQI Council, C&C-02, 10/15/12 o LSSLC organizational chart, undated, probably June 2013 o LSSLC policy lists, undated, probably June 2013 o List of typical meetings that occurred at LSSLC, undated but likely June 2013 o LSSLC Self-Assessment, 6/27/13 o LSSLC Action Plans, 6/21/13 o LSSLC Provision Action Information, most recent entries 5/31/13 o LSSLC Quality Assurance Settlement Agreement Presentation Book (none) o Presentation materials from opening remarks made to the monitoring team, 7/8/13 o List of all QA department staff and their responsibilities, 10/1/12 o LSSLC QA department meeting notes, January 2013, April 2013 (2 meetings) o LSSLC data listing/inventory, hard copy (no electronic version), slightly updated from last review o LSSLC QA and discipline meetings final indicator list, June 2013 o LSSLC QA plan narrative (none) o LSSLC QA plan matrix (none) o Set of blank tools used by QA department staff (6 tools) o Sets of completed tools used by QA department staff (none) o Trend analysis report, for all four components, last two quarters o LSSLC DADS regulatory review reports, November 2012-May 2013 o LSSLC QA Reports (none) o LSSLC risk threshold documents: guidelines, next day, 30-day, total events 3/22/13-6/30/13, and sample review process for Individual #305 o QAQI Council meeting agenda and handouts for 7/8/13 o QAQI Council minutes, 11/14/12 to 7/8/13, 15 meetings o LSSLC Corrective Action Plan info: new system, 4 CAPs documents o DADS SSLC family satisfaction survey online summary, 12/12 through 5/13, 76 respondents • Summary data o Self-advocacy monthly meeting minutes/notes, monthly December 2012 to May 2013, two different groups met each month o Home (staff) meeting agenda and notes, last two from each home, March 2013-April 2013 o Facility newsletters, Pine Bark, Winter 2013

	Interviews and Meetings Held: o Paula McHenry, Director of Quality Assurance (Georgette Brown, the new QA director from Richmond SSLC was present to observe many of the week's meetings and interviews) o QA staff: Elizabeth Carnley, Robert Cheshire, Shela Gibson, Paul Vann o Gale Wasson, Facility Director o Residential Director and Unit Directors: Keith Bailey, Rotley Tankersley, Kenneth Self, Todd Miller, Mary Stovall Observations Conducted: o QAQI Council meeting, 7/8/13 o QA staff meeting, 7/10/13 o Self-advocacy meeting, 7/11/13
	Facility Self-Assessment The QA director made a number of very good improvement to the self-assessment for all five provisions of section E. The updated self-assessment for E1 was an improvement because it did a better job of following the items in the monitoring team's report and, therefore, provided information that was more in line with the monitoring team's findings. The results of her self-assessment activities and her rationales for the self-ratings were more in line with the monitoring team's than ever before. The QA director should use the current report and the recently submitted list of indicators for her next self-assessment. 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: The QA program at LSSLC focused on the development of indicators for each of the 20 Settlement Agreement provisions, the creation of a risk threshold process, and addressing many DADS regulatory findings. The QA program also initiated a new CAPs process. The QA department worked with each Settlement Agreement section leader to develop a list of key important quality indicators for each section. It included the QA director working individually with each section leader across multiple meetings. There next needs to be further development and then implementation. When a Settlement Agreement provision was presented to QAQI Council, there was no consistent format to what or how they presented. The facility's QA work on section D represented good coordination between departments, unit directors,

	and the QA department. Data were collected and analyzed. Actions were taken based upon the data. There was no QA report. The CAPs program was new. Four CAPs with 37 action plans were created. Management reported on activity periodically at QAQI Council. The system was new and not yet complete.

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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.	The QA program at LSSLC focused on the development of indicators for each of the 20 Settlement Agreement provisions, the creation of a risk threshold process, and addressing many DADS regulatory findings. The QA program also initiated a new CAPs process. <u>Policies</u> There was a state policy that adequately addressed all five of the provision items in section E of the Settlement Agreement. There were no changes to the state policy, titled #003.1: Quality Assurance, dated 1/26/12. Positive aspects included: • It seems to have reserved policies for statewide development, and procedures for facility development. This will keep the terminology consistent and the facility should not have to re-label the state policy to adopt it. • It included language for CAPs to both remedy and prevent (reduce recurrence), acknowledging both important roles. • The policy language was simple and straightforward and the bullet style will make it easy for staff to read. • It required disciplines to keep account of their databases and the QA department to keep track of all databases. Other comments: • The policy hinted at addressing both systemic issues and serious individual ones, but stopped short of encouraging the facilities to have procedures to deal with both. • There did not appear to be a list of key indicators or a directive to develop a list. • The tie between QA and the self-assessment was not well described. This could, however, be covered in procedure or in a guideline for the self-assessment. Also, given that the statewide policy was disseminated more than a year ago, edits may already be needed. State office should consider this.	Noncompliance

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		There were not LSSLC facility policies that adequately supported the state policy for quality assurance. The QA director reported that the facility followed the state policy, however, the state policy did not provide the procedural detail that would be expected in a facility policy. The QA director was aware of this and reported that once additional QA processes were worked out, she would develop an appropriate facility-specific QA policy. Once the facility-specific policy (or policies) is updated, training should be provided to QA department staff. <u>QA Department</u> Paula McHenry continued in her role as QA director. She remained present and active at many meetings and presentations throughout the week of the onsite review. There was a new SAC. They had not yet worked out how to best collaborate towards meeting the requirements of section E of the Settlement Agreement. The QA director held two QA staff meetings since the last review. She reported that she was in regular contact with her staff and had lots of more informal meetings. The topics of the two documented meetings were relevant to QA staff and their assignments and activities. The QA staff remained an active group. Their work tasks appeared to be better defined than ever before, due to the guidance and supervision provided by Ms. McHenry. Staff spent their time addressing DADS regulatory findings, monitoring the new risk threshold process, and conducting reliability checks of unified record reviews. They were no longer doing reliability checks of self-monitoring (and other) tools of the many LSSLC departments. That responsibility was now each department's. <u>Quality Assurance Data List/Inventory</u> There was not a complete and adequate data list inventory at the facility. The data list inventory was not current. The inventory given to the monitoring team was almost identical to the one from the last review. The QA director noted that their focus was instead on the development of indicators for each provision (see below). <u>Quality Assurance Plan Narrative</u> The QA plan narrative at the facility was not current, complete, and adequate. The QA director reported that she would develop the QA narrative as the QA program developed over the next six months.	

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		<u>QA Plan Matrix</u> The QA plan matrix should contain the data to be submitted to the QA department; these data are then included in the QA reports and presented to the QAQI Council. LSSLC did not have a QA plan matrix. On the other hand, the QA department worked with each Settlement Agreement section leader to develop a list of key important quality indicators for each section. The monitoring team was impressed by this effort. It included the QA director working individually with each section leader across multiple meetings. The QA director described this as a large project (it appeared to be) and one that was only at the first steps. First, the 20 lists were developed, but had not yet been edited, analyzed, or reviewed by the QAQI Council. Second, not every data item on the lists was yet being collected. Third, the lists needed to then be incorporated into the larger data list inventory (the list that will contain other data collected by the department). Ultimately, with the addition of additional information, the LSSLC Indicators List can be the facility's QA plan matrix. For the next review, the QA director should be prepared to demonstrate to the monitoring team that: 1. An adequate set of key indicators is included in the QA matrix (i.e., LSSLC Indicators List) for all 20 sections of the Settlement Agreement. • The QA director should describe how the content was validated. 2. These key indicators include both process and outcome indicators for all of the 20 sections of the Settlement Agreement. • The QA director should show that both types of indicators were included in each list. 3. These indicators provide data that could be used to identify the information specified in E1: 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. • The QA director should describe how each list sets the occasion for data to be used to identify the information above. The QA matrix should also include the self-monitoring tools used for each of the 20 sections of the Settlement Agreement (or indicate that a self-monitoring tool was not necessary because the collection of the set of data in list covered all aspects of the provision that needed to be monitored). The QA matrix listed self-monitoring tools (or the need for the development of a tool) for many of the 20 sections (80%).	

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		All data that QA staff members collected were not listed in the matrix (LSSLC Indicator List). QA staff members collected data for DADS regulatory findings (four), risk threshold reviews, and unified record reliability. The latter could be reported along with the section V data. Satisfaction surveys were included in the QA matrix (LSSLC Indicator List). • An individual satisfaction survey was not yet developed. • Self-advocacy activities can be one way of obtaining satisfaction information from individuals. The self-advocacy group, under the guidance and facilitation of Stephen Webb, the HRO, had developed into an organized group that held regular meetings with relevant topics. Moreover, the HRO developed two monthly meetings to accommodate the varying levels of need and ability of the individuals at the facility. • At LSSLC, weekly home meetings for staff were held. Minutes/agendas indicated relevant topics were always discussed. • The statewide family/LAR satisfaction survey was implemented. Across the past six months, the surveys contained many positive comments. The data were summarized nicely by the facility. Follow-up was reported to be done on those items for specific individuals when there was enough information to do so. • There was no community business or staff satisfaction survey. The QA matrix (LSSLC Indicator List) was really a subset of the larger data list/inventory. Therefore, all items on the data matrix should also be in the data list inventory (once it is developed). The development of a risk threshold monitoring and reporting process was also the subject of much work of the QA director since the last review. Most of the process was related to sections D and I and is discussed those sections of this report. Some of the process, however, was related to section E, specifically the verification of implementation of the risk threshold process, and the provision of aggregate data to the QAQI Council (items I and J in the facility's risk threshold guidelines document). These two items were included in the QA plan matrix (LSSLC Indicator List) for section E. The other items might be added to the section D and/or I indicator lists. <u>QA Plan Implementation</u> Items in the QA plan matrix (LSSLC Indicator List) should be implemented as written, submitted, and reviewed. Therefore, the QA director should indicate which of the items in the QA matrix were: 1. Submitted/collected/received by the QA department for the last two reporting periods for each item	

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		2. Reviewed or analyzed by the QA department and/or the department section leader 3. Conducted as per the schedule. A percentage can also be calculated, perhaps monthly, bi-monthly, or quarterly, for each of the three items in the list above. Documentation and observation did not indicate that QA staff assisted each discipline in analysis of data, or if there was no assistance provided, there was documentation that it was not needed. <u>Self-Monitoring Tools</u> The use of self-monitoring tools was an important component of the self-assessment activity at all of the SSLCs and had been so for the past few years. A great deal of importance was placed on these tools and their outcomes. Facilities can develop their own tools (or modifications of state-provided tools) for each of the Settlement Agreement sections. As the QA director and the department section leaders work towards improving their self-monitoring tools, the monitoring team recommends that they review the comments made in previous monitoring reports regarding these tools. Further, for the next onsite review, the QAD should be prepared to present to the monitoring team information regarding the following aspects of the self-monitoring tools at the facility: 1. Content/validity: A description of how the content of the tools was determined to be valid (i.e., measuring what was important) and that each tool received a review sometime within the past six months. 2. Adequate instructions: A description of how it was determined that the instructions given to the person who was to implement each of the tools were adequate and clear. 3. Implementation: A report or summary showing whether the tools were implemented as per the QA matrix. 4. QA review: A report or summary showing that there was documentation of QA department review of the results, at least once each quarter, for each of the 20 sections of the Settlement Agreement. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Further development of the indicator lists. 2. Implementation of the collection of the data from the indicator lists. 3. Development of useful self-monitoring tools.	

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E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	There was no consistent presentation of data across Settlement Agreement provisions or departments. When a Settlement Agreement provision or a department presented to QAQI Council, there was no consistent format to what or how they presented. A consistent presentation would, for example, include a presentation of self-monitoring tool data, trended across 12 months, and broken down areas (as required by section E); and a similar presentation of other relevant indicator data, trended across 12 months, and broken down by areas. A brief narrative analysis would also be typical. Data from 1 of the 20 (5%) sections of the Settlement Agreement were summarized and graphed showing trends over time (section D). To make this determination, the monitoring team reviewed the QA reports, minutes from QAQI Council, and the handouts presented at QAQI Council. The facility's QA work on section D represented good coordination between departments, unit directors, and the QA department. Data were collected and analyzed. Actions were taken based upon the data. <u>Monthly QAD-SAC meeting with discipline departments</u> These meetings began since the last onsite review and focused upon the development of key indicators for each of the 20 Settlement Agreement sections. There was no information regarding the frequency, content, or dates of these meetings. Once these meetings are occurring regularly, the QA director should ensure that the topics listed the four metrics below are always touched upon. Moreover, the QAD-SAC meeting may also be a forum to address (and document) an analysis across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals, as required by this provision. 1. Since the last onsite review, a meeting occurred at least twice for XX of the XX (XX%) sampled sections of the Settlement Agreement. All five topics below were conducted during XX of the XX (XX%) meetings that occurred. One or more of these five topics, however, was discussed at XX (XX%) of the meetings. • Review the data listing inventory and matrix, • Discuss data and outcomes (key process and outcome indicators), • Review conduct of the self-monitoring tools, • Create corrective action plans, • Review previous corrective action plans.	Noncompliance

#	Provision	Assessment of Status	Compliance
		2. Since the last onsite review, during XX of the XX (XX%) meetings, data were available to facilitate department/discipline analysis of data. 3. Since the last onsite review, during XX of the XX (XX%) meetings, data were reviewed and analyzed. 4. Since the last onsite review, during XX of the XX (XX%) meetings, action plans (and/or CAPs) were created for systemic problems and for individual problems, as identified. <u>Other QA-Related Meetings</u> The facility did not hold any other meetings that were related to quality assurance. <u>QA Report</u> In the last six months, a facility QA report (for dissemination at the facility and for presentation to the QAQI Council) was created for 0 of the last six months (0%). Of the 20 sections of the Settlement Agreement, 5 (25%) appeared in QAQI Council meeting minutes at least once in each quarter (i.e., twice since the last onsite review). These were D, K, L, R, and U. Another 13 appeared once. Two did not appear at all (Q, V). Of the 18 sections of the Settlement Agreement that were presented at least once, one (5%) contained all of the components listed below (section D). The presentations for sections K and N, although not containing the components listed below, did discuss each of the numbered items in those provisions and included some narrative analysis. This was good to see. Overall, however, the content of the presentations across all 18 of the provision presentations varied greatly and the monitoring team had a difficult time determining what exactly was presented. • Self-monitoring data o reported for a rolling 12 months or more o broken down by program areas, living units, work shifts, etc., as appropriate • Other key indicators/important data for the section o reported for a rolling 12 months or more o broken down by program areas, living units, work shifts, etc., as appropriate • Narrative analysis	

#	Provision	Assessment of Status	Compliance
		QAQI Council This meeting plays an important role in the QA program. The monitoring team attended a meeting during the onsite review and read the minutes of all QAQI Council meetings from November 2012 through June 2013. There was an adequate description of the QAQI Council in the policy. Since the last onsite review, the QAQI Council met at least once each month. Minutes from all (100%) QAQI Council meetings since the last review indicated that the agenda included relevant and appropriate topics (though presentation of Settlement Agreement sections was not done in any organized manner). For example, at the QAQIC Council meeting observed by the monitoring team, each unit director presented his or her unit's activities regarding reduction of injuries. Minutes from all (100%) QAQI Council meetings since the last review indicated that there was appropriate attendance/representation from all departments. Minutes (and attachments/handouts) from all (100%) of the QAQI Council meetings since the last review did not document or show that (a) data from QA plan matrix (key indicators, self-monitoring) were presented, and (b) the data presented were trended over time. There was no indication that (c) comments and interpretation/analysis of data were presented for most of the items (exceptions were D, K, N, and L). The minutes did not, but should, reflect discussion that occurred. If there was no discussion or commentary, this should be indicated in the minutes, too. Similarly, the minutes should reflect if recommendations and/or action plans were discussed, suggested, or agreed to during each portion of the meeting. During a QAQI Council meeting observed by the monitoring team, there was active participation of participants other than the presenter for all (100%) of the reports/data presented during the meeting (section D and various other topics). The meeting was again held in the chapel. The monitoring team recommends a better space be used for future QAQI Council meetings that are to be observed by the monitoring team.	

#	Provision	Assessment of Status	Compliance
		Corrective Actions The QA director had re-worked the entire corrective action plan system at LSSLC. She reported that it was in the very early stags of being revised. The previous set of CAPs was reviewed and discarded by the QA director because it was not a useful or functional way to manage corrective actions in her opinion. There were now four CAPs. They were in the new format. They addressed reducing and preventing falls, reducing injuries, changing the groupings of individuals who lived together, and development of a retirement program for individuals. Each of the four CAPs had a set of action plans (4 to 12 each). There were a total of 37 action plans. An adequate written description did not exist that indicated how CAPs (or action plans) were generated, including the criteria for the development of a CAP. Therefore, when considering the full set of CAPs and action plans, the monitoring team could not determine if they were developed/chosen following written description, policy, or procedure. Of the 4 CAPs reviewed by the monitoring team (100% of the total), 100 % appeared to appropriately address the specific problem for which they were created. Based on these 4 CAPs: • All (100%) included the actions to be taken to remedy and/or prevent the reoccurrence. • 4 (100%) included the anticipated outcome of each action step. o However, there were no specific criteria to determine if the CAP was met, or if progress had occurred (0%). • 4 (100%) included the name of the person(s) responsible, however, all included the job title. • 4 (100%) included the time frame in which each action step must occur. The QA director might consider keeping track of each of the action plans separately because it is possible that some action plans might be completed whereas others might not be completed. Lastly, the monitoring team recommends that the QA director maintain and graph some simple data on CAPs/action plans. These data can be part of the section E data list inventory (and possibly the QA matrix, too). For example: • Total number of active CAPs/action plans • Number of CAPs/action plans completed and closed out for the month (or quarter)	

#	Provision	Assessment of Status	Compliance
		• Number of CAPs/action plans that are active (i.e., not completed) past their due date To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Set a clear and consistent expectation for what should be gathered (i.e., QA report) and presented (i.e., at QAQI Council) for each Settlement Agreement provision each quarter. 2. CAPs program needs criteria for having a CAP. 3. Consider managing/tracking each of the CAP action plans.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a review of the CAPs tracking document of the 4 CAPs: • 0 (0%) included documentation about how the CAP was disseminated • 0 (0%) included documentation of when each CAP was disseminated, and • All 4 (100%) included documentation of to whom it was disseminated, including the specific name and title (100%).	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.	The four CAPs appeared to have been implemented (100%) (but it was not clear if all 37 of the action plans were implemented). Management staff reported on CAPs-related activities at QAQI Council meetings. The monitoring team, however, could not determine the following and will be looking for: • Indication that all aspects of CAPs were implemented fully and in a timely manner. • An adequate system for tracking the status of CAPs/action plans (e.g., monthly) that indicates the status of the CAP/action plan and any action taken if a CAP/action plan had not been implemented. • Summary information/data regarding CAPs and their status that was updated within the month prior to the onsite review • Presentation of this information to QAQI Council at least quarterly.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The QA director did not have a method for evaluating the effectiveness of CAPs and for determining which CAPs needed modification. The monitoring team will be looking for: • Evaluation of the effectiveness of CAPs, including outcomes and timely completion • CAPs are modified when needed • Modifications/results are discussed at QAQI Council. • Modifications are implemented as written fully and timely.	Noncompliance

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 DADS Policy #004.1: Individual Support Plan Process o DADS Policy #051: High Risk Determinations o LSSLC Policy: Individual Support Plan Process revised 5/21/13 o Curriculum used to train staff on the ISP process o LSSLC Section F Presentation Book o LSSLC Self-Assessment o The last 10 section F monitoring tools completed by the QDDP Coordinator o Monitoring tool used to assess the quality of the ISP and the ISP meeting o List of all QDDPs and assigned caseload o A list of QDDPs deemed competent in meeting facilitation o Data summary report on assessments submitted prior to annual ISP meetings o Data summary report on team member participation at annual meetings. o A list of all individuals at the facility with the most recent ISP meeting date, date of previous ISP meeting, and date ISP was filed. o Draft ISPs and Assessments for Individual #207 and Individual #192. o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews (for a subsample): • Individual #502, Individual #151, Individual #145, Individual #238, Individual #301, Individual #594, Individual #258, Individual #306, Individual #522, Individual #176, Individual #410, Individual #60, Individual #110, Individual #369, Individual #305, Individual #235, Individual #20, and Individual #134. <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 Melissa Latham, Facility Investigator o Sylvia Middlebrook, Director of Psychology o Luz Carver, QDDP Coordinator o Royce Garrett, Consumer and Family Relations Director o Steven Webb, Human Rights Officer o Paula McHenry, QA Director o Keith Bailey, Residential Director o Todd Miller, Unit Director o Rotley Tankersley, Unit Director o Kenneth Self, Unit Director

	o Mary Stovall, Unit Director Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 7/9/13 and 7/11/13 o ISP preparation meeting for Individual #116 and Individual #185 o Annual IDT Meeting for Individual #192 and Individual #207 o Lone Pine Unit Meeting 7/9/13 o QAQI Council Meeting o Self-Advocacy Meeting
	Facility Self-Assessment: LSSLC continued to use the self-assessment format it developed for the last review. It had been updated on 6/27/13 with recent activities and assessment outcomes. The QDDP Director 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, as well as other activities for each provision. The facility was also observing ISP meetings, reviewing completed ISPs, tracking attendance at team meetings, and tracking completion and submission of assessments prior to the annual ISP meeting. For example, for F1b in regards to team participation in developing the ISP, data were gathered from the Settlement Agreement Monitoring Tools and meeting attendance was compared with information recorded on the Preferences and Strength Inventory regarding designation of relevant team members. These are the same type of activities that the monitoring team looks at to assess compliance. The facility had developed action steps to address deficiencies noted on the self-assessment. This should ensure that progress will continue to be made on developing an adequate ISP process. 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 Since the last monitoring visit, LSSLC IDTs had implemented the newest ISP and risk identification process. Additional action taken to address the requirements of section F included: • A data tracking system was implemented to track the submission of assessments prior to the annual ISP meeting. • Department leads began addressing the late submission of assessments. • QDDP and QA staff were completing a monthly sample of Settlement Agreement Monitoring Tools to assess compliance with the requirements of section F.

	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. 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. The monitoring team requested a set of recent ISPs with supporting assessments. Unfortunately, only four ISPs were submitted in response to this document request. Two of the four were from April 2012. Therefore, additional newer ISPs that were requested onsite (12) were used as part of the section F review, but many did not include ancillary plans and current assessments. Therefore, sample size varied for each provision item. There was positive progress evident with the new ISP process. At three ISP meetings and two pre-ISP meetings observed by the monitoring team, it was noted that significant progress had been made towards integrating the risk identification process into the ISP process. At the ISPs observed, rather than being two separate discussions held within the same meeting (as had been observed in the past), the risk discussion was to some degree woven into the discussion regarding the individual's preferences, daily schedule, and support needs. Each IDT was in a different stage of integration, but all were moving in a positive direction. To move forward towards compliance with the many provisions in section F, the monitoring team recommends a focus on the following activities during the next six months: • All departments need to ensure that assessments are completed at least 10 days prior to the annual IDT meeting and available to all team members for review. • IDTs need to ensure that deadlines are set and responsibility assigned when additional assessments are recommended by the team. Barriers to implementing recommendations in a timely manner need to be addressed. • IDTs should focus on developing action plans that expand on preferences by providing opportunities to learn new skills and explore new activities in the least restrictive setting. • Recommendations from assessments should be integrated into all supports and services. • All team members need to ensure that supports are monitored for consistent implementation and adequacy. Data collected during monitoring should be used to revise supports when there is regression or lack of progress. The new process, thus far, was not resulting in adequate supports and measurable outcomes in many cases. Though considerable progress was noted, the facility was not yet in compliance with any of the provisions of section F.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	During the week of the review, the monitoring team observed three ISP meetings in the new format. The QDDP facilitated the meetings. Two of three meetings were good examples of facilitation that ensured that team members participated in the meeting and all topics were covered. Very little discussion occurred among IDT members during the IDT for Individual #207. Thus, overall, progress continued to occur and was evident, with regard to the facilitation of meetings. The facility used the statewide Q Construction Facilitation Training in conjunction with a competency tool used to assess competency in facilitation skills. Twenty of 23 QDDPs had been assessed for competence in regards to facilitation skills. Three scored higher 90% or higher on the assessment. A revised ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was used 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 QDDPs used this template to draft portions of the ISP prior to the meeting. The QDDPs 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. A sample of IDT attendance sheets was reviewed for presence of the QDDP at the annual IDT meeting. QDDPs were in attendance at all annual meetings in the sample reviewed. The assigned QDDPs remained responsible for monitoring and revision of the ISP. As noted throughout this report, the monitoring team found the QDDPs did not consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed. The facility did not have an adequate monthly review process to ensure that plans were updated when there was regression or lack of progress. Good progress had been made towards developing an ISP that integrated all identified supports and services and focused on the individual's strengths and preferences. As noted throughout this report, to move forward, the facility needs to focus on monitoring progress/regression and revising supports and services when needed.	Noncompliance

#	Provision	Assessment of Status	Compliance
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 pre-ISP meeting, as well as professionals dictated by the individual's strengths, needs, and preferences. According to the state office policy, the Preferences and Strength Inventory (PSI) was the document that should identify the individual's preferences, strengths, and needs. This information should assist the IDT in determining key team members. LSSLC was using the PSI process to identify assessments to be completed prior to the annual ISP meeting and team members that should be present at the annual ISP meeting. The facility was tracking data on attendance at IDT meetings. Data indicated fair presence and participation by relevant team members. Attendance by the physician and psychiatrist when deemed relevant by the IDT remained low, as did participation by the family members or LARs (under 50% attendance rate). Review of a sample of ISP attendance sheets confirmed that there were key staff missing at five of five (100%) of the annual meetings in the sample. For example, • At the annual ISP meeting for Individual #306, there was no participation by his LAR, speech therapist, dietician, PCP, dental staff, and day programming staff. • At the annual ISP meeting for Individual #110, there was no participation by his LAR, psychologist, dietician, LA, or public school teacher. • Individual #151 did not attend her annual ISP meeting. Her LAR and home manager were also absent. • At the annual ISP meeting for Individual #502, there was no participation by her family, dietician, and home manager. • Individual #369's family and DSP were not in attendance at her annual IDT meeting. There was marked improvement in psychiatric attendance at ISP meetings. There was documentation of psychiatric attendance at 71 of a potential 77 ISP meetings (92%). Given that the facility did not have a full time psychiatrist on staff, and relied on contracted, part time psychiatric providers (including one physicians assistant), this level of attendance was commendable. The LSSLC ISP meeting schedule had been adjusted with specific times/days reserved for ISP meetings allowing for psychiatric providers to incorporate these meetings in to their schedule on a routine basis. The facility was not yet in compliance with requirements for the IDT to ensure input from all team members into the ISP process.	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>F1c</td><td>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.</td><td>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 gathered data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. Data gathered regarding the submission of assessments from 12/1/12 through 5/31/13 indicated that assessments were not routinely submitted prior to ISP planning meetings.

For psychiatry, however, psychiatry clinic had been scheduling annual assessments prior to the annual ISP meeting to ensure that all documentation was completed in advance. Psychiatry clinic had been tracking their compliance with timelines, with data indicating a compliance rate of over 90%.

Detailed data were reviewed on assessment submission for annual ISPs meetings held during March 2013 and April 2013. Data did not indicate whether assessments submitted were submitted at least 10 days prior to the IDT meeting for review by all IDT members. The chart below indicates findings from that review.

<table><tr><td>Assessment</td><td>Submission Rate</td></tr><tr><td>Medical</td><td>32/57 (56%)</td></tr><tr><td>Nursing</td><td>53/57 (93%)</td></tr><tr><td>Dental</td><td>58/58 (100%)</td></tr><tr><td>OT/PT</td><td>13/57 (23%)</td></tr><tr><td>Speech</td><td>0/25 (0%)</td></tr><tr><td>Nutrition</td><td>17/57 (30%)</td></tr><tr><td>Psychology</td><td>49/57 (86%)</td></tr><tr><td>Psychiatry (of 16 requested)</td><td>28/28 (100%)</td></tr><tr><td>FSA</td><td>No data</td></tr><tr><td>Vocational (of 19 requested)</td><td>No data</td></tr></table>
Newer ISPs supported the facility's own finding that assessments were not being submitted prior to annual ISP meetings in some cases. Two (40%) of five individuals had all assessment recommended in the PSI completed at least 10 days prior to the annual IDT meeting.
• Nutritional and day service assessments were not completed for Individual #151 prior to the annual ISP meeting. Her PSI identified the need for both.
• A communication and nutrition assessment were not submitted 10 days prior to the annual ISP meeting for Individual #502.</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		• For Individual #301, his nutritional assessment was not submitted 10 days prior to the annual IDT meeting. The facility needs to continue to expand opportunities for individuals to experience new activities and record responses to those activities in order to identify a broader range of preferences. Those preferences should then be used to develop new skill acquisition opportunities. The facility continued to utilize the Functional Skill Assessment (FSA) to identify priority training. As noted in previous reports and in section S of this report, the FSA was not adequate for capturing this information. The facility was not yet in compliance with this item based on the data available. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months • 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.	
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. There had, however, been considerable progress made in integrating assessment recommendations into support plans when available to the team. 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. Some of the newer ISPs were better examples of where assessment results were used to develop supports and services based on preferences of the individual. For example, IDTs were doing a better job of incorporating recommendations from communication assessments into SAPs. Examples where assessment results were not incorporated into the supports and services developed by the IDT included:	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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Individual #301's ISP and IEP noted communication deficits due to decreased intelligibility and a fast speaking rate. His need for communication supports and services were not addressed in his ISP.
The ISP for Individual #238 noted that his PNMP had not been effective at preventing falls. He had 23 falls during the year prior to his annual ISP. The therapist expressed concern that staff were not following his PNMP. The ISP did not adequately address these concerns. An ISPA dated 1/31/13 to address falls for Individual #238 indicated that he was assessed for the use of a walker and weighted gait belt. The team was to reconvene in 30 days to review progress. There was no documentation that the team had met or that assessment information was integrated into supports.
Individual #305 had experienced an increase in seizures (one resulting in a serious head injury from fall). His medical assessment indicated that he had been referred for a neurological assessment. His IDT met several times to discuss his falls and changes in behavior. There was no documentation to indicate that the neurological assessment had been reviewed by the team or that recommendations led to changes in supports. A helmet with a full faceguard was ordered to be worn full time to prevent head injuries. There was no indication that he had been assessed for less restrictive supports (e.g., gait belt) prior the order for the helmet. The team agreed that this was a highly restrictive and aversive support for him.

The facility was gathering data regarding the integration of assessment recommendations in the development of supports. A review of mentoring tools completed from December 2012 through May 2013 found that recommendations from assessments were not consistently integrated into supports.
<table>
<tr><th>Assessment by discipline</th><th>Percent integrated into supports</th></tr>
<tr><td>OT/PT</td><td>88%</td></tr>
<tr><td>Speech</td><td>50%</td></tr>
<tr><td>Psychology</td><td>92%</td></tr>
<tr><td>Work/Active Treatment</td><td>95%</td></tr>
<tr><td>Medical</td><td>84%</td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td><table><tr><td>Dietician</td><td>50%</td></tr><tr><td>PSI</td><td>100%</td></tr></table>
The facility was not yet in compliance with this provision.</td><td></td></tr>
<tr><td>F1e</td><td>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).</td><td>DADS policy mandated that a Living Options discussion 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.

As part of the new ISP process, each discipline was asked to include as part of the pre-ISP assessment process a determination on whether or not needed supports could be provided in a less restrictive setting. Discussion by IDT members regarding community placement included preferences of the individual, LAR (if applicable), and family members, along with, opinions offered by each discipline. Any barriers to community placement were to be addressed in the ISP.

At annual ISPs observed for Individual #207 and Individual #192, team members discussed providing supports in a less restrictive environment.
For Individual #207, the QDDP did not request input from the team and did not discuss barriers to supports being provided in the community. The LA began the discussion by noting that Individual #207 had not had exposure to community living. She then confirmed that her sister did not wish to discuss community living options. The sister stated that she understood that it needed to be discussed, but that she was not interested in more information since her sister would always need supports and would not be able to live on her own in the community. No information was offered to the family on what types of supports were available in the community. The team moved on without adequate discussion of barriers or training that could be offered to facilitate a move to a less restrictive setting.
The IDT for Individual #192 engaged in thoughtful discussion regarding what type of living option would be most appropriate based on her support needs and preferences. The team agreed that expressing her opinion regarding living options and lack of exposure to other settings were barriers to community living. The team then developed outcomes to address these barriers.</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		Seven ISPs were reviewed for the inclusion of training in the community. These were the ISPs for Individual #238, Individual #306, Individual #301, Individual #145, Individual #522, Individual #258, and Individual #502. None (0%) of the ISPs included meaningful training opportunities in the community. Community based outcomes in the sample consisted of generic opportunities to visit in the community with little or no opportunity for training or meaningful integration. For example: • Individual #145 had one outcome to be implemented in the community. The outcomes stated that she "will continue to go on community excursions." • Individual #502 had two community based outcomes that stated she "will participate in a minimum of two community outings" and "will respond yes or no to a question asked in regards to the outing that she is on." Two additional action steps appeared to be based on staff action rather than outcomes that she would achieve included will be scheduled for a community outing to a zoo, park, or museum in the community at least once quarterly and arrangements would be made for her to attend a music event in the community. When outings 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, social interaction, work and volunteer opportunities, and increased exposure to life outside of the facility. There was no focus on providing supported employment or volunteer opportunities for individuals at the facility. The sheltered workshop should be a job training site with a goal to support individuals to work in the community. Meaningful job training was not observed in the vocational program. None of the ISPs in the sample included outcomes developed to increase opportunities to explore job opportunities in integrated work environments. The facility was not in substantial compliance.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		

#	Provision	Assessment of Status	Compliance
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. It will be necessary for all assessments to be completed prior to the annual ISP meeting to ensure the team will have information necessary to determine prioritized needs, preferences, strengths, and barriers. In the ISP meetings observed, IDTs were having a much better discussion of support needs in relation to preferences. This was particularly evident in the annual ISP for Individual #192. The team developed outcomes based on her preferences, strengths, and support needs. Lists of preferences included a much broader range of activities and were individual specific. IDTs were still not developing action plans that would expand on those preferences by providing opportunities to explore new activities, particularly in the community. As noted in F1e, additional opportunities to try new things should lead to the identification of additional preferences. ISPs in the sample provided few opportunities to gain exposure to new activities and learn new skills. As noted in F1e, a majority of plans in the sample offered individuals 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 or work opportunities. In a review of seven recent ISPs, none (0%) offered specific training to be provided in the community. While the community was often listed as a possible training site for outcomes, training was not designed specifically for functional training in the community.	Noncompliance

#	Provision	Assessment of Status	Compliance
		For many of these individuals, community awareness had been identified as an obstacle to living in the most integrated setting, but IDTs did little to develop community integration strategies that would address these obstacles, including use of community settings to teach skills that would support successful community living or integrate preferences identified by and for the individual into SAPs. To move in the direction of substantial compliance, the monitoring team recommends that the facility focuses on developing outcomes to address barriers to service and supports being provided in a less restrictive setting.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	There was considerable progress made at the ISPs observed in IDTs considering what supports would be needed to successfully implement action steps developed by the IDT. A sample of ISPs and skill acquisition plans (SAP) were reviewed to determine if IDTs were developing individualized, observable, and/or measurable goals that included strategies and supports to ensure consistent implementation and monitoring for progress. The monitoring team found, however, that there were still many outcomes not written in a way that staff could measure progress towards completion or did not provide enough information to ensure consistent implementation. For example: • Individual #306 had an outcome that stated, "will be scheduled for medical appointments to determine the cause of seizures to help eliminate/reduce them." The outcome did not specify which medical appointments would be scheduled or when they would be scheduled. • Individual ##258 had action steps "to be taken to the gym frequently so she is able to play sports and exert some energy so she is not tempted to display flight behavior" and "will be presented the opportunity to play her favorite leisure activities: basketball, soccer, running, and swimming." Neither action step was written in measurable terms. • Action steps to address Individual #238's risk for GI problems included "assess for abdominal distention and measure abdominal girth." Documentation did not include criteria for determining when medical staff should be consulted. He had an action step to monitor his drug levels to address his risk for seizures. The plan did not give the frequency or acceptable range. • Individual #301's vocational goal stated that he would work in the workshop Monday through Friday from 1:30 to 4:30. The plan did not specify what training would occur or how staff would measure successful completion of the outcome.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Further detail on the adequacy of skill acquisition plans (SAPs) can be found in section S. Section M and section I also address the writing of measurable strategies to address health care risks. Section T elaborates on the facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. This also requires the development of action plans in ISPs.	
	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. It was designed to assist teams in more comprehensively planning for, discussing, and developing ISPs that addressed the individual's array of needs for protections, supports, and services, while approaching this in a person-centered manner and incorporating individuals' preferences and strengths. The development of action plans that integrated all services and supports was still an area with which the facility struggled. At both ISP meetings observed, the team spent more time than before trying to identify areas where measurable outcomes were needed (this was good to see). The teams also engaged in more integrated discussion regarding support needs in relation to preferences. For example, the IDT for Individual #192 integrated recommendations from her communication and psychology assessment in developing strategies to reduce the use of her helmet to prevent self-injurious behaviors. Communication strategies were also considered when developing outcomes to increase her ability to express her preferences. 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. Assessments and recommendations will need to be available for review by the IDT prior to annual meetings. The revised ISP meeting guide prompted the teams to discuss, revise, and approve plans that previously had been viewed as separate plans, such as the PNMP, PBSP, crisis intervention plan, psychiatric treatment plan, and integrated health care plans. The facility had made significant progress in developing comprehensive ISPs that integrated all supports and services. Examples were still found in some of the ISPs in the sample, however, where all services were not integrated into the ISP. For example, the ISP for Individual #301 did not integrate educational services into supports provided by the facility.	Noncompliance

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		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. It is expected that progress will continue to be made in developing comprehensive plans as IDT become more familiar with the new ISP process and more adept at developing measurable outcomes.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	<u>Method for implementation</u> As discussed in F2a2, action steps in the sample of ISPs reviewed did not include clear methodology for implementation in some cases. Without clear instructions for staff, it would be difficult to ensure consistent implementation and determine when progress or regression occurred. Teams will need to develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. IHCP action steps were generally brief statements of action to address the risk. Most did not include methodology. For example: • Individual #151 had an action step to address his risk for GI problems that stated "documentation of all known bowel movements." Criteria were not included for staff to notify medical staff if he did not have a bowel movement for a specific period of time. An action step for nephrology consults was included to address his cardiac risk. The action step did not include frequency of consultation. • Individual #60 also had an action step to address constipation that stated "chart all bowel movements." • Individual #310 had an action step to "monitor B/P weekly and pulse rate BID." The plan did not include an acceptable range for his blood pressure and pulse or action that should be taken if his blood pressure or pulse did not remain in a safe range (e.g., notify the physician if it was not within a stated range.) <u>Time frame for completion</u> Outcomes in the sample reviewed generally included a completion date of 12 months after implementation began. Completion dates should be assigned with a realistic expectation of when the outcome may be completed based on each individual's rate of learning. For outcomes that require staff to complete action, the team should set completion dates that ensure any barriers to supports are addressed as soon as possible. Examples where this did not occur included:	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Individual #410 had an action step for OT to perform a chair side evaluation. No completion date was given. • Individual #151's IHCP included an action step that stated "bone density exam." The plan indicated that the medical secretary would schedule the exam, but no completion date was assigned. • Individual #369's IHCP included an action step to request a modified barium swallow study to address her risk for choking and aspiration. The completion date was one year after a need for further assessment was identified. <u>Staff responsible</u> All SAPs and IHCPs in the sample included designation of which staff would be responsible for implementation of the outcome and which staff would monitor the plan. The facility was not in compliance with the requirement for identifying methods for implementation and time frames for completion.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	The new ISP format provided prompts to assist the IDT in considering a wider range of supports and services when developing the ISP. Without accurate and comprehensive assessment, it was not possible to clearly identify the specific needs of the individual and establish specific teaching goals from which to measure progress. As noted in previous reports, many of the outcomes in the ISPs reviewed were functional at the facility, but often were not practical or functional in the community and did not allow for individuals to gain independence. None of the ISPs in the sample included outcomes for functional participation or integration in the community. For example, there were no outcomes to shop in the community for food to prepare a meal, complete transactions at a community bank, pick up prescriptions at the pharmacy, seek membership at a gym or library, or take a community art or fitness class. Outcomes were not developed to provide training on domestic skills, such as food preparation, housecleaning, or laundry care that would be necessary to live more independently in the community. Vocational skills were often taught in relation to jobs at the facility, but would not necessarily translate well in a community work environment. For example, individuals at the facility had part-time schedules for work or day activities. Lengthy lunch breaks during which individuals went back to their residences did not allow opportunities for individuals to learn to either bring lunch to eat at their work sites or in the vicinity of their activity or vocational setting. These low expectations failed to provide individuals with functional skills to allow successful transition to a community setting, where regular participation in a day program or job would be expected. The different set of rules on campus coupled with individuals' limited exposure to the community could become a disadvantage for individuals who	Noncompliance

#	Provision	Assessment of Status	Compliance
		decide to transition to the community. To move forward, IDTs will need to accurately identify needed supports and services needed to gain independence and function in a less restrictive setting through an adequate assessment process and then include those needed supports in a comprehensive plan that is functional across settings.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	DADS Policy 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. The new ISP format included columns for person responsible for implementation, type of documentation, and person responsible for reviewing progress. Integrated Health Care Plans included similar information. The frequency of implementation was found on the SAP, IHCP, or on the ISP outcome summary. As noted throughout F2a, IDTs were still struggling with developing measurable outcomes with methods that would allow for consistent data collection to permit the objective analysis of progress. A greater number of SAPs, ISP outcome summaries, and IHCPs now included the person responsible for data collection and the person responsible for review of that data. As noted in F2a4, IHCPs did not always include a date for completion when assessments were recommended by the team. It was also not clear when data would be reviewed and thresholds were not set to ensure the team revised supports when data indicated a need for a change in supports. As noted in other sections of this report, IDTs were still developing general action steps such as "monitor blood pressure" and "monitor bowel movements" without including criteria that would trigger a review of supports or change in status.	Noncompliance
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	This provision item will 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 F1, 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. To move forward, the facility will need to ensure that recommendations from various assessments are available to all members of the IDT prior to the annual ISP meeting, and then are integrated throughout the ISP.	Noncompliance

#	Provision	Assessment of Status	Compliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	A sample of individual records was reviewed in various homes at the facility. Current ISPs were in place in 16 out of 16 (100%) records reviewed. The facility reported that 57 (33%) of 173 ISPs were filed more than 30 days after the annual ISP meeting from November 2012 through April 2013. During observation in the residences, it was noted that supports were not being consistently implemented and were not always clearly written to ensure consistent implementation. For example, Individual #305's ISP noted that he had a VNS, but it did not indicate when staff should use his VNS magnet. His HMP to address seizures stated that it should be used for all seizures. It was noted that staff did not use the VNS for seizures on 7/10/13, 6/9/13, 5/19/13 or 5/15/13. When questioned, DSPs were not sure why the magnet was not used on those dates. Similarly, a number of PNMPs reviewed in the homes indicated that staff should provide contact guard assistance when the individual was unsteady. DSPs gave inconsistent answers to questions regarding how they knew when an individual needs contact guard assistance. The facility needs to ensure that all plans are comprehensible to staff assigned to implement the plan and staff can clearly communicate what supports should be provided. 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. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: • The facility needs to ensure that plans are distributed and available to staff implementing the plan within 30 days of development.	Noncompliance
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in	Teams were required to meet to review any incidents, significant injuries, or changes in status immediately when determined necessary. Each discipline was assigned responsibility for reviewing specific services and supports in the ISP. QDDPs were responsible for reviewing the overall plan. The facility had implemented a new QDDP monthly review process to review all supports and services. Not all QDDPs had begun using the new monthly review process. It was not evident that an adequate review process was in place to ensure that the review of supports and services led to timely implementation of assessments or changes in supports when necessary. A small sample of QDDP monthly reviews was submitted for review including reviews for Individual #238, Individual #110, Individual #502, and Individual #369. An adequate review process was only in place for one (25%) of the ISPs in the sample.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• The April 2013 monthly review of services for Individual #238 noted that progress had not been made on seven of 11 outcomes. No comments were made regarding the lack of progress or the need to review supports to ensure that progress could be made. • The April 2013 and May 2013 monthly reviews for Individual #110 were not completed in the new format. The QDDP submitted a brief paragraph commenting on supports for both months. The QDDP noted that data were not available for review of his behavior support plan for either month. There were no recommendations for follow-up to ensure that data were being collected and reviewed. • The QDDP for Individual #369 offered no detail on specific progress or lack of progress for each outcome. Her monthly review consisted of a grid listing each action step with a column for monthly review summary. In the monthly review summary column, she noted "ongoing" for each action step. • The QDDP for Individual #502 had completed a comprehensive monthly review of all services for March 2013 and April 2013. She was detailed in describing progress or lack of progress for each outcome and noted when follow-up action was needed to resolve any issues found. As detailed in section I regarding the identification of risks, it was not evident that IDTs were meeting and revising supports when supports were not effective and individuals remained at risk for untoward outcomes. 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. To move forward towards compliance, • 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.	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. The facility had been trained by the state office on developing and implementing the ISP. QDDPs were still learning to use the new statewide ISP format. As noted throughout	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised</td><td>section F, adequate plans had not yet been developed for a majority of the individuals at LSSLC.

The facility was providing staff training on individualized specific plans, but as noted throughout section F, staff instructions for many plans did not offer enough information to ensure consistent implementation.

Informal interviews throughout the facility indicated that staff were generally able to describe supports and services developed through the ISP process and plans were readily available for reference. This was an improvement from findings during the last review.</td><td></td></tr>
<tr><td>F2f</td><td>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.</td><td>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 ISPs were available in 16 (100%) of 16 individual notebooks in the sample.

Data provided by the facility reported that 57 of 173 (33%) of ISPs were filed more than 30 days after the annual ISP was held. Two (50%) of the four ISPs submitted by the facility in response to the document request for a sample of the most current ISPs were out of date. As evident by data collected by the facility, there had been a significant improvement in ensuring that ISPs were implemented within 30 days.

<table><tr><th>ISPs developed by month</th><th>Implemented within 30 days</th></tr><tr><td>December 2012 – 29</td><td>48%</td></tr><tr><td>January 2013 – 34</td><td>65%</td></tr><tr><td>February 2013 – 32</td><td>81%</td></tr><tr><td>March 2013 – 27</td><td>75%</td></tr><tr><td>April 2013 – 31</td><td>81%</td></tr></table>
The facility needs to ensure that plans are distributed and available to staff implementing the plan as soon as possible, but no more than 30 days after development.</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
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 assurance 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

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, revised 4/15/13 o LSSLC Facility Operational Procedures Manual Committee and Councils -12, Clinical Services Morning Meeting, 1/24/12, revised 6/1/13 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 Andra Self, Clinical Services Coordinator o Paula McHenry, QA Director o Paul Van, 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 Dental Clinic o Neurology Clinic o Psychiatry clinics o Morning 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 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 number of items such as (1) review of meeting participation, (2) assessment of clinical participation, (3) assessment of processes that promoted integration, and (4) assessment of the outcomes of integration work, such as the development of desensitization plans. Overall, this appeared to be a good approach to completing the self-assessment because it utilized a range of activities to assess compliance in a manner similar to that of the monitoring team. For future self-assessments, the facility director should review the recommendations and comments included in this report and give consideration to that information 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 with improved integration noted in several areas. The integration policy was revised to include statements regarding integration for nursing and dental. Some processes, such as the Dental Desensitization Workgroup, demonstrated continued progress, as did the integration of neurology and psychiatry. The primary care providers continued to have minimal involvement with the annual ISPs and the review of PNMPs. The consultation follow-up and tracking processes did not make any substantial gains in spite of multiple tracking systems. Primary providers were reviewing consults in a timely manner based on the documentation on the consultation forms but most were not following the guidelines for IPN documentation, and assessing the need for referral to the IDT. The monitoring team had the opportunity to meet with the facility director, clinical services director, QA director, QA nurse and state office representative to discuss integration activities at the facility. The facility director discussed the revised policy that now addressed Provision H. She also provided some examples of work at the facility that demonstrated integration of clinical services. The monitoring team noted that integration was indeed occurring in many areas. However, there was an overwhelming need to improve integration, particularly integration of the primary medical providers. 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 receive the clinical services they need.	The facility director served as lead for this provision. She reported that the state policy had not been finalized, so she reviewed the policies of other SSLCs prior to revising LSLLS's local Integrated Clinical Services Policy. The policy addressed integration of services as well as the minimum common elements of care covered in section H. With regards to integration of clinical services, the procedure added sections on the approach to integration by the nursing and dental departments. Statements of integration philosophy for the other clinical services were previously developed. The facility director noted that integration of medical services improved, citing that four LVNs were assigned to the medical department to provide support to each of the primary care providers. The intent was to give the primary providers more time to attend ISPs and pre-admission meetings. She reported improved attendance by the medical staff at these meetings. She also discussed the utilization of the ISP audit tool to assess the effectiveness of integration for each clinical discipline. The clinical services director highlighted the daily clinical services meeting as a good example of integration of clinical services. 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 clinical services director facilitated these meetings during the week of the compliance review. All clinical disciplines were represented in the meeting. Information regarding the past 24 hours was discussed. During the meetings attended by the monitoring team, the nurse practitioner 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. 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 and then submitted to the IDT for further action such as obtaining consent. There was little discussion regarding the consultations even when it was clear that additional information was needed. • Medical and Dental Desensitization Workgroup – Collaborative efforts between medical, dental, psychology, residential, and other disciplines continued. The monitoring team observed this meeting and found that it appeared useful in helping to develop and implement strategies related to barriers to dental	Noncompliance

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		treatment. This is discussed in further detail in section Q2. • The PNMT worked well together for assessment but there was no evidence that their findings and recommendations were integrated into the IHCPs, ISPAs, or ISPs. The PNMT generally made recommendations to the IDT. There were very few actions or interventions to be implemented by the PNMT. In some cases, there were recommendations for monitoring or data gathering that were recommended in the assessment rather than implemented as an aspect of the assessment, with actions or interventions recommended based on those findings. This slowed the process down and resulted in the PNMT merely reviewing the supports and services already generated by the IDT rather than exploring new alternative supports and interventions that might have been effective. • When quarterly psychiatry clinics or other psychiatric clinical consultation occurred, there were generally members of the IDT present for integration including psychology, nursing, and therapy services. In addition, there were marked improvements in psychiatric attendance at the ISP meetings. • Integration of psychology and psychiatry was very good. Psychologists and psychiatrists appeared to have meaningful interactions during psychiatric clinic meetings observed. Several areas offered great opportunities for improvement: • Physician participation in annual ISPs was poor. In fact, the medical staff attended only 10% of the ISPs conducted during the reporting period. This was an improvement compared to the complete lack of attendance noted during the previous compliance review. • Integration of psychiatry and neurology improved, but did not occur for most individuals who had a seizure disorder and psychiatric diagnosis. The psychiatry nurse was attending neurology clinics periodically and initiating telephone calls between providers for consultation. This practice, while helpful, did not occur for many individuals who required integration of the two disciplines. It also did not appear to be a sustainable process. • Most of the referrals to the PNMT were generated by the IDTs rather than self-generated, but none of the seven reviewed had an assessment initiated within five days of the referral as per policy, nor was the assessment completed within 30 days of the referral. Referrals to the PNMT reflect an urgent need and the response to these should be swift and comprehensive. The physicians also did not attend PNMT meetings, nor did it appear they attended IDT meetings held to review PNMT assessments. A system of the PCP attending during specific discussion about an individual on their caseload may be a good approach to provide integrated supports and services in a timely manner. Needs were	

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		identified during the meeting and the physician would be able to initiate orders and other directives to ensure timely implementation. • There remained challenges with regard to psychiatric integration with primary care (likely due to the lack of a facility medical director) and pharmacy (due to a vacancy in the clinical pharmacist position). • Pretreatment sedation – The process was rooted in the daily clinical services meeting. The monitoring team observed during this meeting that the process appeared to be a reflexive one in which the members present simply agreed and moved on. One identified problem was that the practitioners who completed the form were not always present at the meeting. The dental director pointed out during interviews that the process was not achieving the desired outcome because the sedation was ineffective for many individuals. A workgroup had been developed to review the pretreatment process. This was a good idea based on the observations of the monitoring team. • The identification and determination of risk, was both challenging and problematic for the teams, indicating a need for more training and education in the discussion, assessment and application of risks. There appeared to be little attention to the assessment of risk and risk mitigation by the primary medical providers based on the lack of attention to this area in all of the documentation reviewed. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: • The facility should continue the evaluation of the current pretreatment sedation process with focus on ensuring there are meaningful discussions among the clinical disciplines regarding the appropriate use of medications. • Medical staff attendance and involvement in the ISPs must be addressed. The clinical outcomes experienced by the individuals indicated that there was a need for the medical staff to have more participation in the annual discussion of the health status of the individuals. The identification and mitigation of risks should receive more attention from the medical staff during these meetings. The criteria for physician attendance should be re-assessed. • The facility must address the integration of neurology and psychiatry due to the many individuals that are dually diagnosed. The reliance on the psychiatry nurse did not meet the needs of all individuals. The facility will need to explore other options for having greater collaboration between the neurologist and psychiatrists.	

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G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The facility implemented a system to electronically track all outside appointments on 10/1/12. The database reviewed by the monitoring team allowed for sorting by specialty, date ordered, status, and home. It should serve as an effective method of tracking consultations. The facility director reported that Questions 25 – 28 of the medical audits assessed compliance with the requirements of this provision item. Question #25, however, did not pertain to this provision item because it pertained to the providers referring individuals for consultations based on need and diagnosis and not the management of the recommendations. Question #26 addressed the provision of appropriate information in the consult and Question #27 assessed if consults were addressed "within five business days after the consult." Nonetheless, the external audits showed compliance rates of 78% and 63% for Questions #26 and #27, respectively. The internal audits showed 100% compliance with both items, indicating a need to evaluate inter-rater reliability. The facility presented information on two tracking systems. The Order Tracker and Consult Database. While the facility reported high rates of compliance related to the providers following up of consultations, it was evident that the systems in place were not effectively tracking diagnostics and consults. There were several examples in which consults ordered were not completed or the primary provider did not receive the consult. The facility director and clinical services director were aware of the problems. The monitoring team was informed that a policy/procedure was developed to ensure that consults were received in a timely manner because failures in the systems correlated with some poor outcomes. The monitoring team was surprised by the description of the process and was later informed that the incorrect information was provided. The facility director was made aware that staff still appeared unclear on this process. <u>Consultation Referrals</u> The consults and IPNs for five individuals were requested. A total of 45 consults completed after September 2012 (including those from the record sample) were reviewed: • 25 of 45 (55%) consultations were addressed in accordance with state policy The Settlement Agreement required that medical providers review and document whether or not to adopt the recommendations and whether to refer the recommendations to the IDT for integration with existing supports. State policy required that an entry be made in the IPN explaining the reason for the consultation and the significance of the results within five working days. Nearly all consultation forms indicated the appropriate review by the primary provider. Documentation in the IPN varied widely among the four primary providers. One provider consistently utilized an	Noncompliance

#	Provision	Assessment of Status	Compliance
		IPN template that indicated the consult, summarized the recommendations, indicated agreement, disagreement, and referral to the IDT. Another provider was beginning to utilize the template in the weeks just prior to the compliance review. This was an effective means of documenting and summarizing consultations. Furthermore, the use of the template, when executed properly as noted in the records, fulfilled state and Settlement Agreement requirements. However, not all providers utilized the template and in those cases, the providers failed to adequately document consultations. As noted in the previous review, one primary provider continued the same practice of writing a one word diagnosis and directing the reader to "see consult." In addition to the documentation in the IPN, the monitoring team observed that each consult was read in the daily clinical services meeting, but there was little discussion, questions or comments when this occurred. It appeared that the information could be helpful but it did not fulfill the requirements of the Settlement agreement. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: • Providers must review and document consults in accordance with state guidelines. The use of the IPN template appeared to be an effective means of doing this as it covered all requirements. • The oversight and follow-up process for receipt of consults should be codified in policy and procedure. All relevant staff should be apprised of the procedure.	

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, 10/1/12, revised 4/15/13 o LSSLC Facility Operational Procedures Manual Committee and Councils -12, Clinical Services Morning Meeting, 1/24/12, revised 6/1/13 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 Andra Self, Clinical Services Coordinator o Paula McHenry, QA Director o Paul Van, 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 Dental Clinic o Neurology Clinic o Psychiatry clinics o Morning 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 each provision item, 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. As noted in other sections of this report, some data elements, reported by the medical compliance nurse, were actually assessments of the adequacy of medical care. Such assessments required review by a peer. The facility found itself in noncompliance with all seven provision items. The monitoring team agreed with six of these seven, finding H2 to be in substantial compliance.
	Summary of Monitor's Assessment: During the week of the onsite visit, the monitoring team had the opportunity to meet with the facility director, QA director, and QA nurse. The facility's QA nurse served as the lead for this provision item. He explained that each department was responsible for tracking assessments, which were also entered into a centralized database. At the time of the compliance review, the facility had addressed the timeliness of the scheduled annual assessments. The timeliness of quarterly assessments was not addressed nor was any aspect of the interval assessments. Improvement was seen in the diagnostic formulation for psychiatric assessments. The medical providers generally utilized ICD nomenclature and the diagnoses were consistent with the signs and symptoms of illness. The facility focused its efforts on Provisions H1 and H2. The development of the risk thresholds policy had the ability to impact the progress seen in the provision items H3-H6, however, the policy was newly implemented at the time of the compliance review and therefore no significant impact on the progress of the provision was observed. The facility developed a detailed policy for addressing this provision. It addressed every provision item and was a good start in describing the activities that were needed to move towards substantial compliance. A policy from state office was needed to provide additional guidance to the facility.

#	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	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. As discussed in section G, the facility director developed a local policy to guide the work for provisions G and H. The policy described the facility's approach to management of assessments in addition to providing guidance for the other provision items of Section H.	Noncompliance

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	timely detection of individuals' needs.	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 facility lead reported that each clinical discipline tracked the timeliness of completion of assessments. There was also a centralized tracking database, but discrepancies were reported between the internal and centralized databases. The facility reported the following compliance data:	

Facility Assessments 2012 -2013						
	Dec	Jan	Feb	Mar	Apr	May
Dental	96	94	100	100	100	96
Dietary	0	15	16	30	30	43
Hab: T/OT	71	63	7	11	33	10
Hab: Speech	--	0	0	0	0	8
Medical	86	61	50	70	43	78
Nursing	86	94	96	93	93	20
Pharmacy	96	94	96	100	100	97
Psychology	93	94	100	85	87	83
Psychiatry	38	19	58	100	100	90
Overall Rate	72	63	63	67	67	60

Assessments were considered timely when submitted 10 days prior to the ISP. Although several departments were in need of improvement, the dietary department was the only department that developed an action plan to address the deficiencies. The QA nurse reported that psychiatry and nursing were also looking at the quality of scheduled annual assessments, but no data were reported to the monitoring team. Additionally, the facility had yet to begin looking at the timeliness and quality of quarterly and interval assessments. Several departments including nursing, pharmacy and psychiatry were internally tracking quarterly assessments. The monitoring team reviewed the full spectrum of assessments including annual assessments, quarterly assessments, and interval assessments. The monitoring team noted the following with regards to the evaluations of the facility's various assessments:

- For this review, the compliance for timely completion of Annual Medical Assessments was 82%. This was a decrease in compliance since the previous review when 100% of assessments were noted to be timely. The data provided by the facility documented a precipitous drop in compliance in December 2012. Even though providers were given additional support, the compliance ratings continued to fall, with improvement seen in the last month of reporting period.

#	Provision	Assessment of Status	Compliance
		Medical assessments are discussed in detail in section L1. • Quarterly Medical Assessments were found in all records included in the record sample. • The completion of Quarterly Drug Regimen Reviews improved compared to the previous compliance review. Evaluations were found in all records. The quality of the assessments also improved. • Annual Dental Assessments – Compliance with timely completion for the review period was 84%. This was an improvement compared to the previous compliance review. However, the monitoring team's findings differed significantly from the facility's self-reported compliance rates. It was noted that the data provided for section H indicated that an assessment was completed or "filed" on a date in 2013, but the dental reported data for section Q listed the most current annual assessment in another year. This may have been due to unsuccessful attempts or other reasons which were not explained. • Psychiatry clinic had completed over 95% of annual comprehensive psychiatric evaluations and was providing timely quarterly reviews. There was 1.5% of the population (a total of three individuals) currently overdue for psychiatric quarterly clinic. In addition, there was documentation regarding the use of the Reiss screen for individuals experiencing a change in status, with timely psychiatric assessment for those individuals with positive screens. • With regards to nursing assessments, in a sample of the most current quarterly and annual assessments, there were improvements in the review of the individuals' past and present health status and response to interventions, including treatments and medications. • There were dramatic improvements in assessments completed by psychology. Initial and annual psychological assessments were completed for all individuals. Functional assessments were completed for all individuals with PBSPs. • The PNMT conducted assessments for individuals referred to the team. The assessments were not completed in a timely manner. These assessments resulted in a series of recommendations for the IDT to complete rather than evidence of a collaborative approach. In some cases, actions such as monitoring or data gathering were recommended in the assessment that should have been an aspect of the assessment findings. There was no evidence of integration of these in the manner of IHCPs, ISPAs, or ISPs based on the sample of assessments (7) and supporting documentation submitted. • The OT/PT assessments were not generally completed prior to the ISP. One of 13 OT/PT current assessments (8%) for individuals in Sample P.1 were dated (dates of signatures) as completed at least 10 working days prior to the annual ISP. Additionally, there were 169 assessments listed in the tracking log for ISPs dated 12/17/12 through 6/14/13. This list documented the dates that the	

#	Provision	Assessment of Status	Compliance
		assessments were electronically submitted (data processing date). Based on this log, only 19% of the assessments were performed on or before the designated due date. At least 22 of these assessments were not completed at all at the time of this review. The communication assessments also were not generally completed annually, but rather completion continued to be very slow based on the Master Plan that prioritized these. To move in the direction of substantial compliance, the monitoring team recommends the consideration of the following: 1. The facility must monitor all three elements that this provision item addresses: (1) the timelines for completion of scheduled assessments, (2) the appropriateness of interval assessments in response to changes in status, and (3) the quality of all assessments (compliance with accepted standards of practice).	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	The 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. The APLs were not always appropriately updated with current data. • The review of psychiatric documentation revealed appropriate justification of diagnoses including review of the diagnostic criteria required for a particular diagnosis. • Across the majority of IPNs reviewed, there were episodes of identified acute illness and injury. Nursing interventions included assessments of the complaint/problem and implementation of interventions. • There was documentation of approved NANDA diagnoses in the Acute Care Plans and Nursing Assessments. <u>Compliance Rating and Recommendations</u> The monitoring team disagreed with the facility's self-rating of noncompliance. While the facility did not have an adequate process for determining compliance with this provision item, the monitoring team found that the outcomes for this provision item were achieved. To maintain substantial compliance, the monitoring team recommends that the primary providers improve the accuracy of the APL documentation.	Substantial compliance

#	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 medical staff was aware of the state issued protocols, but no local policies were developed at LSSLC. Assessing compliance with a given protocol will require that a measurable standard or metric (i.e., clinical indicators) be developed. It appeared that some clinical indicators were developed through the QA department, but staff in the medical department had very little knowledge of this. The policy for provision H outlined requirements for the development of clinical indicators across all disciplines. This policy provided an extensive list of examples of structural, process and outcome indicators, as well as the criteria for appropriate oversight. The minimum common elements of clinical care could be applied to many conditions. For example, in the management of diabetes mellitus, an individual at risk would have a medical assessment that would include measurement of the HbA1c. Following implementation of treatment, nursing would perform monitoring and general assessments. Physical therapy might develop exercise programs for select individuals. The nutrition department would provide data on nutritional requirements. The primary provider would ensure that re-valuations were done at the appropriate intervals to assess the effectiveness of treatment. Many of these activities were already occurring at the facility. As discussed in Section L1, individuals received preventive care, immunizations, cancer screenings, and treatment of various medical conditions. LSSLC lacked a mechanism for adequately assessing the effectiveness of the activities that were taking place. The clinical indicators would be helpful in objectively determining if treatments and interventions were timely and clinically appropriate. They also provide a quantitative basis for quality improvement, or identifying incidents of care that trigger further investigation.	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.	As discussed in section H3, the QA department reported that clinical indicators were developed. The local policy, consistent with the state draft policy, included a relatively long list of data for the facility to collect and monitor in areas of medical staffing, timeliness of actions, equipment and resources, quality of care severity indices, expected death rates, morbidity, clinical indicators for a variety of conditions, diabetes care, and patient satisfaction. It would also appear that in selecting the data elements that the facility was establishing the framework for a medical quality program. Additional measures of medical quality should be selected. A good starting point would be the six disease entities chosen by state office. For each condition, a number of specific and measurable metrics could be developed. Periodic auditing using these metrics would allow the facility to determine if treatments were clinically justified, appropriate, and timely. The internal and external medical audits provided some assessment of efficacy of treatments, but as discussed in section L3, additional metrics related to clinical outcomes were needed.	Noncompliance

#	Provision	Assessment of Status	Compliance
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	The facility did not have an overarching plan to address this provision item. There was no evidence that there was an ongoing review of medical data. At the time of the compliance review, there were no systems for effectively monitoring the health status of individuals that were being consistently implemented at LSSLC. Although nursing processes, such as performance of acute, quarterly, and annual assessments, potentially served as such systems, there was no substantial evidence that they were satisfactorily implemented. The Health Care Plans that were in place, were not adequately reviewed/revised in accordance when identified changes occurred in their health status and risks. For the provision of psychiatric care, the facility could use individualized data to determine treatment efficacy of psychiatric interventions. Additionally, outcome indicators, such as reductions in the use of protective supports and chemical restraints, could also be considered. Currently, there were no other objective clinical indicators of the efficacy of treatment and interventions outside of the data gathered for each individual in order to determine individual efficacy of treatment. Quarterly assessments for the medical and pharmacy departments were two very good means of monitoring chronic health status. The QDRRs were found in all records and the medical staff were completing QMSs. The need to link all of the current monitoring systems remained an important and outstanding one. Monitoring health status requires a number of processes, reviews, and evaluations due to the need to monitor both acute changes and chronic long-term disease. The monitoring team noted several components that would contribute to monitoring health status: • The risk management policy addressed this issue, to some degree, by requiring that the IDTs review individuals who showed a change in status based on crossing a risk threshold. • Periodic assessments (medical, nursing, therapies, psychiatry, and pharmacy) • Acute assessments via sick call • Reports of acute changes via the daily clinical services meetings • Medical databases (preventive care, cancer screenings, seizure management) • The medical quality program would be the designated quality program and would report certain data elements to the QAQI council. Through the appropriate execution of these systems, an individual's care and monitoring could be assessed across this continuum of activities. Developing a comprehensive format to monitor health status will require collaboration among many disciplines due to the overlap between risk management, quality, and the various clinical services. The	Noncompliance

#	Provision	Assessment of Status	Compliance
		facility will need to develop a set of clinical indictors to define what is important to the individuals and what is important that the facility monitor. The facility should utilize, but not limit itself, the clinical protocols in the development of additional indicators.	
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.	At the time of the review, the facility was not tracking changes in treatments and interventions based on signs and symptoms used as clinical indicators. The facility needs to establish a comprehensive set of clinical indicators. Many of those should be based on clinical guidelines developed and should be reflected in the risk threshold policy. 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 significant untoward events and have therefore crossed a defined threshold. The monitoring team was concerned that the current risk threshold required too many adverse events occur prior to triggering reviews. Once clinical indicators are established, the medical director/medical designee could conduct audits of acute care based on persons who were seen for sick call and individuals who required transfer for acute care. Reviews of chronic care could also be completed as part of the medical quality program. Clinical guidelines or protocols define the standards of treatment. Thus, following the implementation of a specific treatment, the medical provider would conduct reassessments to measure the response to treatment. Results of those diagnostics would assist in decisions regarding further treatment. The medical quality program would assess the care provided to individuals for a given chronic condition.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	State office had developed a draft policy for Provisions G and H. The facility used this draft and the policy of other facilities to develop a local policy that addressed Provisions G and H.	Noncompliance

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:** Documents Reviewed: o DADS Policy #006.1: At Risk Individuals dated 12/29/10 o LSSLC Policy: At Risk Individuals revised 5/21/13 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 individuals admitted to the infirmary in the past year o List of individuals with serious injuries in the past year 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 individuals 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 constipation o List of individuals with a pica diagnosis 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 individuals who received enteral feeding o List of individuals with chronic and acute pain o List of individuals with challenging behaviors 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 Draft ISPs and IRRF for Individual #207 and Individual #192. o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews: • Individual #502, Individual #151, Individual #145, Individual #238, Individual #301, Individual #594, Individual #258, Individual #306, Individual #522, Individual #176, Individual #410, and Individual #60.

	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 Steven Webb, Human Rights Officer o Paula McHenry, QA Director o Keith Bailey, Residential Director o Todd Miller, Unit Director o Rotley Tankersley, Unit Director o Kenneth Self, Unit Director o Mary Stovall, Unit Director Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 7/9/13 and 7/11/13 o ISP preparation meeting for Individual #116 and Individual #185 o Annual IDT Meeting for Individual #192 and Individual #207 o Lone Pine Unit Meeting 7/9/13 o QAQI Committee Meeting
	Facility Self-Assessment: LSSLC submitted its self-assessment. Along with the self-assessment, the facility submitted an action plan that addressed progress towards meeting the requirements of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility planned to engage 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. The facility had engaged in the following activities to assess compliance: • Reviewed facility policies regarding risk identification, • Reviewed a sample of IRRFs to ensure all individuals had a current risk rating for each risk category, • Reviewed a sample of IHCPs, • Reviewed the assessment data base to determine if assessments were completed and submitted at least 10 days prior to the ISP date, and • Observed a sample of IDT meetings to determine the adequacy of the risk discussion.

	The facility recognized that the risk process was a very new process for the IDTs and it would take some time to develop an adequate system for addressing risks. 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: The statewide risk assessment procedure, with guidelines for rating risk, was in use at the facility. While some progress had been made on meeting substantial compliance, through an initial attempt to ensure individuals were accurately assessed and action plans were in place to address risks, the facility was not in compliance with the three provisions in section I. Revisions to the risk identification process 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. The monitoring team had a chance to observe three teams hold meetings utilizing the new format. Progress was observed towards integrating the risk discussion in relation to each individual's preferences, strengths, and daily schedule. However, the monitoring team found that IDTs were not yet using the IHCP to track the completion of assessments and document resulting recommendations. The process to ensure timely completion and implementation of action plans needs to be refined to meet substantial compliance with section I. The facility was not adequately assessing and addressing risks to ensure the safety and health of individuals at the facility. 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 reviewing supports following a change in status, but failing to ensure that assessments were completed and recommendations were implemented. Plans should be implemented immediately when individuals are at risk for harm, and then monitored for efficacy.

#	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. Integrated Health Care Plans (IHCP) were designed to provide a comprehensive plan that will be completed annually and updated as needed.	Noncompliance

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		The monitoring team was able to observe three 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 all meetings. IDTs were utilizing the newly created Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP). At the ISP meetings observed for Individual #207 and Individual #192, the team engaged in a more integrated discussion regarding risk ratings and developing action plans to address risks. Assessment information was taken into consideration for each risk rating and the IDTs considered many relevant factors that contributed to each risk category. Overall, both IDTs made rational determinations on risk ratings based on information available. • Individual #192's team did a nice job of integrating the risk discussion into the deliberation regarding her preferences, lifestyle, and support needs. • Individual #207's IDT still conducted somewhat of a segmented risk discussion, and then moved into discussion regarding his preferences and support needs. Further integration of the planning process will take additional mentoring and practice. In both ISP meetings, the IDTs stopped short of developing measurable goals for all risk categories and designating who would be responsible for monitoring and ensuring that supports were effective. While progress had been made in the risk process, additional training is still needed to ensure that team members develop action plans that will reduce the chance of untoward outcomes. The state policy required that all relevant assessments be 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. 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. 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 #151 was rated as medium risk for constipation and bowel obstruction. She had a significant history of constipation and hemorrhoids (a hemorrhoidectomy was performed on 12/12/12). She was taking two medications to prevent constipation and had required seven enemas for constipation in the past year. She had a health care plan with supports in place	

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		to address constipation, but continued to experience bouts of constipation. She was at high risk for constipation. The IDT rated her as low risk for fractures. She had a diagnosis of osteopenia and had at least 15 falls over the past year. Her risk for fractures was also high. The facility had initiated a new risk threshold system (managed by the QA Department) to identify individuals with incidents and injuries that might signal a change in risk status or indicate that current supports were not effective for preventing untoward outcomes. The QA Department was routinely providing data to IDTs for review. As further discussed in I2, it was not yet evident that IDTs were using this data to trigger a referral for further assessments or revise supports when warranted. The facility had taken many steps towards ensuring that an adequate risk assessment process was implemented. It was not evident through a review of outcomes that progress had been made towards reducing the health and safety risks for individuals residing at the facility.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	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. Health risk ratings will need to be consistently implemented, monitored, and revised when significant changes in individuals' health status and needs occurred. A sample of records was reviewed to determine if a determination of risk resulted in an assessment of current services and support, risk ratings, and/or plan revisions. It was difficult to determine if assessments were obtained and discussed by the team in a reasonable amount of time when recommended. Due to the lack of revisions made to the IRRFs when individuals experienced a change in status or hospitalization, the monitoring team was unable to determine what additional assessments were needed and/or conducted in response to the change of status. The monitoring team noted concerns during the onsite visit that changes in status were not being addressed in a timely manner with any sense of urgency. When plans were developed to address risks, IDTs were not following through to ensure that plans were consistently implemented and then monitored for efficacy. IDTs were not yet using the IHCP to track the completion of assessments and document resulting recommendations. Thus, it was not possible to determine if assessments were completed or if recommendations from assessments were incorporated into supports and tracked for efficacy. For example,	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Individual #151 was referred for a PNMT and pharmacological assessment following a fall on 5/8/13. According to her QDDP monthly review, both assessments were completed, and recommendations were made to change her PNM supports and medications to lower her risk for falls. On 5/23/13, she sustained a serious injury due to another fall. According to her PNMP provided to the monitoring team and information given to the monitoring team after the onsite visit, her PNMP had not been updated and her PNM assessment started 5/15/13 and finished 6/12/13. • Individual #258 was hospitalized for nine days on 3/18/13 due to pneumonia and dehydration. His IRRF was not updated following his hospitalization and there was no indication that the IDT met to review his risk status or supports. He was rated as high risk for respiratory compromise and had been hospitalized seven times in a one year period due to pneumonia. The team needs to meet and determine if further assessment or a revision of supports is needed. Current supports did not appear to be effective. • Individual #369's quarterly review of services dated 11/14/12 noted that her weight was above her ideal weight range and the dietician was considering a change to her diet. Minutes from her pre-ISP meeting on 1/23/13 documented her last nutritional assessment as May 2011. It was noted that a new nutritional assessment would be requested by the team. Her quarterly review dated 2/26/13 indicated that the RN case manager and dietician were aware of her gradual weight gain and would evaluate her diet. There was no further documentation that an assessment had been completed or discussed by the IDT. The monitoring team reviewed a sample of assessments from each discipline to determine whether or not an adequate assessment process was in place to address identified risk. Findings by discipline are summarized below, <u>Nursing</u> Based on a review of 20 records of which eight had completed nursing assessments, IRRFs and IHCPS, seven of eight (87%) included sufficient nursing assessments to assist the team in developing appropriate plans sufficient to meet the individual's health care needs. A comprehensive assessment was not found for Individual #517. The assessment did not include sufficient information in the nursing summary related to the significant numbers of meals or frequency of, medication refusal, weight loss over time, (e.g., per quarter, semi-annually, and/or annually) considering gastrointestinal level of risk. <u>PNM</u> Based on a review of 15 individual records, for whom current OT/PT assessments, 14 had been completed to address the individuals' at risk conditions. Ten (71%) included adequately addressed risk concerns, interventions, and supports to mitigate high and	

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		medium PNM risk issues and indicated whether these had been effective over the last year in order to assist the team in developing an appropriate plan. While each of the assessments addressed health and safety issues effectively, functional skill acquisition was not addressed adequately. Individuals without an OT/PT assessment current within the 12 months included Individual #174. Current assessments that did not adequately address risk concerns included Individual #425, Individual #294, Individual #488, and Individual #511. For Individual #511, rationale for PNM risks were identified, though supports provided to address these were not complete and there was no assessment as to whether they had been effective in mitigating the identified risks. Risks, rationale, and supports were identified for Individual #488 and Individual #294, but the effectiveness of these was not reported. Risk concerns were not addressed at all in the OT/PT assessment for Individual #425. <u>Psychiatry</u> Based on a review of nine examples of comprehensive annual psychiatric assessments, information regarding the individual's at risk information was documented by psychiatry in five of the nine. This documentation was sparse, however, when reviewing the totality of the psychiatric documentation, a plethora of information regarding the risk determination process could be gleaned. For those examples that included IRRF documentation, two questions were answered, (a) are psychiatric symptoms stable or unstable? and (b) is the response to treatment and supports adequate or inadequate? Responses to these queries in the documentation were brief and, generally, one word answers. This would not provide the information necessary to make a risk determination in the absence of a full record review. It is worth noting that since the previous monitoring review, psychiatry attended 71 out of 77 ISP meetings (92%). Psychiatry attempted to be present for the integrated risk rating discussion. Their participation in this process was observed during this monitoring visit. It was notable that psychiatry came to the meeting prepared to provide information to the IDT. <u>Psychology</u> Generally, psychology functional assessments were found to be very good (as discussed in K5). The quality of PBSPs was much improved (as discussed in K9). There was not, however, sufficient data to ensure that those plans were implemented with integrity (see K10 for more detail). IDTs were not sufficiently documenting that the IDT conducted comprehensive assessments of the conditions associated with a change in status as evidenced by multiple restraints of individuals (see C7 for details).	

#	Provision	Assessment of Status	Compliance
		Medical Based on a review of 25 Annual Medical Summaries, 0 of 25 (0%) included comments from the primary providers on risk assessments. This is discussed further in section L1. Integrated Risk Rating forms did not consistently include specific clinical data that should indicate that a change in status review was needed. Thus, the monitoring team was unable to determine if a change in status had occurred for most individuals in the sample unless a significant illness or injury was documented elsewhere in the record. There was no sense of urgency, even following a significant change in status, to ensure that supports were adequate to prevent a serious incident or illness. For example, • The October 2012 monitoring team report noted that Individual #238 did not have adequate risk protections in place to reduce his risk of falls. At that time, he had 12 injuries related to falls including three serious injuries in a one year period. It was noted that his PNMP had not been revised when supports failed to protect him from harm and staff, when questioned, were not clear what supports should be provided. His ISP dated 1/3/13 included a review of his PNM assessment and resulting plan. The summary of his PNM assessment stated "It is questionable whether PNMP is being followed. PNMP must be followed to prevent injuries." Conflicting information regarding the effectiveness of supports was found in his ISP. In one place the ISP indicated that the PNMP "was meeting his needs." Another excerpt in the ISP stated that PNMP strategies "had not been successful in that he had 23 falls during the past year." His IDT met on 1/31/13 following another fall resulting in a head injury requiring four staples to close the laceration on 1/28/13, and an additional fall on 1/30/13. At that time, the team agreed to provide a gait belt with one-to-one supervision and an assessment for the use of a walker. The ISPA stated that the team would meet to review supports on 2/28/13. The IDT did not meet again until 5/9/13 to implement recommendations from the assessment for a walker. At that time, the PNMP was revised to read "encourage" the use of the Pacer walker for ambulation on the home. Again, instructions were not sufficient to ensure that staff were providing consistent supports to prevent additional serious injuries. IDTs were not yet using the IHCP to track the completion of assessments and document resulting recommendations. The process to ensure timely completion and implementation of action plans needs to be refined to meet substantial compliance. The facility is not adequately assessing and addressing risks to ensure safety and health.	

#	Provision	Assessment of Status	Compliance
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. 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. All ISPs in the sample included general strategies to address identified risks, but again, not all assessments were submitted prior to the determination of risk ratings, thus, it was unlikely that risk ratings were based on current data. As noted in I2, IDTs were not yet using the IHCP to track the completion of assessments and document resulting recommendations. IDTs were not documenting when plans were implemented. Thus, it was not possible to determine if IDTs implemented all recommendations from assessments within 14 days. For example, • As noted in I2, Individual #238's IDT met following a serious injury from a fall and requested an assessment for a walker. Documentation indicated that his PNMP was not revised to include recommendations from that assessment until three months later. He had 23 falls and numerous injuries, yet the IDT was still not following up on assessments and recommendations in a timely manner. • Similarly, Individual #410 had over 100 restraint incidents in a one year period. Following an increase in behaviors leading to restraints, his psychiatrist recommended a specialty consultation with a neurologist to rule out seizure activity as a trigger to behavior resulting in restraints. There was no documentation that the assessment was obtained or if obtained that the assessment was reviewed by the team. 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. As noted in section F, a comprehensive monthly review process was not yet in place to ensure that plans were being implemented and monitored as needed. Many of the risk action plans in the sample reviewed did not include specific risk indicators to be monitored for all areas of risk. Risk action plans often referred to an ancillary plan in place or instructions were too general (e.g., follow diet, follow PNMP). Not all ancillary plans were integrated into the ISP, so staff did not have a comprehensive plan to monitor all supports. It was not evident that clinical data were gathered and reviewed at least monthly for all risk areas.	Noncompliance

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		To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following: • Develop action plans with measurable criteria for assessing outcomes. • Document the implementation of action plans. • Document that clinical data is gathered and reviewed at least monthly. • Document action taken to revise supports when data indicates that current supports are not effective.	

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 nine 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 Five dental skills acquisition plans and three 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 indicating if the assessment was completed. o Training sign in sheets facility nursing staff regarding administration of MOSES and DISCUS examinations. o Examples of MOSES and DISCUS examination for 10 different individuals. This included the psychiatrist's progress note for the psychiatry clinic following completion of the MOSES and DISCUS examinations. o A separate list of individuals being prescribed each of the following: anti-epileptic medication being used as a psychotropic medication in the absence of a seizure disorder, lithium, tricyclic antidepressants, Trazodone, beta blockers being used as a psychotropic medication, Clozaril/Clozapine, Mellaril, Reglan. o List of new facility admissions for the previous six months and whether a Reiss screen was completed. o Spreadsheet of all individuals (both new admissions and existing residents) who had a Reiss screen completed in the previous 12 months. o For five individuals enrolled in psychiatric clinic who were most recently admitted to the facility:

	individual Information Sheet; Consent Section for psychotropic medication; personal Support Plan, and ISP addendums; Behavioral Support Plan; Human Rights Committee review of Behavioral Support Plan; Restraint Checklists for the previous six months; Annual Medical Summary; Quarterly Medical Review; Hospital section for the previous six months; X-ray, laboratory examinations and electrocardiogram for the previous six months.; Comprehensive psychiatric evaluation; Psychiatry clinic notes for the previous six months; 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. o Nine 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 All information presented, doctor's notes and documentation regarding Dr. Buckingham's clinic on 7/9/13 regarding Individual #22, Individual #317, Individual #290, and Individual #504. o All information presented, doctor's notes and documentation regarding Dr. Vyas' clinic 7/10/13 regarding Individual #249. o All information presented, doctor's notes and documentation regarding Doug Douglas, P.A. clinic 7/10/13 regarding Individual #574. o Pretreatment sedation documentation regarding Individual #34. o Slides from polypharmacy meeting 7/10/13. o For the last three months, the tracking document regarding response to pretreatment sedation. o All information presented, doctor's orders and documentation from neurology clinic 7/10/13 regarding Individual #31, Individual #308, Individual #368, and Individual #500. o Ten examples of the neurology/psychiatry consultation report. o Reiss screen data regarding change of status reviews. o Total number of ISP meetings vs. number of ISP meetings psychiatry attended for the previous six months. o List of diagnosis changes per psychiatry for the previous six months. o Final documentation from the ISP dated 7/11/13 regarding Individual #67. o All information presented, doctor's orders and documentation from Dr. Buckingham's clinic 7/11/13 regarding Individual #507 and Individual #345. 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 #33, Individual #23, Individual #305, Individual #319, Individual #59, Individual #382, Individual #60, Individual #410, Individual #93, Individual #240, and Individual #522. <u>Individual Interviews and Meetings Held</u>: o JoAnne Lancaster, R.D.H. and Dr. Jafri, facility dental director o Judd Williamson, R.N., Psychiatric Nurse o James Buckingham, M.D., lead psychiatrist o Kacie Collins, Administrative Assistant o Luz Carver, Director of QIDP services o Sylvia Middlebrook, Ph.D., Director of Psychology and Robin McKnight, psychologist o Tom Middlebrook, M.D., facility psychiatrist o Mary Bowers, R.N., Chief Nursing Executive o Jodella Winn, psychiatry administrative assistant o David Leeves, R.Ph. and Janis Rizzo, R.Ph., pharmacy staff o Andra Self, clinical services director

	Observations Conducted: o Dr. Buckingham's clinic on 7/9/13 regarding Individual #22, Individual #317, Individual #290, and Individual #504. o Dr. Vyas' clinic 7/10/13 regarding Individual #249. o Doug Douglas, P.A. clinic 7/10/13 regarding Individual #574. o Neurology clinic 7/10/13 regarding Individual #31, Individual #308, Individual #368, and Individual #500. o Dr. Buckingham's clinic 7/11/13 regarding Individual #507 and Individual #345. o ISP dated 7/11/13 regarding Individual #67. o Polypharmacy Committee Meeting o Medical/Dental Desensitization (DERST) workgroup meeting o Pharmacy and Therapeutics Committee o Clinical Services Meeting o Quality Assurance risk meeting
	Facility Self-Assessment: LSSLC had continued to utilize the revised self-assessment which 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. 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 facility self-rated itself as being in substantial compliance with seven provision items: J1, J2, J3, J5, J6, J7, and J12. The monitoring team agreed with four of these J1, J2, J6, and J12. Additionally, J8 and J14 were found in substantial compliance based on appropriate collaborative case formulations and informed consent procedures. The monitoring team did not agree with the facility self-assessment regarding J3, J5, and J7. This was due to the need for consistency regarding documentation of the psychiatric review of the PBSP, the need for additional psychiatric resources, and insufficient Reiss screen data regarding the screening of individuals not currently participating in psychiatry clinic.
	Summary of Monitor's Assessment: Psychiatry services at LSSLC made progress towards substantial compliance. The facility was found to be in substantial compliance with six of the 15 items in this provision of the Settlement Agreement. Over half of the individuals residing at the facility received psychopharmacologic intervention (193 of 347, 55%). The facility had identified a lead psychiatrist. 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 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. There were marked improvements in psychiatric documentation precipitated by peer review and inclusion of prompts for dictation. Most impressive was the scheduling change with a consistent day and time identified for ISP meetings allowing for psychiatric attendance at 92% of ISP meetings during the monitoring period. 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. The monitoring team observed four psychiatric clinics, and one Neuro-Psychiatry clinic. Per interviews with psychiatrists and psychology staff, as well as observation during psychiatry clinics, IDT members were attentive to the individual and to one another. There was participation in the discussion and collaboration between the disciplines (psychiatry, psychology, nursing, QDDP, direct care staff, and the individual). A review of psychiatric documentation revealed improvements with the justification of diagnoses and identification of nonpharmacological interventions. Issues related to collaboration with neurology remained; however, the facility had a plan identified to improve collaboration, although the sustainability of this plan was questionable. There were improvements reported in the psychiatric participation in the development of the BSP. This was occurring during psychiatry clinic; however, documentation of this process was not uniform, and the psychiatrist's signature was not located on the BSP document. There were several areas where the facility was able to achieve substantial compliance ratings (e.g., J1, J2, J6, J8, J12, and J14). While there were some areas where psychiatry needed improvements in documentation, in other areas, psychiatry was approaching substantial compliance, however, it was notably the functions that were dependent upon other departments (e.g., primary care, pharmacy, psychology) that were impeding this. Approaching this section as an isolated task list will not achieve the desired results, instead, a comprehensive, collaborative, integrated psychiatric service is required.

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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. The facility had designated a lead psychiatrist. Experience Of the three part-time physicians, one had been providing care at the facility for over four years. A second part-time physician had been providing care at the facility for over two years, and the third part-time psychiatrist had begun providing services at the facility approximately one year 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 16 months ago. Given 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 developed a "pearls of wisdom" book in an effort to assist psychiatry staff in their transition to the supports and services center model. It was reported that this was beneficial to a psychiatric locum tenens provider who was retained to provide services for approximately one month during this monitoring period. Ultimately, the facility will need to continue the development of 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, 92.7% of individuals participating in psychiatry clinic had completed comprehensive psychiatric assessments, however, there were questions regarding the accuracy of these data (for additional information regarding this issue please see J6). 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). In previous monitoring reviews, variability in the quality of case formulations or description of what led the psychiatrist to make a specific diagnosis was discussed. During this monitoring period, marked improvement in the quality of documentation was noted. It was apparent that this was the result of quality improvement efforts of psychiatry clinic. Specifically, psychiatry clinic staff had begun a systematic review of all comprehensive psychiatric assessments. In doing so, they noted areas where documentation was routinely deficient. In an effort to address this, an evaluation guideline was created for the psychiatrist to utilize when dictating and/or documenting, resulting in improvements in both the quality and consistency of documentation among psychiatric providers. Clinical Justification All individuals prescribed psychotropic medication had a five-axis diagnosis documented, and appropriate case formulations or descriptions of what led the psychiatrist to make a specific diagnosis was noted. A review of 16 records of individuals at LSSLC revealed appropriate documentation in the quarterly medication reviews (five records were regarding new medication starts, with one being a new admission and therefore, some documentation was pending). Therefore, this provision item was found to be in substantial compliance. Examples are provided below in J8 and J13. Psychiatry clinic had also instituted a process of peer review. Via this process, psychiatric providers regularly reviewed the documentation generated by their peers and documented this review via a form entitled, "Comprehensive Psychiatric Evaluation/Assessment Monitoring." Ten examples of the completed assessment along with the document reviewed were provided. A review of this documentation revealed attention to detail and helpful comments provided. For example, in the review of the documentation regarding Individual #407, it was noted, "what specifically is her SIB (e.g., head banging), what triggers it, how severe, how long does it last?" With regard to the diagnostic assessment, comments regarding the documentation included, "list what criteria the patient meets to support diagnosis…mention previous depressive symptoms to justify bipolar." The forms	Substantial Compliance

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		were signed by the psychiatrist being reviewed, often with comments such as "thank you…will try to improve based on your recommendations." Given the above, it was apparent that the facility psychiatric staff were working hard to improve their evaluations and the documentation associated with them. This process was apparently positive because the document review performed for this monitoring visit revealed marked improvements. <u>Tracking Diagnoses and Updates</u> LSSLC had continued the tracking of diagnoses, medications, and of dates when psychiatric quarterly clinics were due in order to ensure timely services. A review of the data revealed that, of the 193 individuals participating in psychiatry clinic, the majority of individuals where quarterly psychiatric clinic reviews were outdated, the individual was due for clinic in either June 2013 or July 2013 as noted on the clinic tracking document. Therefore, information for June 2013 might have been added after the document was printed. There were three individuals who were far overdue for psychiatry clinic. Individual #428 was last seen in clinic in November 2012. Per the document, this individual was not prescribed psychotropic medications. Individual #175 was last seen in clinic December 2012. Per the document, this individual was prescribed antipsychotic medication. Finally, Individual #176 was last seen in psychiatry clinic February 2013. This individual was prescribed multiple psychotropic medications including Clozapine, Lithium, and Lorazepam. <u>Challenges</u> The facility had made great strides with regard to the completion of the psychiatric assessments. Given the lack of a full time psychiatrist and a reliance on part time providers, this was particularly impressive. In addition, they managed to generally perform timely quarterly psychiatric reviews. The facility psychiatric clinic staff have continued to perform reviews of documentation with regard to clinical quality, and to implement documentation guidelines for the psychiatrists. <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. The facility psychiatric staff had begun peer review and quality improvement monitoring of documentation resulting in improvements overall. In addition, there were improvements noted in the tracking of services provided and with regard to scheduling. Given these improvements, this provision is in substantial compliance, in agreement with the facility self-assessment.	

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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 16 records, all had diagnoses noted in the record. Individuals prescribed psychotropic medication must have an active positive behavior support plan (PBSP). In 11 of the 11 records reviewed, there was a PBSP on file. An additional five records reviewed were for new admissions, and only one of these included a PBSP that was signed by the treating psychiatric provider. Of the 11 records reviewed for individuals who were not recently admitted, three included PBSP documents that were signed by the treating psychiatric provider. It was difficult to determine the psychiatrist's input and/or review of the PBSP. In all records, information regarding the PBSP was included in the psychiatric documentation indicating discussion during psychiatry clinic. In two records, the psychiatrist had signed with regard to attendance at the ISP where the PBSP was discussed. In three records, the psychiatrist had signed the actual PBSP document, as this form had been revised to include a signature line for the treating psychiatrist. In order to ensure that this process was occurring, documentation of this process must be uniform across all providers. It should be noted that in all four clinic observations performed for this monitoring period, the PBSP was reviewed by the psychiatrist and discussed via the IDT present in psychiatry clinic. 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). 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. Given the team approach to psychiatry clinic that was utilized 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. Since the previous monitoring visit, there had been improvements in the review of non-pharmacological interventions, both occurring or proposed, for a specific individual. Review of psychiatric documentation revealed some excellent examples of non-pharmacological interventions (see the example below). It will be important for collaboration to continue between psychology and psychiatry in case formulation, and in the joint determination of target symptoms and descriptors or	Noncompliance

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		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 continue to 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. 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). • Review of psychiatric documentation did reveal recommendations regarding non-pharmacological interventions. For example, the psychiatric documentation regarding Individual #60 stated, "recommended continuing one-to-one observation to help with reinforcing positive behaviors…which she has started to demonstrate in the last few months. Sensory and communication evaluations have been ordered…they are in the process…schedule has been modified to the point that she is starting to adapt…has been referred to workshop…also been to classroom." <u>Emergency use of Psychotropic Medications</u> The facility use of emergency psychotropic medication for individuals during periods of agitation/aggression had increased. During the previous monitoring period, there were four incidents. For this monitoring period, there were a total of 14 incidents. These 14 incidents were attributed to three individuals with Individual #522 receiving emergency psychotropic medication on nine occasions. In 12 of the 14 instances, intramuscular injections were administered. In one instance, the individual was given oral medications. In one instance, data did not indicate the route of administration of the chemical restraint. In 13 of 14 incidents, the chemical restraint was authorized by the primary care physician. Documentation was received for all 14 incidents. A review of the documentation revealed that in one of the incidents, the psychiatrist had not completed the "Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint." In seven instances, the psychiatrist had completed this documentation. In the remaining six instances, documentation indicated that the completion of the "Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint" was pending. It was noted that the last restraint episode was dated 5/19/13 approximately six weeks prior to this monitoring visit. 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 regular documentation of the psychiatrist's participation in the development of the PBSP. Review of documents revealed documentation of the review, but in various locations in the record, with a paucity of signed PBSP documents. Improvements had been noted, specifically the psychiatric review and documentation of nonpharmacological interventions. With regard to chemical restraints, there had been an increase in instances, however, the majority of these instances were attributable to one individual, a recent admission to the facility. In the period of time preceding the monitoring visit, this individual had improved greatly and was responding to behavioral interventions. While improvements in documentation regarding the review of chemical restraint were noted, there were delays in the completion of these evaluations. Given the issues outlined above, this provision will remain in noncompliance in contrast to the rating assigned in the facility self-assessment. The facility self-assessment did not review the physician's participation in the development of the PBSP and the documentation thereof. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. ensure the regular documentation of the psychiatrists' participation in the development of the PBSP 2. increase psychiatric input into the chemical restraint process (e.g., consider requiring psychiatry to authorize chemical restraints in lieu of the primary care physician) 3. Improve the timeliness of the completion of the post restraint review and debriefing document.	
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	Extent of Pretreatment Sedation The facility reported a total of 156 instances of pretreatment sedation between 12/3/12 and 5/20/13. Of these, 65 were reported as medical pretreatment sedation and 91 were dental pretreatment sedation. TIVA (general anesthesia) accounted for 35 of the 91 instances of dental pretreatment sedation. Interestingly, of the total of 156 instances of pretreatment sedation, 106 (or 68%) were for individuals participating in psychiatry clinic who were prescribed psychotropic medications. Interdisciplinary Coordination During the month of September 2012, the facility instituted a pretreatment sedation consultation process. This system was included in policy and procedure entitled "Client Management" dated 5/20/13. Per this policy, attempts must be made to treat individuals without sedation and/or restraints, if treatment attempts continue to be unsuccessful	Noncompliance

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	medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	despite efforts at desensitization and behavioral modification, then authorization for treatment must be obtained. Included in the policy and procedure entitled "Psychiatric Services Procedure Manual" was language indicating the need for interdisciplinary coordination, however, the process for consultation between providers (e.g., dental, primary care, psychiatry, and pharmacy) was not delineated. Per the policy the "IDT will ensure that pretreatment sedation planning is coordinated with all relevant clinical disciplines." The facility continued to perform interdisciplinary consultation with regard to 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 reportedly occurred in the morning clinical meeting. During this monitoring visit, there were reportedly no consultations to review. Of the 10 examples available for review, three did not include the second page where the consensus recommendations are documented. Of the remaining documents, three were blank in that they did not include any documentation of the consensus meeting. The primary care provider signed five 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. 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. In addition, a review of the documentation revealed concerns that the pretreatment consultation process was simply a "rubber stamping" of the original request for sedation. 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. <u>Monitoring After Pretreatment Sedation</u> A review of documentation for nine 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.	

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		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 continued their focus on training direct care staff with regard to toothbrushing and oral care. This process included visits to the individual's home by the dentist and dental staff in an effort to reach out to individuals and increase the likelihood of compliance with dental care. The list of individuals with medical and dental desensitization plans or skills acquisition plans was reviewed. Per this document, 22 individuals required a SAP, dental simulation, dental desensitization, medical desensitization, or a combination of these modalities. Of these, 17 individuals had a shaping SAP, five individuals had utilized the dental simulation room (with two of these occurring in 2013), four individuals had a dental desensitization plan (with two of these authored in 2013), and three individuals had medical desensitization plans (all authored in 2012). A review of current plans, formulated following the formation of DERST, revealed five of plans targeting dental desensitization (both actual desensitization plans and SAP) three examples of medical desensitization plans. Of the desensitization examples, all were individualized. For additional information regarding the quality of these plans, please see section K. 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	

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		great efforts with regard to developing a process to review individuals who require pretreatment sedation. They had also progressed with regard to the assessment of individuals as with regard to the development of both SAPs and desensitization plans for those individuals requiring pretreatment sedation for dental treatment. In order to move toward substantial compliance, it is recommended that over the next six months, the facility focus on improving the quality of documentation and interdisciplinary consultation regarding pretreatment sedation. It is also recommended that they address desensitization with regard to the use of sedation for medical procedures.	
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.	<u>Psychiatry Staffing</u> Approximately 55% of the census (193 individuals) received psychopharmacologic intervention requiring psychiatric services at LSSLC as of 7/8/13. 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 a lead psychiatrist designated. <u>Administrative Support</u> Psychiatry clinic staff previously included a psychiatric nurse, a psychiatry assistant, and a psychiatric administrative assistant. Just prior to this monitoring visit, the psychiatry assistant moved to another position on campus. The facility was in the process of posting this position and planned to recruit a new staff member. The psychiatry clinic team remained organized and enthusiastic, and had benefitted from both the designation of the lead psychiatrist and their interaction with the lead psychiatrist. This team was previously 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. It was noted that over the course of the period since the previous monitoring visit that with the influence of the lead psychiatrist, the psychiatry clinic staff had made great strides. <u>Determination of Required FTEs</u> The current allotment of psychiatric clinical services may 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.	Noncompliance

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		LSSLC rated this item in substantial compliance and documented their review of the current psychiatric resources in the self-assessment, indicating that the psychiatrists have been able to perform timely annual and quarterly psychiatric reviews, attend ISP meetings (attending 55 of 56 annual ISP meetings since January 2013), attend required committee meetings, and participate in the development of the PBSP. The self-assessment also indicated that psychiatrists have been able to collaborate with neurology, however, this was an area of deficiency. See the discussion under J15 for more information. While it was laudable that with improvements in scheduling and coordination the psychiatry staff had been able to improve many services, issues remained, specifically in the areas of neurology consultation. There were currently a total of 197 psychiatric clinical resource hours per month, with a caseload of 193 individuals there were enough hours for each individual to have a minimum of one hour of consultation with psychiatry monthly. The computation of appropriate resources 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 well structured and there were noted improvements in psychiatric integration across campus, however, in order to expand psychiatric presence and continue to provide quality clinical services, additional resources appeared to be necessary. During the previous monitoring reviews, 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 an additional consulting 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 to the lack of sufficient psychiatric resources to provide the services required, this provision remained in noncompliance. This was in disagreement with the facility self-assessment where a substantial compliance rating was documented.	

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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.	Policy and Procedure A review of the facility's current policy and procedure manual revealed a document entitled "Psychiatry Services Procedure Manual" dated 5/23/13. 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. Evaluations Completed A listing of all individuals evaluated per Appendix B was requested. This list contained the names of 179 individuals. Interestingly, data presented for the previous monitoring review included the names of 185 individuals. As there were a total of 193 individuals receiving treatment via the psychiatry clinic, the facility psychiatric practitioners had completed 92.7% of the evaluations on the individuals currently assigned to clinic. For the previous monitoring period, 99.5% of the evaluations had been completed. Given this, it was considered that the data were incomplete. Review of Completed Evaluations A review of nine completed comprehensive evaluations revealed that these evaluations were completed between 3/25/13 and 5/2/13. (Note, these annual evaluations were not included in the data list discussed above.) There were sample evaluations provided from all facility practitioners. The evaluations reviewed were improved over those reviewed for previous monitoring reports. There were improvements with regard to the quality of the collaborative case formulation, the justification of diagnoses, the generation and documentation of the behavioral-pharmacological hypothesis, and identification of non-pharmacological interventions outside of the PBSP. In general, the physicians followed the required format, and per interviews with psychiatry clinic staff, a guideline had been developed for the psychiatric providers to utilize when dictating evaluations in order to ensure that all required elements were addressed. The psychiatry clinic staff had been engaging in peer review activities where providers routinely reviewed each other's documentation providing feedback to one another. This process was reportedly a positive one for the providers, allowing them to see one another's work, review it from a quality perspective, and integrate what they learned from this process into their own practice at the facility. Monitoring Team's Compliance Rating During the previous monitoring period, facility staff had made a team effort and thereby completed the large number of outstanding comprehensive psychiatric evaluations. There were issues noted with data provided, in that more recent annual assessments were not documented in the listing of individual's with completed comprehensive assessments.	Substantial Compliance

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		Regardless, the review of documentation revealed improvements in all areas with annual assessments that were consistent with generally accepted practices. In addition, the psychiatry clinic had engaged in peer review of clinical documentation. As such, this provision is in substantial compliance. It is recommended that the facility psychiatry clinic staff review the data regarding dates of completion of annual comprehensive assessments for accuracy in reporting.	
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 seven individuals admitted to the facility since 12/3/12. Of these, five individuals were assessed via the Reiss Screen, with documentation indicating that at the time this information was generated, two individuals were within thirty days of admission. A review of the dates of admission versus the dates the Reiss Screen was completed for the five new admissions revealed that the screen was performed an average of 10 days after admission (range 1-15 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 347, with 193 individuals enrolled in psychiatry clinic. Therefore, 154 individuals were eligible for baseline Reiss screening. Information received for this visit revealed that from January 2012 through May 2012 a total of 70 individuals not noted as participating in psychiatry clinic were screened. Given the presentation of these data, it was difficult to ensure that all individuals not participating in psychiatry clinic had received a baseline screen. In previous monitoring visits, data were provided from 2011 indicating that a total of 47 individuals were screened during that calendar year. Taken together, individuals screened during 2011 and those reported via the current document request revealed a total of 117 individuals had been screened. In addition, more recent data revealed that all new admissions had received the Reiss Screen.	Noncompliance

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		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 receiving a baseline screening as required. Regardless, it appeared that the facility psychology staff had made strides with regard to the screening of individuals, although data were not provided in a manner to allow for easy confirmation. Reiss Screen for Change in Status Data provided from psychiatry clinic revealed that 11 individuals had received the Reiss Screen due to a change in status in the period between 1/9/13 and 7/22/13. In all but one case (performed 7/22/13 and noted as "pending") there was a notation regarding the results of the evaluation performed by psychiatry as a result of the screening. When reviewing the dates of the completion of the Reiss Screen and the dates that a psychiatric assessment was performed, it was noted that there was an average of 11 days between referral and assessment (range 0-22). Referral for Psychiatric Evaluation Following Reiss Screen 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 5/23/13 indicated 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…assessment will occur no more than 21 working days from the date Reiss Screen results are reported to the psychiatry department…will perform a preliminary assessment in no more than seven working days from the date of referral to determine severity of the presenting psychiatric symptoms and an appropriate timeline in which the comprehensive assessment needs to occur…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." This policy and procedure revision was positive as it outlined timelines within which psychiatry would review an individual with a positive Reiss Screen. Monitoring Team's Compliance Rating The facility has made strides with regard to policy and procedure revision, use of the Reiss Screen for change of status, use of the Reiss Screen at the time of admission, and timeliness of a psychiatric assessment and/or evaluation following referral due to a positive Reiss Screen. The challenge is that based on the data provided, it was not possible to ensure that all individuals not participating in psychiatry clinic had received a baseline Reiss Screen. As such, this provision will remain in noncompliance in disagreement with the facility self-assessment.	

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		The facility self-assessment reviewed Reiss Screens performed at admission, timely completion of psychiatric assessments following the admission screening, Reiss Screens due to change of status, and revisions to policy and procedure regarding timelines for completion of psychiatric assessments. Unfortunately, baseline Reiss Screens for individuals not participating in psychiatry clinic were not reviewed in the facility self-assessment. In order to reach substantial compliance, the facility must ensure that all individuals not participating in psychiatry clinic have received a baseline Reiss Screen and present data regarding the completion of this process.	
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.	<u>Policy and Procedure</u> Per the "Psychiatry Services Procedure Manual" dated 5/23/13, "each State Center will develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation…annual and quarterly reviews will be conducted with participation of the IDT and the individual (if the individual is able to participate)." The policy then defined the roles of IDT members including nursing, psychology, QDDP, DSP, dietary, habilitation therapy, and workshop representatives outlining a system to integrate pharmacological treatment with behavioral and other interventions. <u>Interdisciplinary Collaborative Efforts</u> 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. Psychiatry staff had attended ISP meetings with attention to attending annual meetings. Psychiatry staff had focused on the completion of comprehensive psychiatric evaluations. A review of these revealed case formulations/diagnostic assessments. There was documentation in all 10 examples provided for review 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. <u>Integration of Treatment Efforts</u> There were marked improvements with regard to integration between psychiatry and psychology. 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. It was also notable that there was an improvement in the graphs presented to the physician (e.g., notation of medication changes), with increased attention to the identification of other	Substantial Compliance

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		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. <u>Collaborative Diagnostic Formulations</u> A review of the comprehensive psychiatric evaluations of nine individuals revealed that all contained a case formulation. In all 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 improved from previous reviews. • Individual #401: Per the comprehensive psychiatric evaluation dated 4/10/13, documented as completed in collaboration with the IDT, "Bipolar Disorder Type I, most recent episode manic…history of depression and manic symptoms…depressive symptoms…decreased energy, sad mood, withdrawn behaviors, social isolation guilt, helpless, hopeless, worthless, suicidal ideations, and manic behaviors…increased energy, decreased need for sleep, increasing goal directed activity….she has physical aggression and self injurious behavior…includes attempts to harm herself by scratching her arms and legs causing them to bleed. Physical aggression includes hitting, slapping, pinching others…history of destroying property…people who have problems with communication tend to have external manifestation of physical aggression, self injurious behavior, which…is manifesting…even though her speech is normal, she has a hard time communicating her needs…" The evaluation continued with a similar review of the secondary diagnosis of anxiety disorder, not otherwise specified. The document further reviewed biological, psychological, and social issues contributing to this individual's psychiatric symptoms and behavioral challenges. 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.	

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		It was notable and indicated throughout this monitoring report that there were marked improvements in the psychiatric documentation. It was considered that the psychiatric clinic's attention to the peer review process had resulted in these improvements. <u>Monitoring Team's Compliance Rating</u> There were marked improvements in the quality of the collaborative case formulations. In many documents, there was documentation of the collaborative process. It was noted during this and previous monitoring visits that the psychiatry clinics included members of the IDT, allowing for the collaborative process to occur during the clinical encounter. Given these improvements, this provision will be rated in substantial compliance in disagreement with the facility self-assessment. The self-assessment assigned a rating of noncompliance based on issues with the psychiatric participation in the ISP and with the psychiatrist's contribution to the BSP. These issues will be addressed in J9.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	<u>Psychiatry Participation in PBSP</u> Per interviews of both psychiatrists and psychology staff, the psychiatrists did not attend meetings regarding behavioral support planning, however, the PBSP documents were reviewed in psychiatry clinic at the time of the annual evaluation. As discussed in J3 above, there were challenges with the document review regarding psychiatric input into the PBSP because this process was documented in different areas, and there were deficiencies with regard to the psychiatrist's signature on the PBSP document. Therefore, this provision item was rated as being in noncompliance, in agreement with the facility self-assessment. To meet the requirements of this provision item, there needs to be indication that the psychiatrist was involved in the development of the PBSP as specified in the wording of this provision item J9. 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 should continue to be reviewed annually during regularly scheduled quarterly clinic, with additional reviews as clinically indicated. The review of this document should be noted in the annual evaluation, with the psychiatrist's signature present on the final document. Documentation of psychiatric attendance at IDT, ISP, and BSP meetings was reviewed. Between 1/3/13 and 7/3/13 there were a total of 77 ISP meetings with documentation indicating that psychiatry was present at 71 meetings (92%). There were no notations of psychiatric attendance at PBSP meetings. It was laudable that psychiatric attendance at ISP	Noncompliance

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		meetings had increased from zero in the previous monitoring period to a 92% attendance rate in the current monitoring period. Treatment via Behavioral, Pharmacology, or other Interventions Per a review of the PBSP documentation provided in the records of 11 individuals, a signature line had been included in the PBSP document for the treating psychiatrist. This was appropriate because participation of the individual's actual treating psychiatrist is the generally accepted professional standard of care. While it is not necessary for the psychiatric physician to participate in all meetings regarding the PBSP, there must be some participation/collaboration and documentation of this participation/collaboration in the process in order to satisfy the requirements of this provision item. As discussed in J3, of the 11 records reviewed, three included PBSP documents that were signed by the treating psychiatric provider. It was difficult to determine the psychiatrist's input and/or review of the PBSP. In all records, information regarding the PBSP was included in the psychiatric documentation indicating discussion during psychiatry clinic. In two records, the psychiatrist had signed with regard to attendance at the ISP where the PBSP was discussed. In three records, the psychiatrist had signed the actual PBSP document, as this form had been revised to include a signature line for the treating psychiatrist. In order to ensure that this process was occurring, documentation of this process must be uniform across all providers. It should be noted that in all four clinic observations performed for this monitoring visit, the PBSP was reviewed by the psychiatrist and discussed via the IDT present in psychiatry clinic. ISP Specification of Non-Pharmacological Treatment, Interventions, or Supports Non-pharmacological interventions were discussed during some of the psychiatric clinic encounters observed during the monitoring visit. These included references to 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. There were improvements noted in the breadth of non-pharmacological interventions identified for individuals during the annual psychiatric evaluation process. For example: • Individual #368- "sensory interventions by hab therapy...a quiet non-provocative place if he becomes highly agitated…decrease the level of supervision to line of sight from every 10 feet…continue with his new shoes and helmet that has helped with his functioning…participation in the new training room for four hours a day in order to develop his vocational skills…greater participation off campus and in community settings…continue other aspects of the positive behavioral support plan that…limit his target symptoms in improves his functionality."	

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		There were other examples where improvements were needed. For example: • Individual #189- "positive behavioral support plan will continue to be implemented with staff continually trained on using this. Attempts will be made to encourage him to seek attention in more positive ways and express disapproval or escape also in more positive ways…he will be redirected when interacting in appropriately with staff sexually...staff will try to get him outside and away from the home when he is starting to be more agitated. This seems to be helpful to him as far as getting him redirected." 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 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. In order to move toward substantial compliance in is recommended that over the next six months the facility focus on: 1. ensuring consistent documentation of the psychiatric review and input into the PBSP inclusive of their signature on the document. 2. the identification and documentation of non-pharmacological interventions.	
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	<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	Noncompliance

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	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.	treatment strategies are likely to be less effective or potentially more dangerous than the medications." Facility-specific policy "Psychiatry Services Procedure Manual," dated 5/23/13 stated, "the psychiatrist will solicit input from and discuss with the IDT any proposed treatment with psychotropic medication…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…for every individual receiving psychotropic medication, the IDT, including the psychiatrist, will ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis…"" 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. This form included sections that required the prescribing physician to document "potential risk/side effects related to using this medication" and to document "any alternatives that exist (including non-pharmacologic) 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 had continued and had been expanded since the previous monitoring visit. A review of the records of 16 individuals at the facility who were prescribed various psychotropic medications (11 requested records and five records provided via the document request regarding individuals most recently prescribed psychotropic medications) revealed improvements in the quality of psychiatric documentation regarding this issue. While this was not highlighted in a specific section of the documentation, the information was included when documentation was considered in toto. When reviewing the records of five individual's most recently prescribed psychotropic medication, there were two records that did not include psychiatric documentation. Of the remaining 14 records where psychiatric documentation was included, there were four examples where improvements in the risk/benefit analysis were necessary. Regarding this set of documents: • Individual #368- per the annual psychiatric assessment dated 3/15/13, "polypharmacy does not exist…taking two medications, Zyprexa and Depakote, for treatment of agitation associated with Autism Spectrum disorder…prior efforts to reduce medications have not been successful…the Interdisciplinary Team is	

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		electing to taper… off on Valproic acid completely with the hope that his treatment with Zyprexa alone can be adequate to maintain adequate affective stability and reduction of impulsiveness associated with his developmental disorder…likely that…will have a reduction of risk with only one medication. It is certainly possible that some of the decreases in red blood cells and platelets may be due to Valproic acid." o This evaluation went on to include nonpharmacological interventions that were varied and in addition to the PBSP. This was an example of an acceptable analysis of risk including descriptions of nonpharmacological interventions. • Individual #574-per the annual psychiatric assessment dated 4/11/13, "effectiveness of treatment seems to be lacking…labile affect and outbursts of physical aggression which may not respond to any psychiatric medications, as he is suffering from true dementia." o This document went on to review specific atypical antipsychotics that could be utilized in the treatment of this individual's symptoms. While the documentation alluded to specific side effects related to antipsychotic medications, it was concerning that issues with the utilization of atypical antipsychotic medications for individuals with dementia diagnoses were not included. The document did note nonpharmacological interventions, including recommendations for preparing this individual for transitions, and improved early recognition of agitation, with plans of intervention. Improvements noted in consent documentation are reviewed below in J14. Even so, 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.	

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		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. Observation of Psychiatric Clinic During the psychiatric clinics observed by the monitoring team, the psychiatrist discussed the medication regimen with the team members present in clinic. This process was also noted in the facility self-assessment, which indicated the need for improvement with regard to capturing these discussions in documentation. 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 during the clinic process. The QDDP, psychologist, psychiatrist, and nursing staff must all contribute to the development of this section. Recommendations include accomplishing this goal together with the IDT currently participating in psychiatry clinic, access to equipment, and typing information received in the clinic setting. Of course, for the initial entry in the documentation, some prep time will be necessary to set up the shell of the document. The monitoring team is available to facilitate further discussion in regards to this recommendation, if requested. The documentation should reflect a thorough process that considers the potential side effects of each psychotropic medication, weighs those side effects against the potential benefits, includes a rationale as to why those benefits could be expected, a reasonable estimate of the probability of success, and also compares the former to likely outcomes and/or risks associated with reasonable alternative strategies. Human Rights Committee Activities A risk-benefit analysis authored by psychiatry, yet developed via collaboration with the IDT, would then provide pertinent information for the Human Rights Committee (i.e., likely outcomes and possible risks of psychotropic medication and reasonable alternative treatments). Monitoring Team's Compliance Rating As noted above, the facility needs to develop a consistent 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.	

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		In order to move toward substantial compliance, it is recommended that over the next six months, the facility focus on: 1. improving 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.	
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 has held monthly polypharmacy committee meetings since that time. Currently, psychiatry clinic staff was responsible for polypharmacy data collection and presentation. In order to alleviate the potential for bias in the review process, it will be necessary for this process to be initiated via pharmacy. Included in the meeting minutes of the monthly polypharmacy committee were eight examples of polypharmacy clinical review. These forms documented the discussion regarding polypharmacy justifications. There was a space for the signature of the psychiatrist under review in order to acknowledge receipt and review of the critique. None of the eight examples included a signature of the psychiatrist. Once this process is firmly established, a mechanism of quality assurance to ensure that specific recommendations were considered and either implemented or if not, addressed in documentation, will be necessary. <u>Review of Polypharmacy Justifications</u> Psychiatric providers were currently justifying polypharmacy in the comprehensive psychiatric assessment and quarterly psychiatric assessment. In response to the document request, polypharmacy justifications were provided for 44 individuals, these justifications were collated from the document referenced above. There were marked improvements in documentation as compared to previous monitoring reviews. For example: • Individual #363- documentation included a detailed review of the medications prescribed for this individual, the rationale for continuing the current regimen, concerns regarding medication interactions, and reviewed the physician's thought processes with regard to future medication management planning. In contrast to previous monitoring reviews, it was noted that the majority of polypharmacy justifications reviewed included information as described in the example above. There were rare exceptions, however, the overall improvement in the quality of the documentation was remarkable.	Noncompliance

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		It was discussed at length during the previous 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> Documentation presented during the polypharmacy oversight committee meeting 7/9/13 was reviewed. Psychiatry clinic staff compiled these data with a focus on regimens meeting criteria for polypharmacy only. There was no tracking or trending with regard to the use of antipsychotic medication or other medication classes. Per the data presented, an average of 24% of the individuals participating in psychiatry clinic met criteria for polypharmacy. These cases were generally evenly divided across providers with the psychiatric physician's assistant having the least number of individuals with regimens inclusive of polypharmacy on his caseload. Polypharmacy regimens were distributed evenly among male and female individuals, and there were more individuals meeting criteria for polypharmacy in the age range of 46-65 years. In addition, polypharmacy was broken down by unit, and it was notable that 42% of the individuals meeting criteria for polypharmacy were residing in Castle Pines. This is valuable information and should be objectively reviewed to determine if there are issues in that particular unit resulting in increased use of medication. The data revealed a total of 13 individuals meeting criteria for intraclass polypharmacy. Of these, nine were prescribed two antipsychotic medications. The remaining four individuals were prescribed two antidepressants (n=3) or two mood stabilizers (n=1). There were 26 individuals prescribed three psychotropic medications, 14 individuals prescribed four psychotropic medications, and one individual prescribed five psychotropic medications. The data included a listing of pending polypharmacy discontinuations as well as individuals recently added to the list as meeting criteria for polypharmacy. It was not possible to observe interactions between the psychiatric clinicians and the clinical pharmacist as the clinical pharmacy position was vacant at the time of this monitoring visit. <u>Monitoring Team's Compliance Rating</u> Psychiatry clinic staff have done a laudable job of authoring polypharmacy justifications, and initiating the facility level polypharmacy meetings in the absence of a clinical	

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		pharmacist. Given the ongoing challenges noted above, this provision was rated in noncompliance, which was the same self-rating by the facility in the self-assessment. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. It will be necessary for the responsibility for the generation of polypharmacy data and the initiation of the review of polypharmacy regimens to reside in the pharmacy department. 2. Documentation of the review of polypharmacy justifications should be signed by the psychiatrist under review, and a feedback or quality improvement mechanism, perhaps associated with the QDRRs should be developed in order to ensure that recommendations generated during the facility level review are considered and if not implemented, that documentation outlining the rationale for not implementing is clear.	
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 tracking information regarding the revealed timely completion of both evaluations for via a spreadsheet outlining completion of the assessments for the months of January 2013 through May 2013. In previous monitoring reviews, this document had included actual dates of completion of the assessment. Current data only indicated if the assessment was delinquent, completed, not due, or not applicable. A review of these data revealed few delinquent notations. Where delinquencies were noted, it was not possible to determine when or if the assessment was completed. Review of 14 records and 10 examples of MOSES and DISCUS documentation provided revealed timely completion of the assessments (note, one record provided was for a new admission, and MOSES and DISCUS assessments had not yet been performed). 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 Nurse 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 provided for the previous monitoring review revealed that a one hour and 15 minute 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	Substantial Compliance

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		a 15-minute block of training regarding MOSES and DISCUS included in nursing annual inservice training. The information provided included sign-in sheets for one nurse who attended new employee orientation in November 2012. Additional training documentation was not provided for review. Review of the facility self-assessment did not reveal information regarding training for nursing staff with respect to MOSES and DISCUS assessments. <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 (10 examples of each assessment tool), all were completed appropriately and included the signature of the psychiatrist. In addition, nine included subsequent quarterly psychiatric clinical documentation. For example: • Individual #441-the psychiatric quarterly review noted, "on 1/24/13 and 10/18/12 his DISCUS scores were 2. This is primarily due to some tremors of the upper extremities. MOSES score 1/24/13 was 8 and on 7/16/12 it was 8. These scores reflect problems with urinary incontinence and some drooling which I believe is medication induced." • Individual #594- the psychiatric quarterly review noted, "DISCUS was performed…4/19/13…a score of 2, based on minimal toe tapping and toe movement…not believed that this represents tardive dyskinesia…a MOSES assessment…total score was 8, based upon minimal agitation, drowsiness, irritability, withdrawal, slurred speech, blurry vision, headache, and restlessness. These symptoms do not necessarily represent side effects of his current medications although some akathisia may be indicated by his restlessness." 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	

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		clinic, this area will remain in substantial compliance. It was noted that there was increased attention to completion of the clinical correlation/evaluation section of the instruments, and/or documentation of the clinical correlation in psychiatric progress notes. For the facility to maintain this rating, there must be improvements with regard to documentation of nursing training regarding MOSES and DISCUS administration. In addition, the facility should consider a return to entering the dates of completion of the instrument into the tracking data for easier data review.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	<u>Policy and Procedure</u> Per a review of the DADS statewide policy and procedure "Psychiatry Services," dated 8/20/11, "state centers must insure that individuals receive needed integrated clinical services, including psychiatry." In section 7.b., the policy directly quoted the language in this provision. The facility had implemented facility specific policy and procedure entitled "Psychiatry Services Procedure Manual." This manual had been updated as of 5/23/13. The manual outlined the requirements for psychiatric practice consistent with statewide policy and procedure, and had been updated in order to outline procedures necessary to accomplish specific tasks. <u>Treatment Plan for the Psychotropic Medication</u> Per record reviews for 16 individuals, much of the information required to meet the requirements of this provision item were included in the psychiatric evaluation and the quarterly psychiatric review. Psychiatry clinic staff had developed a prompt sheet for psychiatric providers to utilize when documenting resulting in better documentation and inclusion of necessary items. For example, in the record of Individual #319, the quarterly psychiatric assessment treatment plan dated 3/26/13 reviewed, in depth, this individual's target behaviors and symptoms. The comprehensive annual assessment dated 9/11/12 outlined this individual's psychiatric diagnosis, justifying the diagnosis via a review of the current symptomatology. The comprehensive annual assessment reviewed the risk/benefit of the current psychopharmacological regimen, and outlined the specific target symptoms that would be monitored. In the record of Individual #59, there was excellent documentation regarding this individual's target behaviors and symptoms included in the quarterly psychiatric assessment treatment plan dated 3/4/13. This document also included the rationale for the prescription of Zyprexa, as well as potential side effects and benefits that may be expected. Nonpharmacological interventions were included. Other required elements (the expected timeline for the therapeutic effects of the medication	Noncompliance

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		to occur, the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur) were not consistently located in the documentation. Given the need for inclusion of these items in order for the facility to reach substantial compliance, the inclusion of these items as prompts on forms the physicians routinely utilize may improve documentation. Overall, while documentation was improved over prior reviews, there was variability in the documentation between providers. This was an area where ongoing quality assurance or peer review may be helpful. <u>Psychiatric Participation in ISP Meetings</u> At the time of the onsite review, there was marked improvement in psychiatric attendance at ISP meetings. There was documentation of psychiatric attendance at 71 of a potential 77 ISP meetings (92%). Given that the facility did not have a full time psychiatrist on staff, and relied on contracted, part time psychiatric providers (including one physicians assistant), this level of attendance was commendable. Per interviews with facility staff, the ISP meeting schedule had been adjusted with specific time/day reserved for ISP meetings allowing for psychiatric providers to incorporate these meetings in to their schedule on a routine basis. In an effort to utilize staff resources most effectively, the facility could consider incorporating IDT meetings into the psychiatry clinic process. Given the interdisciplinary model utilized during psychiatry clinic, the integration of the IDT into psychiatry clinic may allow for improvements in overall team cohesion, information sharing, collaborative case conceptualization and management. <u>Psychiatry Clinic</u> The psychiatrists did have contact with IDT members during psychiatry clinic. During this monitoring review, four clinic observations were conducted. These clinical observations were improved over previous monitoring visits 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 treating psychiatrists were noted to encourage staff members to participate and ask for feedback and information, fostering IDT interaction. 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.	

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		During clinic, the psychiatrists reviewed behavioral data. In general, the data were graphed, and up to date. There were improvements in the data graphs as some included timelines for medication dosage changes or stressful life events. It was noted that psychology staff needed to review data presentation to ensure that it was clear. For example, data reviewed were generally graphed by the month via taking an average of incidents over that period and using the average as the data point. For individuals who were experiencing a spike in behavioral incidents over a period, it would be better to graph that data daily with the inclusion of timelines for specific occurrences over the course of the month. In addition, now that data presentation was improved, psychology staff must begin to analyze the data presented including an interpretation of the data. 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. A review of the tracking data regarding timeliness of quarterly psychiatric assessments revealed that in general, individuals were both scheduled and seen by psychiatry within appropriate timeframes. There were three individuals who were far overdue for psychiatry clinic, Individual #428 was last seen in clinic in November 2012. Per the document, this individual was not prescribed psychotropic medications. Individual #175 was last seen in clinic December 2012. Per the document, this individual was prescribed antipsychotic medication. Finally, Individual #176 was last seen in psychiatry clinic February 2013. This individual was prescribed multiple psychotropic medications including Clozapine, Lithium, and Lorazepam. Given the total number of individuals participating in psychiatry clinic (n=193), only 1.5% of the clinic population was overdue for a clinical encounter. <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	

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		for psychotropic medication that not only identifies a clinically justifiable diagnosis and the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy but also includes the expected timeline for the therapeutic effects of the medication to occur. Given the deficiencies noted via this document review that were consistently documented in the facility self-assessment, this provision will remain in noncompliance, in agreement with the facility self-assessment. In order to approach substantial compliance, it is recommended that during the next six months, the facility focus on: 1. Further improving psychiatric documentation to include a timeline for the therapeutic effects of medications to occur. 2. 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), and include the psychologist's analysis or interpretation of the data. Individuals must be reviewed in psychiatry clinic on a quarterly basis.	
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.	<u>Policy and Procedure</u> Per DADS revised policy and procedure "Psychiatry Services," dated 8/30/11, "State Centers must provide education about medications when appropriate to individuals, their families, and LAR according to accepted guidelines…State Centers must obtain informed consent (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures." In the facility-specific policy "Psychiatry Services Procedure Manual," dated 5/23/13, "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 had generated a procedure for psychiatrists entitled, "Steps for completing a new medication consent" that outlined the minimum documentation requirements for medication consent. One issue noted in the previous monitoring report regarding documentation of the discussion with the individual's LAR was addressed via the procedure, where it was noted that "documentation of the psychiatrist's discussion with the guardian to be included in the comments section" of the consent form. The "Consent/Authorization for Treatment with Psychotropic Medication" form included	Substantial Compliance

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		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. Specifically, 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, documentation of this process in the event of a new medication consent was not routinely noted in the records reviewed. With regard to the annual medication consent process, six of ten records reviewed revealed medication consent documentation inclusive of medication information sheets that were sent to the individual's LAR. <u>Current Practices</u> Per interviews with facility staff, including the facility psychiatrists and the psychiatric nurse, as well as review of facility medical records, psychiatric physicians were involved in the informed consent process. In addition to informed consent activities for newly prescribed medications, facility psychiatrists had engaged in obtaining informed consent for annual medication renewals. The manner in which the data 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 ten records revealed six records included documentation regarding annual medication consent. 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. All of the examples regarding new medication prescriptions included an attached signed ISP addendum document regarding review of the proposed medication, with eight of these including documentation of psychiatric attendance at the IDT. There were improvements in quality with regard to the completeness of information provided on the form. One specific weakness noted in the previous monitoring report was the documentation of alternatives to medication treatment and the rationale for not implementing these at the time medication was recommended. The consent for treatment with psychotropic medication form completed by psychiatry had been revised to include a section entitled, "document any non-pharmacological alternatives that exist and rationale for not implementing them at this time." Given this revision, documentation in this area was improved. For example: • Individual #301- "multiple behavioral and pharmacologic interventions have had	

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		limited success." Per the attached psychiatric progress note, "goes to work and school and does fairly well there…affectively labile at times…has gained weight, developed hypertension and may be in metabolic syndrome…IDT recommended…cross tapering with a different atypical…being assessed for counseling." Per the attached ISPA document, "when…engaging in SIB and PA staff should follow the preventive measures and interventions in his PSBP to help redirect…from environments and situations that tend to increased these behaviors." • Individual #220- "has done well in past on Zyprexa…only psych med he was on. Degree of behavioral problems and autism mandate medication in addition to behavioral interventions." Per the ISPA attached, this individual was admitted to the facility on an emergency basis, and at that time, the prescribed medication regimen met the definition for polypharmacy. "Ultimately the goal is to taper from numerous, less efficacious medications to only medications with demonstrated efficacy for his symptoms and behaviors." 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 routinely included in the psychiatric annual evaluations or progress notes. Some of the facility psychiatric providers included this information routinely; however, this was not noted in the case of all providers. 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 appropriate practice. The facility now had policy and procedure in place with regard to medication consent, and psychiatry staff were actively following the requirements. A facility review of the quality of the documentation was performed via the facility self-assessment. Per the documentation, 24% of the new medication starts (a total of five records) were reviewed. For future self-assessments, it is recommended that the facility also include a review of annual medication consents. Given the improvements noted above as well as the initiation of a quality review of the documentation, a substantial compliance rating is appropriate. This rating is in disagreement with the facility self-assessment where a noncompliance rating was assigned.	

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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.	<u>Policy and Procedure</u> Per DADS policy, Psychiatry Services dated 8/30/11, "the neurologist and psychiatrist must coordinate the use of medications, through the IDT process, when the medications are prescribed to treat both seizures and a mental health disorder." Facility policy and procedure dated 5/23/13 requires that "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… the psychiatrist will initiate communication with the neurologist by documenting on the 'Psychiatry/Neurology' Consultation form as well as writing an order for the individual to be scheduled for neurology clinic on campus…psychiatrist and neurologist will collaborate in a face to face manner when both disciplines are present at the facility…when both disciplines are not present within the facility simultaneously, telephone consultation with [sic] occur in lieu of a face to face manner…consultation will be documented in the IPN or the Psychiatry/Neurology Consultation form." This was an improvement over previous policy and procedure, as now the process by which psychiatry/neurology consultation should occur was outlined. <u>Individuals with Seizure Disorder Enrolled in Psychiatry Clinic</u> There were 75 individuals participating in psychiatry clinic who had a diagnosis of seizure disorder. This was an increase over the previous monitoring period where it was reported that there were 45 (note, the accuracy of these data were questioned in the previous monitoring report) individuals participating in psychiatry clinic who had a diagnosis of seizure disorder. Of the 15 records available for review, three had a diagnosis of seizure disorder. A review of these records revealed: • Individual #143 – This individual was admitted to the facility 5/6/13. At the time of admission, a history of diagnoses including "Bipolar Disorder, ADHD, ODD, and seizures" was documented. Medications prescribed included methylphenidate, olanzapine, clonidine, and divalproex. Per the medication administration record, divalproex was prescribed for seizure disorder. At the time of the monitoring visit, approximately two months following this individual's admission to the facility, a neurology consultation had not yet been performed. o This was concerning as medication such as methylphenidate and olanzapine can reduce the seizure threshold increasing the likelihood of seizure activity. In addition, this individual had laboratory examinations performed 5/11/13 revealing a valproic acid level of 65.1 (50-100), indicating this individual's Valproic acid level was in the low normal range. • Individual #220 – This individual was admitted to the facility 3/12/13 and seen in the neurology clinic on campus 3/27/13. Neurology clinic documentation revealed, "referred…for seizure disorder…has been on…Depakote…Keppra was	Noncompliance

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		started…since the Keppra was started…he has had increased behavioral issues…recommend weaning him off of his Keppra." Other information included in the documentation revealed that this individual was seen in neurology clinic with a "caretaker" who provided much of the historical information to the physician. There was no documentation that any psychiatry staff was in attendance at this clinic. An annual psychiatric assessment dated 3/27/13 did not include a seizure disorder as a potential diagnosis. In addition, there was no documentation regarding concerns of increased behavioral challenges in the presence of Keppra noted in this document. Per a review of the integrated progress notes, a primary care physician (indicated by the letters MD) with regard to discipline instituted a taper of Keppra. There was no psychiatry documentation regarding this event. Subsequent psychiatric documentation dated 4/10/13 revealed that psychiatry staff was in attendance at the ISP regarding this individual. o There was no notation of the neurology consultation, rather it was noted that a taper of Buspar would commence with a concomitant increase in the dosage of olanzapine. This case example was illustrative of poor interdisciplinary communication resulting in multiple medication adjustments occurring contemporaneously. <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, and during this period approximately 12 individuals were seen. It was reported that individuals could also travel to the consulting neurologist's office "if need be." During this monitoring visit, the neurology clinic was observed. It was noted that the psychiatric nurse was present in clinic, and when consultative documentation had been submitted by psychiatry, the psychiatric nurse contacted the consulting psychiatrist via telephone and initiated clinical contact between the psychiatrist and neurologist. This process was relatively new and the sustainability of the use of the psychiatric nurse as a clinical conduit between the physician's will need to be determined. 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 75 individuals, 22 had not had neurology follow-up in the past year. Of these, 19 were last seen in July 2012. Of these, three were seen at the July 2013 neurology clinic observed during this monitoring visit. Therefore, a total of 19 individuals had not been seen by neurology in a minimum of one year. Of these, one individual was last seen in 2001, another was last seen in 2001, and a third individual was last seen in 2011. There were three individuals were it was	

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		documented "no data," and these individuals were not included in the total of 22. Given these data, the need for increased neurological clinical consultation was apparent, as 25% of the individuals treated in psychiatry clinic with a concomitant seizure disorder diagnosis had no documented evaluation by neurology in the previous 12 months (this calculation does not include those individual's where no data were available). 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> While there were gains noted with regard to policy and procedure outlining the process for psychiatry/neurology consultation, ongoing issues noted above including deficiencies in collaboration between disciplines and delays in neurology follow-up possibly related to a lack of neurology resources resulted in a noncompliance rating for this provision. This was in agreement with the compliance rating assigned via the facility self-assessment. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. ensuring that all individuals participating in psychiatry clinic who require neurological consultation are evaluated by the neurologist in a timely manner 2. ensure the adequacy of neurology resources 3. improve the collaborative consultation and documentation thereof between psychiatry and neurology providers in a manner that will be sustainable.	

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 #45 (3/1/13), Individual #151 (4/10/13), Individual #285 (3/21/13), Individual #138 (2/7/13), Individual #332 (2/26/13), Individual #129 (12/21/12), Individual #124 (1/8/13), Individual #248 (2/5/13), Individual #582 (3/6/13), Individual #592 (3/15/13), Individual #500 (3/19/13), Individual #20 (2/28/13), Individual #301 (3/1/13), 304 (2/22/13), Individual #249 (2/3/13), Individual #294 (4/19/13) o Positive Behavior Support Plans for: • Individual #45 (8/9/12), Individual #151 (4/17/13), Individual #285 (5/1/13), Individual #138 (3/14/13), Individual #332(2/26/13), Individual #129 (12/31/12), Individual #124 (1/8/13), Individual #248 (2/5/13), Individual #582 (3/5/13), Individual #592 (5/8/13), Individual #500 (4/2/13), Individual #20 (4/3/13), Individual #301 (4/1/13), Individual #304 (2/22/13), Individual #249 (2/14/13), Individual #294 (6/15/13) o Six months of notes on PBSPs progress for: • Individual #45, Individual #151, Individual #285, Individual #138, Individual #332, Individual #129, Individual #124, Individual #304, Individual #249, Individual #294 o Full Psychological Assessments for: • Individual #45 (11/29/12), Individual #151 (4/10/13), Individual #285 (3/21/13), Individual #138 (2/7/13), Individual #332 (2/26/13), Individual #129 (12/21/12), Individual #124 (1/8/13), Individual #248 (2/5/13), Individual #582 (3/6/13), Individual #592 (3/15/13), Individual #500 (3/19/13), Individual, Individual #301 (3/1/13), Individual #20 (2/28/13), Individual #304 (2/22/13), Individual #249 (2/3/13), Individual #294 (4/19/13) o Annual Psychological updates for: • Individual #45 (8/1/12), Individual #129 (1/30/13), Individual #332 (3/20/13), Individual #151 (2/21/13), Individual #424 (5/23/13), Individual #124 (11/16/12), Individual #285 (6/20/13), Individual #294 (4/22/13), Individual #138 (2/6/13), Individual #249 (2/11/13), Individual #539 (5/14/13) o Counseling Assessment and Treatment Plans and progress notes for: • Individual #466, Individual #424, Individual #130, Individual #110, Individual #279 o Psychological & Behavioral Health Services, policy revised 5/21/13 o A list of all individuals at the facility, undated o Counseling Assessment and Treatment Planning Procedures, revised 5/21/13 o Psychology Section K Update of Progress book, undated

	o Section K presentation book, untitled o Section K Self-Assessment, 6/27/13 o Section K action plans, 6/26/13 o Peer review minutes for the past six months o Psychology department meeting minutes for the past six months o A list of all individuals receiving counseling, undated o List of all psychology staff and status of enrollment in BCBA coursework, undated o Spreadsheet of individuals most recent psychological assessment, undated o A list of all individuals with a functional assessment including date of last plan revision/review o Data collection reliability data, IOA, and treatment integrity data for Oak Hill Unit, August 2012-February 2013 o Annual psychological staffing summaries, 7/12-6/13 o Dental/Medical Desensitization meeting agenda, July 10, 2013, <u>Interviews and Meetings Held</u>: o Sylvia Middlebrook, Ph.D., BCBA, Director of Psychology o Robin McKnight, M.A., BCBA; Behavior Analyst o Sylvia Middlebrook, Ph.D., BCBA, Director of Psychology; Martha Thomas, M.S., Associate Psychologist V; Robin McKnight, M.A., BCBA; Behavior Analyst; Mike Fowler, M.A., Associate Psychologist V; Kari Staley, M.A., BCBA; Associate Psychologist V; Edward Hutchison, M.S., BCBA consultant o Kenneth Elerson, M.A., Associate Psychologist o Adam Williams, M.Ed., Associate Psychologist o Traci Swain, M.A., Associate Psychologist o Marvin Stewart, Ombudsman o The department of psychology <u>Observations Conducted</u>: o Psychiatric Review Meeting • Individuals presented: Individual #249 o Psychiatric Review Meeting • Individuals presented: Individual #507 o Restraint Reduction Meeting o Peer Review Meeting • Individuals presented: Individual #465, Individual #594 o Treatment Integrity collection • Staff observed: Kenneth Elerson, M.A., Associate Psychologist o PBSP Staff Trainings • For Individual #301 o Observations occurred in various day programs and residences at LSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals.

	Facility Self-Assessment: Overall, the self-assessment included relevant activities in the "activities engaged in" sections. The self-assessment appeared based directly on the monitoring team's report. LSSLC's self-assessment included a review for each provision item, a list of the activities engaged in by the monitoring team, and the topics that the monitoring team commented upon both positively and negatively. 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, K3, K5, K6, and K7. The monitoring team's review of this provision, as detailed in this report, found K2, K3, K5, K6, K7, and K11 to be in substantial compliance and noncompliance for all other provision items. The reasons for this discrepancy for K11 are discussed below. 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 staff 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: LSSLC made many improvements since the last onsite review. These improvements resulted in substantial compliance in four new items (K5, K6, K7 and K11). Additionally, the facility maintained substantial compliance on the two items (K2 and K3) that were in substantial compliance prior to this review. A summary of these improvements are listed below and described in detail in the following report: • Increase in the percentage of psychologists who are board certified behavior analysts (BCBAs), competed coursework for the BCBA, and/or are enrolled in coursework toward attaining certification (K1) • Expansion of data collection reliability and inter-observer agreement (IOA) data to all PBSPs (K4 and K10) • Improvements in the number and comprehensiveness of full psychological assessments (K5) • Improvements in the timeliness and quality of functional assessments (K5) • Increase in the number of full psychological assessments that are current (K6) • Improvements in the comprehensiveness of the annual psychological assessments (K7) • Improvements in the provision of counseling services (K8)

	• Improvements in the timeliness and quality of PBSPs (K9) • Expansion of the collection of treatment integrity data (K10) • Improvement in DCPs reports that they understood PBSPs (K11) The areas that the monitoring team suggests that LSSLC work on for the next onsite review are: • Ensure that the data system is flexible enough to incorporate the most appropriate measure of an individual's target and replacement/alternative behaviors (K4) • Demonstrate that minimal frequencies and levels of data collection reliability and IOA are achieved (K4, K10) • Ensure that current data are consistently available and graphed at interdisciplinary meetings to ensure that data based decisions are made (K4) • Ensure that when an individual is not making expecting progress, the progress note consistently indicates that some activity (e.g., retraining of staff, modification of PBSP) had occurred (K4) • Expand and develop counseling services (K8) • Ensure that PBSPs are consistently implemented within 14 days of receiving consent (K9) • Expand the collection of treatment integrity to all PBSPs (K10) • Ensure that all psychologists are using the same methodology to collect and calculate treatment integrity (K10) • Demonstrate that minimal established frequencies and levels of treatment integrity are achieved (K10) • Ensure that every staff assigned to work with an individual, including float/relief staff, has been trained in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter (K12)

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs 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	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 board certified behavior analysts (BCBAs). The facility continued to make progress on this provision item. Fourteen of the 15 associate psychologists who wrote PBSPs (93%) either had their BCBA, or were enrolled, or completed coursework toward attaining a BCBA. The one psychologist that was not enrolled or completed coursework toward receiving her BCBA was recently hired and committed to begin coursework in the fall. This is an improvement from the last review when 80% of the facility's psychologists that wrote PBSPs were enrolled in or completed BCBA coursework. The facility maintained three BCBAs that wrote PBSPs. Supervision of psychologists enrolled in the BCBA program was performed by a consulting BCBA from the community.	Noncompliance

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	reasonable safety, security, and freedom from undue use of restraint.	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, it is recommended that LSSLC ensure that all psychologists who write PBSPs attain BCBA certification.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The facility continued to be in substantial compliance with this item. The director of psychology had a Ph.D., was a licensed psychologist in Texas, 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 provision K.	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. In addition to the review of PBSPs requiring annual approval (i.e., Behavior Support Committee meeting), the internal peer review meetings provided an opportunity for psychologists to present new cases or those that were not progressing as expected. Additionally, LSSLC recently established a procedure for an individual's interdisciplinary team to refer individuals to the psychology department's peer review. The internal peer review meeting observed by the monitoring team reviewed Individual #465's and Individual #594's PBSPs. The peer review meeting included active participation from the majority of the department's psychologists, and appeared to result in a clearer understanding of the environmental and biological variables of these individuals' 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 from December 2012 to May 2013 indicated that internal peer review meetings occurred weekly, and that once a month, these meetings included a participant from outside the facility, therefore, achieving the requirement of monthly external peer review meetings. Finally, there was evidence of the implementation of recommendations made in peer review (e.g., Individual #285). Operating procedures for both internal and external peer review committees were established, and were consistent with this provision item. In order to maintain substantial compliance, LSSLC needs to provide documentation that internal peer review	Substantial Compliance

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		consistently occurred weekly, external peer review consistently occurred at least monthly, and evidence of follow-up/implementation of recommendations made in peer review.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	The monitoring team noted improvements in this area. More work, discussed in detail below, is necessary before this provision item can be judged to be in substantial compliance. At the time of the onsite review, LSSLC utilized multiple data systems. In the Woodland Crossing and Lone Pine units, the direct care professionals (DCPs) were required to record the frequency of target and replacement behaviors in one-hour intervals. In the Castle Pines unit, target and replacement behaviors were recorded in two-hour intervals. Finally, the data system in the Oak Hill unit utilized a time sampling procedure that 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., longer intervals for very low frequency behaviors, time sampling for very high frequency behaviors) can improve the practicality and usefulness of a data system. Arbitrarily reducing the number of measurement intervals of target and replacement behaviors, however, could result in the loss of critical information. It is recommended that LSSLC's data system be based on individual need and be flexible enough to incorporate the most appropriate measure of an individual's target and replacement/alternative behaviors. In each of these data systems, DCPs 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 target and replacement behaviors sampled for 9 of 16 data sheets reviewed (56%) were completed up to the two previous recording intervals. This represented a decrease from the last review when 83% of the data sheets were recorded up to two previous intervals. Since the last review, LSSLC had established that every PBSP would have data collection reliability at least quarterly, and they established their goal level to be 80%. LSSLC's self-report indicated that data collection reliability was at 85%. It is not entirely clear why the facility's and the monitoring team's data collection reliability scores were	Noncompliance

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		so discrepant. The monitoring team reviewed the data collection reliability procedures with several associate psychologists and the methodology they reported appeared to be the same as that used by the monitoring team. One possible reason for the discrepancy was the sampling procedures. The facility's self-assessment sampled six data sheets. It was not clear from the self-assessment if those samples represented multiple residences or if they occurred in primarily one or two residences. The monitoring team noted consistently current data in some homes (e.g., 557A), and data consistently not completed for more than two previous intervals in others (e.g., 561A). It is recommended that the facility's self-assessment data sample each residence, and that LSSLC develop a tracking system so that it can document that data collection reliability is collected for each PBSP quarterly, and that the average level is at least 80%. While data collection reliability assesses whether data are recorded in a timely fashion, inter-observer agreement (IOA) assesses if multiple people agree that a target or replacement behavior occurred. At the time of the onsite review, the facility had recently expanded the collection of IOA data across the entire facility. Ten of the 16 PBSPs reviewed (62%) contained a description of IOA data. This was identical to the last review when 62% of PBSPs reviewed contained IOA data. The self-assessment indicated that IOA was collected in each unit and that it averaged 86%. Since the last review the facility had established that IOA will be collected on every PBSP at least quarterly, and that the average level of IOA will be at least 80%. At this point, it is recommended that the facility establish a tracking system to ensure that IOA is collected for each PBSP at least quarterly, and that the average level is at least 80%. As indicated in the last report, all the graphs of target and replacement behaviors reviewed by the 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. Additionally, as recommended in the last report, the facility increased the graphing of replacement/alternative behaviors. Replacement/alternative behaviors were graphed in all PBSPs reviewed (100%). This represented an improvement from the last review when 77% of the PBSPs reviewed had graphed replacement behaviors. The routine use of data to make treatment decisions was mixed. In psychiatric clinic for Individual #507, observed by the monitoring team, the psychologist presented graphs that were current, clearly indicated when important environmental events occurred, and were simple to understand. They showed that Individual #507's target behaviors remained at a low frequency. The clear and current graphs contributed to a very productive discussion by Individual #507's team, and to data based decisions concerning her use of medications. In another psychiatric clinic observed (i.e., for Individual #249) simplified graphs of target and replacement behaviors were presented and discussed, however, the graph did not include the last five weeks of data, and did not indicate when	

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		important environmental events occurred (e.g., medication changes). In order to achieve substantial compliance with this provision item, LSSLC needs to ensure that all treatment decisions are data based. Specifically, the facility needs to demonstrate the value of data by ensuring it is current and reliable, and consistently graphing and presenting data in increments that encourage data based treatment decisions. In reviewing six months of PBSP data and progress notes for nine individuals (Individual #129's progress notes included only one month of data on the current target behavior), three (33%) indicated a lack of progress in at least one severe target behavior. This represented another consistent improvement from the last two reviews when 58% and 40% of PBSPs reviewed indicated a lack of progress. As discussed in the last review, the monitoring found examples of action taken to address the lack of progress in two (Individual #151 and Individual #124) progress notes. Individual #138's progress note, on the other hand, indicated a steady increase in psychotic symptoms from January 2013 through March 2013, but no action (e.g., retraining of staff, modification of PBSP, etc.) had been documented in his progress note. It is recommended that in those instances when an individual is not making expecting progress, that the progress note or PBSP consistently indicate that some activity 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. Over the next six months, it is recommended that the facility ensure that the data system is based on individual need, and is flexible enough to incorporate the most appropriate measure of individual target and replacement/alternative behaviors. Additionally, LSSLC needs to have documentation that data collection reliability and interobserver agreement (IOA) have been collected at least quarterly for each individual with a PBSP, and that IOA and overall data collection reliability levels of at least 80% have been achieved. LSSLC also needs to ensure that all treatment decisions are data based. Finally, the facility 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.	
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,	Since the last review, LSSLC increased the percentage of individuals with full psychological assessments to 97% of individuals, and increased the percentage of individuals with current (i.e., reviewed/revised at least every 12 months) functional assessments to 97%. Additionally, the full psychological assessments and functional assessments reviewed consistently were complete and clear. Therefore, this item is now rated as being in substantial compliance.	Substantial Compliance

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	and of other psychological needs that may require intervention.	Psychological Assessments A spreadsheet of full psychological assessments indicated that 340 of the 352 (97%) individuals at LSSLC at the time the spreadsheet was completed had a full psychological assessment. This represented a dramatic improvement from the last review when 68% of individuals had a full psychological assessment. The spreadsheet indicated that 61 full psychological assessments were completed in the last six months, and 16 of those (26%) were reviewed to evaluate their comprehensiveness. As found in the last two reviews, 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. Functional Assessments A spreadsheet provided to the monitoring team indicated that 193 of the 352 individuals at LSSLC at the time the spreadsheet was completed had a functional assessment. One hundred and eighty-nine of those functional assessments (98%) were current (i.e., revised/reviewed within one year). This represented an improvement over the last review when 85% of the functional assessments were current. Additionally, there was evidence that some functional assessments at LSSLC were reviewed and modified before 12 months when an individual did not meet treatment expectations (e.g., Individual #304). Finally, the monitoring team sample, and reports from facility staff, indicated that all individuals with a PBSP had a functional assessment. The spreadsheet indicated that 97 functional assessments were completed in the last six months. Sixteen of these functional assessments (16%) 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. Fourteen of the 16 functional assessments reviewed (88%) were judged to contain adequate direct assessment procedures. This was similar to the last review when 85% of direct observation procedures were judged	

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		to be acceptable. An example of a complete direct assessment procedure is: • Individual #45's functional assessment included a description of a direct observation of how the withdrawal of staff attention, was related to an increase in her aggressive behavior, suggesting that staff attention was maintaining her target behavior. In one of the direct assessment procedures rated as unacceptable (i.e., Individual #138) a direct observation was conducted, but it 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. In the other functional assessment (i.e., Individual #129) rated as unacceptable, no direct assessment of the individual was discussed. 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. All 16 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. Overall, 14 of the 16 functional assessments reviewed (88%) were evaluated to be comprehensive and clear (Individual #138 and Individual #129 were the exceptions). This is consistent with the last review when 85% of the functional assessments reviewed were evaluated as acceptable. LSSLC staff are to be commended for their efforts to achieve substantial compliance on this provision item. In order to maintain substantial compliance with this provision item LSSLC needs to ensure that at least 90% of individuals have a full psychological assessment, and that at least 85% of those reviewed need to be judged as complete. Additionally, the facility needs to ensure that at least 90% of the functional assessments are current (reviewed/revised at least every 12 months), and that at least 85% of the functional assessments are judged to be complete.	

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K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	Another notable improvement from the last review was an increase in the percentage of full psychological assessments that were current. This provision item is now rated as being in substantial compliance. A spreadsheet of the dates of all psychological assessments (including intellectual and adaptive assessments) at LSSLC indicated that 307 of the 340 (90%) full assessments (see K5) were completed in the last five years. This represented a sharp increase in the percentage of individuals at LSSLC with current psychological assessment reported in the last two reviews (30%, 77%). In order to maintain substantial compliance with this provision item the facility needs to ensure that at least 90% of all full psychological assessments are current.	Substantial Compliance
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.	This provision is now rated as in substantial compliance due to significant improvements in the comprehensiveness of the annual psychological assessments. In addition to the full psychological assessment, LSSLC completed annual psychological updates. As found in the last review, annual psychological updates were completed for all individuals at LSSLC that had been at the facility for at least one year. A spreadsheet indicated that 97 annual psychological assessments were completed in the last six months, and 11 (11%) of these were reviewed by monitoring team to assess their comprehensiveness. Ten of those annual psychological assessments (91%) 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 annual assessment (i.e., Individual #539) was missing a standardized assessment of intellectual ability. This represented an improvement from the last two reviews when 36% and 70% of the annual assessments reviewed were rated as comprehensive. Psychological assessments should be conducted within 30 days for newly admitted individuals. A review of recent admissions to the facility indicated that all individuals admitted to the facility in the last six months had psychological assessments within 30 days of admission. In order to maintain compliance with this item of the Settlement Agreement, at least 90% of the individuals at the facility will need to have an annual psychological update, and at least 85% of those assessments will need to be judged as complete (i.e., 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). Additionally, at least 85% of individuals admitted to the facility in the last six months will need to have	Substantial Compliance

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		a psychological assessment completed with 30 days of admission.	
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.	There were improvements in the provision of psychological services, other than PBSPs, at LSSLC. This item was rated as being in noncompliance, however, because at the time of the onsite review it was not clear that all individuals who would benefit from these services were receiving them, that services reflected evidence-based practices, and progress was not consistently documented. Since the last review, LSSLC implemented a counseling policy that was consistent with the requirements of this provision item. Additionally, the facility initiated a referral process that provided a mechanism for teams to refer individuals that they believed would benefit from counseling. As discussed in the last review, LSSLC had 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 five individuals. This represented an increase from the last review when only one individual was seen for counseling. The facility, however, indicated that additional individuals would likely benefit from these services. The monitoring team reviewed all five treatment plans, and they were all found to be goal directed, with measurable objectives and specific treatment expectations. They also included a fail criterion and a plan for the generalization of acquired skills. At the time of the onsite review, only one associate psychologist provided counseling services. He appeared to be qualified to do so through specialized training. The treatment plan reviewed, however, did not indicate that they were derived from evidence-based practices, and there were no progress notes for two of the five plans reviewed (40%). In order to achieve substantial compliance with this provision item, the facility now needs to document the need for these services, and that individuals that would benefit from these services receive it. Additionally, LSSLC should ensure that documentation and review of progress is included with each treatment plan. Finally, it is recommended that the facility 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.	Although there were dramatic improvements in the overall quality and timeless of PBSPs at LSSLC, this item was rated as being in noncompliance because PBSPs were not documented to be consistently implemented within 14 days of receiving consent. A list of individuals with PBSPs indicated that 193 individuals at LSSLC had PBSPs and 190 of these (98%) were current (i.e., reviewed/revised at least every 12 months). This represented an improvement from the last review when 85% of PBSPs were current. As reported in the last review, all PBSPs had the necessary consent and approvals. There was, however, no documentation that PBSPs were implemented within 14 days of receiving consent. The director of psychology indicated that implementation of PBSPs within 14 days of receiving consent was inconsistent. LSSLC should ensure that PBSPs are implemented within 14 days of receiving necessary approvals and consents. Ninety-six PBSPs were completed since the last review, and 16 (17%) of these were reviewed to evaluate compliance with this provision item. All PBSPs reviewed (100%) included operational descriptions of target and replacement behaviors. This represented another improvement from the last review when 77% of PBSPs reviewed included operational definitions of target and replacement behaviors. All 16 (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 is consistent with the last review when 100% of the PBSPs reviewed were judged to be consistent with the stated function. Replacement behaviors were included in all of the 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 12 of the 12 (100%) replacement behaviors that could be functional (the hypothesized function in the other four PBSPs reviewed was automatic, therefore it was impossible to determine if the replacement/alternative behaviors were functional) were functional. This represented another improvement from the last review when 92% of all replacement behaviors that could be functional were functional. When the replacement behavior requires the acquisition of a new behavior (as it appears to in Individual #285's PBSP), it should be written as a skill acquisition plan (see S1). If, however, the replacement behavior is currently in the individual's behavioral repertoire (as appeared to be the case in the majority of PBSPs reviewed), the replacement behavior	Noncompliance

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		does not need to be written in the skill acquisition plan (SAP) format. Finally, in all 16 PBSPs reviewed (100%), the reinforcement of replacement/alternative behaviors was included in the PBSP. This represented another improvement from the last report when 92% of replacement/alternative behaviors were included in the PBSP. Overall, 16 of the 16 PBSPs reviewed (100%) represented examples of complete plans that contained operational definitions of target behaviors, functional replacement behaviors (when possible and practical), and clear, concise antecedent and consequent interventions based on the results of the functional assessment. This represented a steady and substantial increase from the last two reviews when 52% and 77% of the PBSPs reviewed were judged to be acceptable. Once again the psychology department should be commended for their significant improvements in the quality of PBSPs, and in ensuring that they are current. In order to achieve substantial compliance with this provision item, the facility now needs to document that PBSPs are consistently implemented within 14 days of receiving consent.	
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.	This item was rated as being in noncompliance because treatment integrity was not being collected on all PBSPs, and IOA and treatment integrity minimal frequencies and levels were not demonstrated to be achieved. As discussed in K4, at the time of the onsite review, IOA collection was expanded to all residential areas and minimal acceptable frequencies (i.e., once per quarter) and levels (i.e., 80%) were established. It is now recommended that the facility demonstrate that these frequencies and levels are attained. All of the DCPs asked about PBSPs indicated that they understood them (see K11). The most direct method, however, to ensure that PBSPs are implemented as written is to regularly collect treatment integrity data. LSSLC was assessing treatment integrity of the PBSPs, however it was not collected for every PBSP, at the time of the onsite review. The facility's self-assessment indicated that treatment integrity was collected on 25% of the PBSPs it sampled. It is recommended that the facility ensure that treatment integrity is collected for each PBSP, and that established minimal acceptable frequencies of treatment integrity collection and levels of treatment integrity are attained. The monitoring team observed the collection of treatment integrity. The procedure was very thorough and included a paper and pencil test and role-playing and performance feedback. It did not include, however, a direct observation component. The psychologist	Noncompliance

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		conducting the treatment integrity session indicated that the psychology assistant assigned that unit collected the direct observation component. Additionally, the psychology staff interviewed indicated that the procedures used to assess treatment integrity, and the calculation of treatment integrity varied across psychologists. It is recommended that the facility ensure that all psychologists are using the same methodology (including a direct observation component) to collect and calculate treatment integrity. Target and replacement behaviors were consistently graphed monthly at LSSLC. As discussed in K4, however, some of the graphs encountered by the monitoring team could be more useful by ensuring that all relevant environmental events are indicated, and that the most recent data are included. The graphs reviewed contained horizontal and vertical axes and labels, condition change lines, data points, and a data path. In order to achieve substantial compliance with this provision item it is recommended that treatment integrity be expanded to all PBSPs. Additionally, it is recommended that LSSLC demonstrate that minimal established frequencies and levels of IOA and treatment integrity are achieved. It is also recommended that all psychologists use the same methodology (including a direct observation component) to collect and calculate treatment integrity. Finally, it is recommended that all graphs contain indications of relevant environmental events, and current data.	
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.	All of the PBSPs reviewed appeared simple, clear, and allowed for staff understanding. Additionally, all DCPs interviewed, indicated that they understood the PBSPs. Therefore, this provision item was rated as being in substantial compliance. LSSLCs self-assessment indicated that the psychology department reviewed all PBSPs that were presented in peer review to ensure that they were simple, clear, and written in a style that would promote staff understanding. The monitoring team reviewed 16 PBSPs written in the last six months and concluded that they were written in a manner that DCPs were likely to understand. The PBSPs reviewed, for example, were consistently brief and concise, the majority contained two or three targets (none contained more than four target behaviors), and technical language appeared to be kept at a minimal. As an objective measure of the readability of PBSPs, LSSLC monitored the reading level (using the Flesch-Kincaid Readability score) of a sample of PBSPs written in the last six months and determined that they averaged an 7.7 reading level. Finally, the monitoring team also asked several DCPs across all treatment sites if they could understand the PBSPs, and all DCPs indicated that the plans were simple, clear, and	Substantial Compliance

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		easy to understand.	
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.	This item was rated as being in noncompliance because, at the time of the onsite review, LSSLC did not have documentation that every staff assigned to an individual was trained on his or her PBSP. 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. The monitoring team observed the training of DCPs on Individual #301's PBSP. The training included a review of the PBSP by the psychologist that wrote the PBSP, an opportunity for DCPs to ask questions, and written questions pertinent to Individual #301's PBSP. The monitoring team found the training to be thorough. The facility's self-assessment indicated that they maintained inservice logs on all staff training. They indicated, however, that float staff were inserviced by the residential charge staff and they not know the method used to train these staff. 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/relief staff, has been trained in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter.	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 347 individuals and employed 15 associate 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

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009.2: Medical Care, 5/15/12 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 LSSLC Medical Policy, Death of a Person Served, 5/22/13 o Infection Control Committee Meeting Minutes, 2012-2013 o Clinical Daily Provider Meeting Minutes, 2012 -2013 o Listing of Medical Staff o Medical Caseload Data o Medical Staff Curriculum Vitae 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 #130, Individual #500, Individual #402, Individual #129, Individual #504, Individual #238, Individual #101, Individual #64, Individual #91, Individual #60 o Annual Medical Assessments the following individuals: • Individual #23, Individual #407, Individual #539, Individual #104, Individual #215,

	Individual #76, Individual #1, Individual #190, Individual #477, Individual #88, Individual #311, Individual #202, Individual #28, Individual #90, Individual #471 o Neurology Notes for the following individuals: • Individual #308, Individual #504, Individual #371, Individual #34, Individual #187, Individual #469, Individual #389, Individual #211, Individual #584, Individual #267, Individual #151, Individual #392, Individual #31, Individual #500, Individual #368, Individual #238, Individual #504, Individual #336, Individual #366, Individual #150 o Consultation Referrals and IPNs and for the following individuals: • Individual #586, Individual #572, Individual #174, Individual #33, Individual #296 <u>Interviews and Meetings Held</u>: o Andra Self, Clinical Services Director o Dickerson Odero, MD, Primary Care Physician o Ronald G. Corley, MD, Primary Care Physician o Nelda Johnson, APRN, Family Nurse Practitioner 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 Risk Meeting o Neurology Clinic 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. The clinical services director served as the lead for this provision, but much of the data collection and reporting was done by the medical compliance nurse who was no longer employed at LSSLC at the time of the compliance review. For each provision item, the clinical services director provided a series of activities engaged in to conduct the self-assessment. The self-assessment was not particularly useful because it attempted to provide an assessment of the quality of medical services and medical care that was not completed by a physician peer. While it was appropriate for the medical compliance nurse to identify the presence or absence of many elements of medical care, a peer was actually needed to assess the quality of care provided. As discussed with the clinical services director during the compliance review, she will need to determine how to accomplish this for future self-assessments. The facility rated itself in noncompliance with provisions L1, L3 and L4. It found itself in substantial

	compliance with provision L2. The monitoring team found the facility to be in noncompliance with all four provision items.
	Summary of Monitor's Assessment: Over the period of three years, the monitoring team has seen improvement in the provision of medical services. The deficits noted during early reviews were tremendous. Thus, positive transformation has not been as swift as needed nor has it been sufficient. Nonetheless, progress has occurred. The improvements have been most obvious in specific areas of physician performance, such as documentation of assessments, documentation of labs and diagnostics, completion of certain cancer screenings, and overall improvements in annual medical assessments. Even so, the monitoring team encountered poor clinical outcomes for many individuals. These outcomes may be due, in part, to the advancing age and declining health of many individuals. However, there were outcomes that were clearly linked to inadequate systems and the failure to implement appropriate corrective actions for recognized systems issues. There were no changes in the medical staff. Each primary provider was recently assigned an LVN to provide support and allow the medical staff more time to focus on medical care and attend ISPs and other clinical meetings. The additional support did not result in any significant improvement in meeting attendance. Since there was no medical director, the facility hired a clinical services director to provide administrative oversight for the health care departments. While the monitoring team saw improvement in some areas, many problems persisted. Documentation of hospital follow-up was inconsistent. The medical staff did not appear to have any reliable means, such as use of a spreadsheet, for tracking consults and diagnostics independently. They relied upon the tracking mechanisms of the facility and there were many examples of systems failures. The monitoring team encountered examples in which labs and diagnostics were not ordered, consults were not obtained, and consultant recommendations were not implemented by the primary providers. The facility implemented a number of corrective actions to address these issues, but the monitoring team was not encouraged when staff appeared uncertain about how the facility would actually follow-up on outstanding consults. Most individuals received routine preventive services and compliance with most cancer screenings was improving. In those cases where screenings were not completed, the documentation of the rationales was limited. There continued to be problems related to the provision of neurological care. Many individuals had dual diagnoses of seizure and psychiatric disorders. The collaboration between psychiatry and neurology was improving. Several clinic notes documented discussion with the psychiatrist prior to clinic. Some clinic notes also indicated that the psychiatry nurse was present during the evaluations. Nonetheless, there were several consultations in which the neurologist clearly stated that the indications for the medications were not known. Other notes documented that important data were not available. Individuals with refractory seizure disorder generally were not referred to an epileptologist. Furthermore, the monitoring team was able to identify, within a small sample of records, individuals who were not recognized as having refractory seizures.

	The external medical reviews were completed, but basic clinical outcome metrics were still not utilized. The status of corrective actions plans was unknown at the time of the compliance review. Mortality reviews continued to be completed and corrective actions were generated. The corrective actions focused primarily on nursing issues. This was likely due to the lack of an objective medical review. The facility director reported that the data from the Quantros reviews were shared with the Administrative Death Review Committee, but there was no evidence that the data were analyzed and used for performance improvement. LSSLC did not address the need to develop a medical quality program. The medical department staff was not aware that the QA department had developed a set of clinical indicators. The department had several data sets that were capable of providing some assessment of the quality of medical care provided. However, data related to hospitalizations, seizure management, and pneumonia were not being reviewed within the medical department for assessing quality. Finally, the requirement to develop and implement policies and procedures to guide medical care remained an outstanding need. The guidelines issued by state office were not localized. The clinical services director indicated that additional policies and procedures were under development.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The process of determining compliance with this provision item included reviews of records, documents, facility reported data, staff interviews, and observations. Records were selected from the various listings included in the 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 three primary care physicians and one advanced practice registered nurse. The previous medical director now served in the role as lead physician. Each member of the medical staff was recently assigned a licensed vocational nurse to provide additional support. The average caseload for the physicians was 91. The APRN's caseload was 75. The agreement between the APRN and physicians was both current and adequate. The facility hired a clinical services director on 3/1/13 to provide administrative oversight for the medical, pharmacy, psychiatry and dental departments.	Noncompliance

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		Physician Participation In Team Process The facility continued the daily 8:00 am clinical services meetings. The lead physician was on leave during the week of the compliance review. In his absence, the clinical services director facilitated the daily meetings. Attendees included the medical staff, QDDP coordinator, CNE, pharmacy director, dentist, and the hospital liaison nurse. The monitoring team attended several meetings throughout the week. During each meeting, there was a review of the events that occurred over the previous 24 hours. External consults were reviewed as well as the pretreatment sedation consultations. The meetings were very brief and the medical staff were generally able to limit this time to approximately 30 minutes. The facility provided data related to physician participation in ISPs.	

	No. of ISPs	Medical Participation Requested	Compliance (%)	Medical Meeting Attendance
Dec	28	4	25	1
Jan	33	10	50	5
Feb	32	12	17	2
Mar	27	10	30	3
APR	30	15	43	6
May	23	6	16	1

A total of 173 ISPs occurred during the six-month reporting period with medical participation requested for 57 (33%). The medical staff attended 18 of 57 (31%) of the required ISPs. Overall, the LSSLC medical staff attended 10% of the ISPs conducted during the reporting period. The self-assessment indicated that physician attendance was much improved. These findings were discussed with the clinical services director ad QDDP coordinator. The monitoring team was concerned about the need to request greater participation by the medical staff in the annual planning process for individuals with significant medical issues because the primary provider plays an important role in the planning process in terms of determining how the individual's health will impact goals, barriers, transitioning etc. The need for greater participation was also discussed with the medical staff. Several of them indicated that they also participated by phone when necessary.

Notwithstanding the minimal attendance in meetings, most staff at the facility reported that the primary providers were very receptive to discussions with other members of the IDT and were readily accessible. Some staff were however concerned that some providers did not respond to emails. The clinical services director should ensure that the facility has an adequate policy/procedure related to acceptable forms of communication with the medical staff to ensure that employees have guidelines on the

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		use of the most appropriate manner of contacting the medical staff. **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 There were no changes reported in ancillary services. Informal agreements remained in place with local providers who continued to provide hospital services. 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. **Documentation of Care** The Settlement Agreement sets forth specific requirements for documentation of care. The monitoring team reviewed numerous routine and scheduled assessments as well as record documentation. The findings are discussed below. Examples are provided in the various subsections and in the end of this section under case examples. <u>Annual Medical Assessments</u> Annual Medical Assessments included in the record sample as well as those submitted by the facility were reviewed for timeliness of completion as well as quality of the content. For the Annual Medical Assessments included in the record sample: • 9 of 10 (90%) AMAs were current • 8 of 10 (80%) AMAs included comments on family history • 10 of 10 (80%) AMAs included information about smoking and/or substance abuse history • 10 of 10 (100%) 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's assessment. For the sample of Annual Medical Assessments submitted by the facility:	

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		• 11 of 15 (73%) AMAs were completed in a timely manner. • 13 of 15 (87%) AMAs included comments on family history • 15 of 15 (100%) AMAs included information about smoking and/or substance abuse history • 15 of 15 (100%) AMAs included information regarding the potential to transition The format of the AMAs varied among providers. LSSLC was piloting a state issued template that required electronic completion. Many items were addressed with a series of checkboxes. A few of the AMAs reviewed utilized this template. Overall, the AMAs had improved since the early monitoring visits. Additional information, such as immunization status and interval care, was included. Nonetheless, the improvements were not consistent among providers and additional work was needed. The format utilized varied among providers and, overall, the sample reviewed lacked adequate plans of care. Active medical problems were omitted from the APL even when individuals received specific medical therapy for the condition. The result was a failure to implement appropriate medical plans for significant medical conditions. Even when active problems were listed, the plans of care were, for the most part, inadequate. The monitoring team noted plans of care such as "a continual preventive medical program is in effect," "acute medical care is provided as needed," and "continue current orders and treatment." Documentation of interval care was provided chronologically, but remained disjointed. For each year, a series of statements was made. In many instances, it appeared that another paragraph was added for the new year with no consideration given to the content of the previous year. For example, one AMA included for each yearly summary a statement that the last GI evaluation occurred during that year. The monitoring team has recommended in the past and continues to recommend that interval care be presented chronologically, but organized by problems. With this approach, a problem, such as aspiration pneumonia, would include all care and events relative to the problem, such as GI evaluation, pulmonary evaluation, etc. <u>Quarterly Medical Summaries</u> The medical department utilized 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: • 7 of 10 (70%) records included a QMS for the most recent quarter	

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		All of the providers were completing QMSs. Some were typed and some were handwritten. Legibility was a problem for several providers. Overall, completion represented an improvement from the 30% compliance score noted during the last visit. Active Problem List For the records contained in the record sample: • 10 of 10 (100%) records included an APL • 6 of 10 (60%) documents included updated information The Active Problem Lists were identified in all records included in the sample. Many were not current and several were updated over a period of one to two years, but never retyped which made them difficult to read. The problem lists should be updated as problems arise and/or resolve. The APLs are included in the transfer packet that is sent with individuals upon transfer to outside facilities. It is important that the APL provide current and accurate information regarding the medical conditions of the individuals. The monitoring team recommends that the documents be re-typed, minimally, each year in conjunction with completion of the Annual Medical Assessment. 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. Physician Orders Physician orders were usually signed and dated. However, there were many issues related to physician orders, including incomplete orders, excessive use of verbal orders, and medication orders written when allergies were documented. This is discussed in further detail in section N1. Consultation Referrals The consults and IPNs for five individuals were requested. A total of 45 consults completed after September 2012 (including those from the record sample) were reviewed: • 25 of 45 (55%) consultations were addressed in accordance with state policy Overall, the documentation of the recommendations of the consultants showed a marked variation among the providers. The Settlement Agreement required that medical providers review and document whether or not to adopt the recommendations	

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		and whether to refer the recommendations to the IDT for integration with existing supports. State policy required that an entry be made in the IPN explaining the reason for the consultation and the significance of the results within five working days. Almost all consultation forms indicated the appropriate review by the primary provider. One provider consistently utilized an IPN template that indicated the consult, summarized the recommendations, indicated agreement, disagreement, and referral to the IDT. This fulfilled state and Settlement Agreement requirements. However, other providers failed to adequately document consultations. As noted in the previous review, one primary provider continued the same practice of writing a one word diagnosis and directing the reader to "see consult." The consultation referral process is discussed in further detail in section G2. **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 could not be determined due to incomplete data. Compliance with colorectal and prostate cancer screening was very good. Compliance with breast cancer screening was somewhat improved, but the monitoring team found different standards cited in various documents. 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: • 10 of 10 (100%) records included PCFSs There were several versions of the PCFS found in the active records. Many were not updated by the PCPs. The forms also continued to have standards that were not consistent with current guidelines. The clinical services director provided a copy of a new PCFS. It provided guidance to the providers on the completion of required care. It also included checkboxes to indicate the rationale when services were not provided. For example, cervical cancer screening not done required an explanation, such as risks outweighs benefits, not necessary per gyn, or referred to IDT for discussion and need to contact LAR. The requirements were also outlined, including requirements for women who had total hysterectomies or supracervical hysterectomies. Similar guidance was provided for mammography, PSA testing, and colonoscopies. This revision was a significant improvement for tracking the preventive care services and explanations for the decision to defer care.	

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		Immunizations • 8 of 10 (80%) individuals received the influenza, hepatitis B, and pneumococcal vaccinations • 9 of 10 (90%) individuals had documentation of varicella status. Screenings • 9 of 10 (90%) individuals received appropriate vision screening • 10 of 10 (100%) individuals received appropriate hearing testing Prostate Cancer Screening • 4 of 5 males met criteria for PSA testing • 4 of 4 (100%) males had appropriate PSA testing A list of males greater than age 50, plus African American males greater than age 45, was provided. The total for both lists was 117 males: • 107 of 117 (91%) males had current PSA results 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 list included 97 females. • 59 of 97 (61%) females had current breast cancer screening Cervical Cancer Screening • 5 of 5 females met criteria for cervical cancer screening • 2 of 5 (40%) females completed cervical cancer screening within three years A list of females age 18 and older was provided. The report appeared to have missing pages and was incomplete. Generally, it appeared that many females were not having cervical cancer screening. The primary providers indicated in the active records that the gynecologist stated screening was not necessary or the PCP believed screening was "not needed." Overall, the records reviewed did not document adequate risk assessments related to deferring pelvic examination and cervical cancer screening. Colorectal Cancer Screening • 4 of 10 individuals met criteria for colorectal cancer screening • 4 of 4 (100%) individuals completed colonoscopies for colorectal cancer screening	

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		A list of individuals age 50 and older was provided. The list contained 201 individuals: • 191 of 201 (95%) individuals had completed colonoscopies • 10 of 201 (5%) individuals did not have current colonoscopies o 2 of 10 (20%) individuals did not complete because of colectomy 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. The new PCFS addressed this need, but it applied only to certain conditions. **Disease Management** The facility had access to numerous clinical guidelines issued by state office, although no local polices were developed to complement these guidelines. 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 69 incidents of pneumonia from December 2012 through June 2013. For the 69 episodes of pneumonia that were reported, only four (6%) were recorded as aspiration events. The facility reported that 12% of pneumonias were attributed to aspiration during the previous compliance review. Many of the individuals who had a documented bacterial pneumonia were at high risk for aspiration. The facility did not track pneumonia in Avatar. The clinical services director explained that the chest x-rays and data were reviewed by the physician with experience in infectious diseases and this information was provided to the infection control committee. The infection control minutes for December 2012 through May 2013 were reviewed. The minutes documented that there was participation by the medical staff in the May 2013 meeting. During this meeting, the ID specialist provided information to participants on aspiration pneumonia. The lead physician also attended this meeting. There was also documentation that the facility director requested that a pneumonia sub-committee we formed, however, there had been no such meetings at the time of the compliance review. The monitoring team discussed the pneumonia review process with the medical staff. The physician completing these reviews described that CXRs and hospital information, if available, was reviewed to assist in making a determination regarding the occurrence of pneumonia and the type of pneumonia. That information was provided to the Infection	

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		Control Committee for review. There was no formal process or checklist utilized for this process. Moreover, the determination was not part of a multidisciplinary review process. The only documentation of this process was found in the infection control minutes, but was no specific data were provided. As noted in the November 2012 compliance report, 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. Individual #129 utilized a gastric tube for nutrition. Nursing IPN documentation on 1/13/13 noted that the individual vomited and possibly aspirated. The oxygen saturation on room air was 85%. The individual was transferred to the local hospital where documentation showed "extensive right pneumonia consistent with aspiration." Documentation submitted to the monitoring team showed that this pneumonia was considered bacterial and not aspiration. The infection control minutes provided no documentation to support the facility's determination that aspiration did not occur. **Case Examples** Individual #64 • This individual had a diagnosis of chronic hepatitis B and was seen by the gastroenterologist in 2006. The individual received treatment with entecavir for chronic active hepatitis. • Orders were written on 8/30/12 and labs were sent to the local hospital. The LSSLC lab did not notify nursing that the hospital cancelled labs until 11/30/12 • On 2/4/13, an order was written for a GI evaluation due to increased liver enzymes from lab studies completed on 12/13/12. The appointment occurred on 2/21/13. The consultant recommended obtaining an alpha feto protein and liver ultrasound, but the consult was not received until 4/16/13. • On 2/12/13, an order was written for an appointment with Dr. Lugo, but was not scheduled. • Orders were written on 4/15/13 for labs due to jaundice, but they were not done. • On 4/20/13, nursing notified the on call MD of increasing jaundice. An order was given for the LSSLC physician to see next day at "earliest convenience." • On 4/21/13 around 11 am, the individual was noted to be confused and	

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		stumbling. The on-call MD was contacted and requested transfer to an acute care facility for evaluation. The CT scan done on 4/21/13 showed a large lesion in the right lobe of the liver with thickened sigmoid colon, questionable primary, metastatic lesion. The individual expired on 4/27/13. Upon review of the records, in addition to the aforementioned delays in care, the monitoring team did not find any documentation that this individual was referred to a hepatologist for evaluation and management. In fact, there was no documentation in the records of follow-up by GI between 2006 and 2013. The AMA listed chronic hepatitis as an "inactive problem" even though the individual received powerful antiviral medication. There was no documentation that the individual had the appropriate surveillance for hepatocellular carcinoma including measurement of alpha-fetoprotein and hepatobiliary ultrasonography. Individual #246 • This individual had a fundoplication and returned to the facility on 5/30/13. The first documentation by a medical provider was on 6/6/13 and this was due to reports of foul smelling urine. The next notes were on 6/6/13 and 7/2/13. The first set of orders written by a physician was on 6/5/13. All orders prior to that time were verbal orders. There also appeared to be orders that were emailed to nursing by physicians. This individual experienced several problems following return from hospitalization and nursing documented numerous times "possible ileus." The physician was notified and orders were given for several enemas. There was never a physician evaluation documented in the IPNs reviewed related to the ileus. **Seizure Management** A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 182 individuals. A separate list of 168 individuals receiving AEDs was also provided. The following data regarding AED use were summarized from the list provided: • 56 of 168 (40%) individuals received 2 AEDs • 28 of 168 (17%) individuals received 3 AEDs • 11of 168 (7%) individuals received 4 AEDs • 2 of 168 (1%) individuals received 5 AEDs • 2 of 168 (1%) individuals received 6 AEDs • 1 of 168 (.6%) individual received 7 AEDS	

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		Neurology clinic was conducted two times a month. The numbers below reflect campus visits for the neurologists. Neurology Clinics 2012 - 2013 Campus Appointments Dec: 6 Jan: 21 Feb: 22 Mar: 22 Apr: 24 May: 26 A total of 121 on-campus appointments were completed over six months. Two clinics occurred each month with the exception of December 2012. The average number of individuals seen each month was 20, which was the same number for the last reporting period. Overall, the number of individuals was increasing. A new contract neurologist with certification in clinical neurophysiology was conducting clinic once a month. The facility reported that 13% of 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, was not provided. Three individuals were reported to experience status epilepticus since the last review. The monitoring team identified individuals (Individual #584 and Individual #469) with refractory disease that were not included on the facility's list. 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 three records included in the record sample: • 8 of 13 (62%) individuals were seen at least twice over the past 12 months • 10 of 13 (77%) individuals had documentation of the seizure description • 11 of 13 (85%) individuals had documentation of current medications for seizures and dosages • 7 of 13 (54%) individuals had documentation of recent blood levels of antiepileptic medications • 4 of 13 (31%) individuals had documentation of the presence or absence of side effects. None of the notes included comments on review of the MOSES/DISCUS information. • 10 of 13 (77%) individuals had documentation of recommendations for medications • 0 of 13 (0%) individuals had documentation of recommendations related to	

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		monitoring of bone health, etc. 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 bone health was not addressed. Several of the consults were initiated by the psychiatrists. In some instances, the neurologist noted that he had a discussion prior to clinic with the psychiatrist. This was not consistently documented. A review of some consultation notes indicated that the neurologist made assumptions about the use of the psychotropic medications. The monitoring team also noted during the compliance review that the psychiatry nurse attended clinic for some, but not all, individuals with dual diagnoses who received medications for management of both disorders. The following are examples of the concerns related to the provision of neurological care: • Individual #308 was seen in clinic on 2/27/13. At the previous clinic, the recommendation was made to increase the dose of Keppra. The neurologist documented "apparently this was not done as the recommendations have not been noted as of yet." The recommendation to increase the dose of Keppra was given again. On 4/23/13, the neurologist documented that the individual was hospitalized with seizures and aspiration pneumonia. He did not have enough information to determine if the individual had a seizure and aspirated or if the increase in seizures was related to the illness (pneumonia). The individual had significant behavioral issues and was followed by psychiatry. On 5/8/13, the individual was seen in clinic again. The psychiatry clinic nurse and RN case manager were present during the evaluation. The individual was experiencing a significant increase in behavioral issues. Trileptal was started with the plan to wean off Keppra. o This case example illustrates the importance of neurology and psychiatry integration. A discussion regarding the psychiatric condition of the individual may have resulted in a decision to use a drug other than Keppra. • Individual #469 was seen in clinic on 8/24/12. The neurologist noted that the seizure records were not available. The individual was seen on 5/8/13 and the consultant noted poor seizure control with the use of three medications. The neurologist recommended consideration of VNS implantation. The lack of the appropriate data, such as the seizure records, did not allow the neurologist to adequately assess the individual. The determination that the individual had intractable seizure disorder and the appropriate referral was delayed eight months.	

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		• Individual #366 was seen on 7/10/13 with well-controlled seizure disorder. The individual was on Dilantin and "a number of other medications." Keppra was started so that Dilantin could be weaned and discontinued due to gingival hypertrophy. There was no ADR related to this in the summary data. The monitoring team attended the neurology clinic conducted during the week of the compliance review. The clinic occurred in a standard medical treatment room. The individuals and members of the IDT attended the clinic. However, there was little discussion between the neurologist and IDT members, such as psychologist, RN Case manager, and DCPs who were present. The clinic arrangement was not conducive to such discussions because team members stood in the examination room, which had limited space. The monitoring team also gathered, through a brief discussion with the consultant, that he had little knowledge about the Settlement Agreement and specific requirements related to neurological care. 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. The monitoring team continues to recommend that individuals with refractory seizure disorder be referred to a qualified epileptologist for evaluation. LSSLC will need to accurately identify those with refractory seizure disorder. **Do Not Resuscitate** The facility submitted a list of individuals who had DNR orders in place. The list included 12 individuals, which represented a three-fold increase in the number of individuals with DNR orders noted during the previous compliance review. The average age was 53 years with a range from 22-85 years. One individual expired in April 2013. The qualifying conditions were listed as anencephaly, seizures, renal failure, chronic respiratory failure, and cirrhosis. The qualifying diagnoses were not provided for three individuals. According to the documentation submitted, the DNRs were initiated at the request of the family. However, there was no documentation of an IDT discussion regarding the qualifying diagnosis and the appropriateness of implementing a DNR order or review by the facility's Ethics Committee. 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. **Compliance Rating and Recommendations** The monitoring team agrees with the facility's self-rating of noncompliance.	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration:
1. The facility director should aggressively pursue the recruitment of a qualified medical director.
2. The medical staff should increase participation in the annual ISPs. The facility should review the criteria currently being utilized to determine when medical participation is required.
3. The medical staff should continue to improve the quality of the AMAs by providing better organization of the interval histories and ensuring that all active medical problems are addressed with an adequate plan of care.
4. The medical staff should address issues related to documentation as outlined above.
5. The facility should proceed with implementation of the new PCFS. The medical staff should review and update the document on a regular basis, perhaps when completing the quarterly reviews.
6. Additional guidelines for management of medical conditions should be developed. Priority should be given to areas identified as problematic.
7. A multidisciplinary committee should be developed to review all cases of pneumonia to determine the most appropriate classification. This process should be standardized.</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 conducted Round 7 of the external reviews from 1/31/13 – 2/1/13. 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. The eight essential elements were 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. Twenty-four records distributed among the four providers were audited. The data submitted by the facility are summarized along with data from previous audits in the table below:
<table><tr><td colspan="4">External Medical Reviews 2011 - 2013
% 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 2011</td><td>71</td><td>78</td></tr><tr><td>Round 5</td><td>March 2012</td><td>76</td><td>88</td></tr><tr><td>Round 6</td><td>August 2012</td><td>90 (97)</td><td>86 (99)</td></tr><tr><td>Round 7</td><td>Jan/Feb 2013</td><td>86 (91)</td><td>85 (94)</td></tr></table>*( ) Internal reviews</td><td>Noncompliance</td></tr>
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		Overall, compliance scores were improving. Inter-rater reliability showed marked variations in the findings of the external and internal reviews. Several areas did not meet an acceptable compliance level. Those with significant deficiencies are listed below. • Compliance scores of 50%: o Documentation of a rationale for the lack of preventive o Documentation in the IPN of responses to and interventions for abnormal labs • Compliance scores between 60 ad 70% o Signing and dating the APLs o Updating the APLs o Documentation of the rationale for not accepting QDRR recommendations o Documentation of consults in the IPN within five days of consult o Documentation in the IPN of pertinent positive and negative findings of assessments • Compliance scores between 70 and 80% o AMA complete with family and medical histories o Documentation of abnormal tests in the IPN o Legibility of provider documentation o Documentation of response to QDRRs within 15 days o Inclusion of appropriate information on consultation referral forms Data for corrective action plans and follow-up are presented in the table below. The corrective action plans were developed by the QA department and follow-up was completed by the medical compliance nurse. The dates that follow-up occurred were unknown. In the absence of the medical compliance nurse, facility staff was not aware of the current status of the corrective action plans or how many plans were outstanding at the time of the compliance review. Generally, in comparison to previous reviews, there was more evidence that the facility was addressing the findings of the general medical audits with the medical staff. The monitoring team reviewed the notes of the inservice conducted on 4/24/13. Participants included the medical staff and the clinical services director. The notes	

	Total Action Plans	Reviewed By QA	Remaining to Review by QA	Completed	Remaining to Complete
External	75	68	7	64	11
Internal	66	52	14	51	15

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		documented discussion of noncompliant areas and potential solutions. Specific issues found during the audits were addressed. Additionally, the medical staff was provided with various handouts related to potential systems improvements and clinical updates, such as new immunization guidelines. Medical management audits were also completed. The conditions reviewed as part of Round 7 were diabetes mellitus, pneumonia, and osteoporosis. Compliance scores are provided in the table below: Medical Management Audits % Compliance Diabetes mellitus: 93 (88) Osteoporosis: 100 (92) Pneumonia: 100 (86) *( ) Internal reviews There was a significant difference in the results of the internal and external reviews, particularly related to pneumonia management. The minutes of the April 2013 inservice previously discussed noted that the medical management audit problems would be discussed at the next inservice. Minutes of that meeting were not submitted. The facility conducted medical management audits on six conditions. The monitoring team agrees that this was a good starting point, however, there is an obvious need to assess the medical management of a number of disease conditions, including hypertension and chronic hepatitis. The facility should draft additional management guidelines to ensure that the medical staff provides the appropriate care. These guidelines could then be utilized to develop brief audit tools to ensure that the care provided is in accordance with generally acceptable standards. This could also translate into a medical management flow sheet that would be included in the records with the preventive care flow sheets. <u>Mortality Management</u> There were six deaths in 2012. The average age of death for the six individuals was 48.5 years. There were six deaths in 2013 at the time of the compliance review. One death occurred a week prior to the compliance review. The facility death reviews were submitted for five deaths and that information is summarized below: • The average age of death was 63.2 years with an age range of 33 to 76 years. • The causes of death were: (1) respiratory failure, hepatic encephalopathy, bibasilar pneumonia, (2) respiratory failure, sepsis, metastatic squamous cell carcinoma, (3) new PEG tube pulled out, (4) respiratory failure, bilateral pneumonia, metastatic masses both lungs, and (5) respiratory failure, bilateral	

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		pneumonia, cancer head of pancreas with metastasis • Two autopsies were performed. • Four individuals died during hospitalization. One died at a hospice facility. The monitoring team met with the facility director, clinical services director, CNE, QA director, and QA nurse to discuss mortality management at the facility. The facility revised the process for clinical and administrative mortality reviews. The Clinical Death Review Committee was expanded to include representatives from psychology, habilitation therapies, residential services, and dietary. According to policy, the committee was required to review the records to assess medical care, nursing care and clinical care from other departments and make recommendations, when appropriate, related to changes in policies and procedures, professional education, and clinical operations. The Administrative Death Review Committee was expanded to include the chair of the Ethics Committee, a QDDP, and a direct care professional. The facility director also provided a series of graphs and charts related to the deaths between September 2010 and June 2013. The data sets included age at time of death, deaths by gender, manner of death, and cause of death. The facility director reported that the data were reviewed by the administrative death review committee, but there was no clear evidence that the data were analyzed to produce useful information that could be used to improve the quality of healthcare services provided. Even though several deaths were related to respiratory issues, such as pneumonia, the facility had yet to develop local medical policies related to pneumonia management. As discussed previously, there was no formal process to review and classify the types of pneumonia. There was also no objective review completed within the SSLC system to assess the quality of medical care provided. The mortality review process relied on the LSSLC physician's discharge summary, QA nursing review, incident reports, and hospital information. The monitoring team noted that recommendations from the administrative death reviews focused on issues related to nursing care. The lack of an objective medical review resulted in the loss of opportunities to evaluate the provision of medical care. The facility director reported that a physician reviewed the cases as part of the Quantros mortality reviews, however, the findings of those reviews were usually received many months after a death occurred. The Quantros reviews assessed care over a relatively limited period of time which did not allow for an adequate assessment of longitudinal medical care. This resulted in limited potential to adequately correlate medical care and outcomes. In the case of the death of an individual with hepatocellular carcinoma related to chronic hepatitis B infection, it would be important to establish if the appropriate actions occurred relative to prevention of hepatitis B, management and treatment of chronic hepatitis and	

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		surveillance for hepatocellular carcinoma. Each of these issues is associated with either disease prevention or early identification of disease at a point in which the outcome may be altered. Generally, the facility did not provide any physician reviews that highlighted evidence that this type of medical review occurred. The facility submitted corrective action plans for recent deaths for review. Correction actions were noted for several problems related to issues highlighted in previous monitoring reports such as the lack of the lack of parameters for physician notification of blood pressures and problems with timely review of labs. The issue of notification of abnormal blood pressures was clearly noted to be problematic in the November 2012 review. It was not clear if this was addressed prior to the mortality review of Individual #570. It was also reported that a policy was implemented to ensure that consults were tracked and received in a timely manner. The monitoring team received conflicting accounts of this process from staff in the medical department. It was later determined that a procedure was not formally developed, but certain measures had been implemented. Overall, the lack of a timely, objective physician review with greater focus on the provision of medical care severely limited the adequacy of the mortality process. <u>Compliance Rating and Recommendations</u> The monitoring team did not agree with the facility's self-rating of substantial compliance. The external medical audits (1) continued to lack the power to adequately assess clinical outcomes, (2) failed to have the breath to determine management of important medical conditions, and (3) did not include adequate follow-up of corrective actions. To move in the direction of substantial compliance, the monitoring team recommends the consideration of the following: 1. The external audits should include greater assessment of clinical outcomes. 2. The medical management audits will need to address clinical outcomes in addition to processes. The six conditions were a starting point, however, there needs to be assessment of other medical problems that are common in the population being supported. 3. Corrective actions for deficiencies need follow-up to closure. 4. Seizure data should be reviewed for accuracy. Individuals classified as intractable should be referred to a qualified epileptologist. 5. The facility should develop a template for use in neurology clinic that includes adequate information on key seizure management issues. Consultants should be provided with all relevant data including labs, seizure records, hospital	

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		discharge summaries, MOSES/DISCUS evaluations, etc. 6. The lead physician and clinical services director should discuss neurology requirements with the neurology consultants. 7. The facility must continue to explore better mechanisms to achieve integration of neurology and psychiatry. 8. The facility director should ensure that the DNRs are being implemented in accordance with state policy given the three-fold increase. 9. The facility must address mortality management and find a means of having an objective physician review of medical care. This review should occur in a prompt manner and provide recommendations for improvements when indicated.	
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. There was no assessment of medical quality apart from the external and internal medical audits. The monitoring team was informed by the QA staff that clinical indicators were developed, but the medical staff did not appear to be aware of this information. The facility was collecting data on a number of issues, such as hospitalizations and preventive care, but there was no process in place to utilize these data in order to improve the quality of the services provided. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. The external medical audits continue to lack the power to adequately assess clinical outcomes. To move in the direction of substantial compliance, the monitoring team recommends the consideration of the following. 1. The facility must develop and implement a medical quality program. 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. Clinical outcomes must assessed as part of this process. 2. 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.	Noncompliance
L4	Commencing within six months of the Effective Date hereof and with	State office issued a series of clinical guidelines and protocols on several diseases and medical conditions. No local policies were developed for the state issued clinical	Noncompliance

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	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.	guidelines in an effort to provide additional guidance to the medical staff. The self – assessment noted that the policies and procedures in place did not adequately address all parts of the provision of medical care and additional policies were needed for the medical department. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team recommends the consideration of the following: 1. Local policies and procedures should be developed based on state issued protocols and guidelines. 2. In addition to the guidelines issued by state office, the facility should have additional guidelines for other common medical conditions such as hypertension, hyperlipidemia, chronic hepatitis and other identified conditions.	

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o LSSLC Section M Self-Assessment, Updated: 6/27/13 o LSSLC Section M Action Plan, Updated: 6/21/13 o LSSLC M Presentation Book o Active Record Order and Guideline o Map of Facility o SSLC Nursing Services Policy Number: 010.3, Effective: 6/17/13 o LSSLC Integrated Clinical Services Operations Procedures Manual Medical Policy Number: 02, Dated: 4/15/13 o LSSLC Operational Procedures Manual Client Management Policy Number #46, Dated: 4/30/13 o LSSLC Nursing Policy and Procedure Manual: Nurse Policy Call Expectation, Revised: September 2012 o LSSLC Nursing Services Organizational Chart, including titles and names of staff currently holding management positions o LSSLC Nurse Administrative Team Meetings, Date: 1/8/13, 4/9/13, and 5/22/13 o LSSLC Nursing staffing reports/analysis for the last six months o SSLC Nurse Competency Based Training Curriculum, Dated: August 2010 o SSLC Nursing Education Handbook Table of Contents o LSSLC Nursing Education Calendar November 2012 through June 2013 o LSSLC New Nurse Orientation Curriculum October 2012 through May 2013 o LSSLC # of Nurses Trained Physical Assessment, SOAP Documentation, Planning Care, Medication Administration, Mosby's Physical Examination Courses, Preceptor Training, and Vascular Access Ports (VAP) Policy/Check-Off o LSSLC Nursing Competencies for Agency or Contract Nurses Policy Number 0513, Dated: February 2011 o SSLC Medication Administration Guidelines, Dated: February 2011 o SSLC Medication Variances Policy Number 053, Dated: 9/23/11 o LSSLC Nursing Guidelines for Reporting Elevated Blood Pressure, Dated: 4/15/13 o SSLC Nursing Services Policy Number 010.1 Revised 5/11/11 o SSLC Guidelines: Comprehensive Nursing Review/Quarterly Review Record/Quarterly Physical Assessment; Dated: 4/23/13 o LSSLC RN Case Management Monthly Meeting Minutes for the last six months o SSLC RN Case Management Responsibilities, Dated: 1/15/13 o LSSLC RN Case Management BMT Master Tracking for the last six months o SSLC Nursing Protocol: Hospitalizations, Transfers and Discharges, Dated: March 2013 o LSSLC Morning Infirmary Reports, 7/4/13, 7/5 - 7/10/13 o LSSLC Clinical Services Morning Meeting Minutes: 7/1/13 - 7/9/13 o LSSLC Emergency Response Policy Number: 044.2, Dated: September 2011

	o LSSLC Code Blue or Emergency Procedures Committee Minutes Dates: 11/16/13 - 6/28/13 o LSSLC Code Blue or medical emergency reports, code blue drill reports and analysis, Dates: December 2012 through May 2013 o LSSLC Emergency Equipment Oxygen, Suction Machine Walkthrough Checklist for July 2013 o LSSLC Automatic Defibrillator and Emergency Bag Checklist for July 2013 o LSSLC Statement of Policies in Relation to the Infection Control Program Policy Number: A.02, Revised: 5/13 o LSSLC Infection and Skin Report Policy Number A.03, Dated: December 2012 o LSSLC Human/Insect/Animal Bite Policy, Dated: 3/1/13, Revised: 5/22/13 o LSSLC Infection Control Meeting Minutes, Dated: 6/20/13 and 7/10/13 o LSSLC Skin Integrity Meeting, Dated: 5/1/13 and 7/10/13 o LSSLC Third Quarter Antibiogram, Dated: 6/13 o LSSLC Infection Control Data Summaries for the last six months o LLSC Individual and Employee Immunizations Policy Number, G.01, Dated: 7/1/12 o LLSC Hepatitis B Vaccine and Hepatitis B Immune Globulin Policy Number G.03, Dated: 8/26/11 o LLSC Emergency Response Management Plan 2008 Evacuation Plan Policy, Revised: 6/1/08 o LLSC Handling and Disposition of Infectious Waste Policy Number B.12.A, Updated: 8/22/11 o LLSC Monthly Nurse Safety Meeting Minutes for the last six months o SSLC Nursing Protocol: Enteral Nutrition: Revised May 2013 o LLSC Gastrostomy Tube: Insertion by a Nurse Effective date; 6/1/13 o A list of individuals ever diagnosed with human immunodeficiency virus (HIV) o A list of individuals diagnosed with Methicillin-resistant Staphylococcus aureus –(MRSA), Hepatitis A, B, C, positive Purified Derivative (PPD), convertors, H1N1, Clostridium Difficile (D-diff) and /or – sexually transmitted diseases (STD's) o LSSLC At Risk Individuals Policy #46, Dated: 4/30/13 o LSSLC Facility Operational Procedures Manual Death of a Person Served Medical 04: Dated: 1/1/13, Revised 5/22/13 o LSSLC Death Review Committee Graphs September 2010 through June 2013 o LSSLC Mortality Recommendations last six months o LSSLC Mortality Summaries o Last six months of QA/QI Council Meeting reports o A list of Individuals at Risks of aspiration choking, aspiration respiratory compromise, diabetes, weight, gastrointestinal problems, constipation/bowel obstruction, fluid imbalance, circulatory, cardiac disease, osteoporosis, falls, fractures, skin integrity, infections, urinary tract infections, seizures, hypothermia, dental challenging behavior, and polypharmacy side effects, 7/10/13 o Last six months nursing audits, analysis reports, plans of correction constipation, urinary tract infections, vomiting, nursing assessments, nursing care plans, acute illness and injury o Last five individuals transitioned to the community completed nursing discharge summary for Individual #216,, Individual #99, Individual #340, Individual #263, and Individual #431 o LSSC Comprehensive Record Review, including MARs/TARs, selected from the Facility At Risk for high/medium risk rated individuals from across campus as follows: Individual #235, Individual #46, Individual #437,, Individual #542, Individual #540 Individual #308, Individual #172,

	Individual #488, Individual #543, Individual #243, Individual #161, Individual #146, Individual #588, Individual #400, Individual #551, Individual #42, Individual #232, Individual #517, and Individual #422 Interviews and Meetings Held: o Mary Bowers RN, BSN, Chief Executive Nurse (CNE) o Laura Bowers RN, BSN, Nursing Operations Officer (NOO) o Christy Infection Control Nurse, Christy Pounders RN, MSN (ICN) o Nurse Compliance Officer, Gerald Davis, RN (NCO) o Jackie Lindsey RN, BSN, Infirmary Nurse Manager o Tanesha Wilson RN, BSN, RN Case Manager Supervisor 7/11/13 o Paul Vann RN, Quality Assurance Nurse o Belinda Byron RN, MSN, Hospital Liaison Nurse Staff RNs and LVNs o Meeting with CNE, NOO, NCO Provision of M4 presentation 7/8/13 o Meeting with Nursing Leadership, Specialty Nurses and Nurse Mangers 7/9/13 o Meeting Review Presentation Book 7/8/13 through 7/9/13 o Nursing Leadership and Management, Weekly Audit Meeting 7/8/13 o Clinical Services Meeting 7/9/13 and 7/11/13 o LSSLC Infection Control Committee Meeting 7/10/13 o LSSLC Skin Integrity Committee Meeting 7/10/13 o Individual Support Plan Individual #67 7/11/13 o Antibiogram Meeting 7/11/13 o LSSLC Medication Variance Committee Meeting 7/9/13 o LSSLC Risk Management Meeting 7/10/13 o LSSLC Mortality Meeting 7/11/13 Observations Conducted: o Residential areas various time of the day and evening o LSSLC Wound and Skin Nursing Rounds for the following individuals conducted on 7/10/13:Indiviudal #42, #Individual #542, Individual #540, Individual #223, and Individual #52 o LSSLC Infirmary Medication Administration Room and after hours Medication Box 7/10/13 o LSSC Infirmary tour of Residential and Isolation rooms 7/10/13 o Medication Administration Observations Individuals: • Individual #437, Individual #549, Individual #45, Individual #135, Individual #51, Individual #526, Individual #110, Individual #93, Individual #418, Individual #572, Individual #363, Individual #111, Individual #511, Individual #504, Individual #248, Individual #128, Individual #584, Individual #304, Individual #62, Individual #561,Individual #85, Individual #82, #306, Individual #349, and Individual #88 o Individual Support Meeting for Individual #67 held on: 7/11/13 o Hospital Liaison Reports and associated documents for individuals: Individual #102, Individual #142, Individual #161, Individual #118, and Individual #424

	o Comprehensive Record Review Individuals: • Individual #400, Individual #488, Individual #46 Individual #437, Individual #422, Individual #232, Individual #42, Individual #588, Individual #146, Individual #551, Individual #543 Individual #235, Individual #137, Individual #172, Individual #517, Individual #540, Individual #161, Individual #243, Individual #542, and Individual #308
	Facility Self-Assessment: The facility submitted its self-assessment for section M, updated 6/27/13. It provided comments/status for provisions M1 through M6 of the Settlement Agreement. The facility rated itself as being in noncompliance with all provisions of section M except M4. The monitoring team, however, found all six of the provisions to be in noncompliance. The content for the self-assessment did not always line up with what the monitoring team looked at. For example, in provision M.5, the self-assessment (and action plan, too) included comments/status actions related to issues regarding infection control issues and practices that were applicable to M.1. The action plan, updated 6/21/13, provided comments/status on the action steps taken for each provision, which included those steps that were completed and/or were ongoing and the projected data of completion. The monitoring team meet with the Chief Nurse Executive (CNE), Nursing Leadership, Nurse Managers, and Specialty Nursing Nurses (Infection Control, Hospital Liaison, Nurse Educator, RN Case Manager Supervisor, Nurse Recruiter), and Nurse Managers to review the Presentation Books. This was the first time for the CNE, who returned to this position in June 2013, to have an opportunity meet simultaneously with all of the Nursing Leadership and Specialty Nurses to review the Presentation books. The CNE and nursing staff reported that they now had a better understanding of progress made, as well as further progress that needed to be made with all provisions, self-assessment, and action plans in order to progress toward substantial compliance. During the meeting, the CNE was complimentary of the nursing team's knowledge, skills, and abilities, and expressed appreciation for their support. The monitoring team was also joined during the ending discussions by the state Nursing Coordinator.
	Summary of Monitor's Assessment: Across all provisions, improvements were found in comparison to the previous monitoring team report . Provision M.1: This provision was in noncompliance. During onsite meetings, which included the CNE, Nurse Operations Officer (NOO) and Nursing Compliance Nurse (CO), the CNE and Section Lead shared their detailed presentation book. The Nursing Department had experienced significant turnover in Nursing Leadership and Specialty Nursing Positions since the monitoring team's last visit, including the CNE, Hospital Liaison, Infirmary Nurse, and Infection Control Nurse. The Immunization, Employee Health, and Wound Skin Nurse positions were also vacated and remained vacant. The most stable positions were the

	Nurse Educator, Nurse Operations Officer, and Nursing Compliance Officer. Notably, this team of nurses had taken on additional duties during the absence of these positions. The requirements for this provision included completion of nursing assessments and development of care plans. Other requirements for provision M.1 included infection control activities, emergency response systems, availability of relevant medical records, assessment and documentation of acute changes in health care status, quality enhancement, and nursing staffing. The facility must meet all these requirements in order to be found in compliance with provision M.1. Provision M. 2: This provision was found in noncompliance. Although improvements were found, there remained the need for continued progress in having a consistent method for implementing quality nursing assessments and developing sufficient health care plans, as well as understanding health risks and risk factors. Provision M. 3: This provision was found in noncompliance. The RN Case Manager Supervisor had a detailed tracking system for the management of timely nursing assessments, communication at nursing meetings, and other forms of communication when documentation changes occurred. As recently as June 2013, there were a number of changes in nursing policies, guidelines, procedures, and protocols at both the state and facility levels. These included protocols for reporting elevated blood pressure, gastrostomy tube nursing management, policy regarding nursing assessments, and other components of the nursing services policy, such as care and coordination, preventative health services, management of acute illness and injury, and nursing care planning. In May 2013, revisions we made in the state protocols for Enteral Nutrition. In addition, LSSLC revised the Human/Insect/Animal Bite Guidelines. Implementation of new/revised policies had a direct impact on the quality of nursing assessments and plans of care. In addition, the Integrated Risk Rating Form (IRRF) was revised in May 2013. Thus, with many policy and protocol changes, the facility had not had enough time to assess and evaluate progress. This was the only section that had sustained stable staff, which was a credit to the management by the RN Case Manager Supervisor. Provision M. 4. This provision was found in noncompliance. The Nurse Educator continued to provide the required annual competency-based training and New Nurse Orientation. The Nurse Educator maintained an excellent tracking system for training to ensure that nurses receive all required trainings. While the Nurse Educator was recognized as doing an outstanding job of completion of all trainings, with an overall completion rate of 96%, nursing care must be demonstrated through actual clinical practice sufficient to address the health status of individuals. Provision M.5. This provision was found in noncompliance. There were improvements found in this provision. For compliance, this provision requires integration of all relevant disciplines to accurately identify risk in order to develop plans of care sufficient to meet the individuals' needs. Provision M.6. This provision was found in noncompliance. Since the monitoring team's last review there were improvements found in practices of medication administration. There remained the need to further

	develop safe medication practice systems that ensure medication errors are harder to make, and that medication errors that do occur are buffered in order to have the least impact upon the individual. Failure to meet substantial compliance with these provisions of the Settlement Agreement was directly impacted by continued vacancies and high turnover in key nursing leadership, and among the ranks. As reported, a significant number of hours of overtime were incurred, as the LSSLC's nurses attended required inservice education/ training. The facility data identified areas in need of improvement. Even so, also needed were a more standardized format for presenting data in a meaningful way that facilitates interpretation and analysis; and training to the disciplines regarding how to analyze their data.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>M1</td><td>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.</td><td>This provision contained requirements that addressed the areas of staffing, medical records, infection control, emergency response, and quality enhancement efforts. The monitoring team conducted its own review of the requirements for this provision through review of information presented in section M, provision M1 of the Presentation Book, review of documents requested, and meetings/interviews with Chief Nursing Executive, Nursing Operations Officer, Program Compliance Nurse, Nurse Educator, Hospital Liaison Nurse, Infection Control Preventionist, RN Case Manager Supervisor, Nurse Managers, and Direct Care Nurses.

<u>Staffing, Structure, and Supervision</u>
At the time of the review there were 334 individuals residing at LSSLC. Since the monitoring team's last visit, Nursing Administration had a significant turnover in leadership positions, including the Chief Nurse Executive (CNE), Hospital Liaison Nurse (HLN), Infirmary Nurse Manager, Lone Pine Unit Nurse Manager, Immunization Nurse, and Infection Control Preventionist (ICP). Over a 16 month period, three positions were vacated more than once: the CNE, Immunization Nurse, and Infirmary Nurse Manager. The Nursing Department Nurse Recruiter had performed excellent work in putting together hiring trends and terminations. Below is a chart representing the facility's total Nursing Hire-Term Trends from November2012 to through May 2013, which includes the number of terminations and hires by month.

<table>
<tr><td>Trends</td><td>Nov.</td><td>Dec</td><td>Jan.</td><td>Feb.</td><td>Mar.</td><td>Apr.</td><td>May</td><td>Total</td></tr>
<tr><td>Term</td><td>3</td><td>1</td><td>7</td><td>2</td><td>3</td><td>8</td><td>3</td><td>27</td></tr>
<tr><td>Hire</td><td>0</td><td>2</td><td>2</td><td>6</td><td>3</td><td>7</td><td>6</td><td>26</td></tr>
</table>

A breakdown for direct care RNs and LVNs for November 2012 through May 2013 from data submitted by the facility as follows:</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Direct Care Nurse	Nov.	Dec	Jan.	Feb.	Mar.	Apr.	May	Total
RN	1	1	1	1	0	1	1	6
LVN	2	0	4	1	1	5	0	13

Although the above data were presented in bar graphs, there was absence of an in-depth analysis of the underlying problems associated with the trends. This data excluded information on additional positions vacated. The facility provided a communication document of the posting on 6/17/13 for four RN positions. Fortunately, the facility had approval to double-fill positions. The monitoring team recommends that the CNE consider setting up meetings with all of the nursing staff, include various shifts, to determine what improvements could be made within the facility to improve the continued call ins and vacancy rates (e.g., scheduling). Even so, the facility reported zero occurrences where staffing fell below minimums ratios during December 2012 and May 2013.

The monitoring team reviewed 17 "Recruiter Meeting Notes," however, there was need for a more formalized action plan. The monitoring team also reviewed the January 2013 through May 2013 Nurse Administrative Team Meetings where RNs met and discussed issues. The CNE should consider eliminating the Recruiter Meeting Notes because the Nursing Administration Minutes for the last six months contained sufficient supporting information regarding reporting, tracking of ongoing activities, and action steps regarding recruitment and retention activities.

<u>Availability of Pertinent Medical Records</u>
Individual notebooks were present and accessible to Direct Support Professionals. Previously, the monitoring team noted recordkeeping and documentation problems. In response to the recommendations, the Nursing Department instituted an audit entitled "Documentation-Non-Clinical." The audit addressed various aspects of legal documentation, legibility of signatures, credentials, and the facility's standard for documenting late entries. The overall results of the monitoring for February 2013 through June 2013 were as follows.

Feb.	Mar.	Apr.	May	Jun.	Overall
63%	65%	66%	70%	66%	66%

The monitoring team's review of the Integrated Progress Notes reviewed for 20 records showed improvement in the legibility of the nursing documentation. One record had documented on a "white piece of paper" rather than the standard IPN record.

#	Provision	Assessment of Status	Compliance
		This was not an acceptable standard for recording documentation. The monitoring team found the same problems as identified by the facility's monitoring tool, that is, continued problems with legibility, writing in the margins of the IPN, incorrect documentation of late entries, and mistaken entries (but also see section V1). <u>Hospitalization and Hospital Liaison Activities</u> The monitoring team, in a meeting with CNE leadership, Hospital Liaison, and other team members, reviewed how the Hospital Liaison position was operationalized at LSSLC. As recommended by the monitoring team during the last visit, the responsibility for conducting death reviews had shifted to the QA Department's RN. The Hospital Liaison Nurse, having been the previous CNE, had a broad scope of understanding the importance of interaction with the Direct Support Professionals who supported the individual at the hospital, and sharing of information with the IDT. In addition, the Hospital Liaison Nurse provided information at the Clinical Morning Meetings on hospital admissions/discharges. The monitoring team was impressed that the facility had an ongoing established relationship with hospitals, where the Hospital Liaison Nurse reported making onsite rounds, visits, and had access to medical records to review at the hospital. As reported, the hospitals also were familiar with the facility's Hospital Liaison Nurse, and had contact information should any urgent or immediate needs rise that need to be communicated for the individual. These activities were excellent examples of the promotion of continuity of care. From the period of 4/22/13 through 4/29/13 the monitoring team reviewed five of the most recent hospitalizations and found: • Five of five Hospital Liaison Reports (100%) were completed and contained associated IPNs that were documented in the SOAP format • Five of five (100%) IPNs contained historical information as to the reason why the individual was admitted to the hospital • Five of five (100%) contained pertinent information on laboratory tests and the results • Two of two (100%) contained sufficient information for special needs upon discharge <u>Infection Control</u> The facility recently hired an Infection Control Nurse from the outside the facility who had a masters in nursing and planned to seek certification as an Infection Control Preventionist. The previous Infection Control Nurse who had two years of experience as the facility's Infection Control Nurse continued to assist in providing guidance and mentoring, as possible, given her work load as the new Nurse Manager.	

#	Provision	Assessment of Status	Compliance

The Infection Control Nurse appeared to be making positive strides in (re)addressing those items that did not have continued monitoring (e.g., Antibiogram reviews).

The facility's self-assessment reported that Employee Tuberculosis (TB) testing compliance was at 99.7%, but there were no data for individual TB testing compliance. During the interview with the CNE, the facility had a two months lag in data review and collection. The CNE's action plan included distribution of this assigned area to other nurses to update the database. More positively, the facility reported from December 2012 to January 2013 that Handwashing and Standard Precaution Audits showed 92.8% compliance rates.

The monitoring team attended the Infection Control Meeting on 7/10/13; chaired by the Infection Control Nurse and reviewed other minutes and reports. The agenda and meeting minutes did not include a substantive review of any occurring and re-occurring infections. The monitoring team was concerned with the high number of infections reported by the facility from October 2012 through June 13 2013. The facility reported:

Infection	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	Totals
UTI	6	2	12	7	9	5	12	8	9	70
URI	11	0	0	14	6	2	6	7	1	47
LRI	6	2	5	1	2	3	2	6	2	29
Pneumonia	20	8	5	2	3	8	2	3	3	54
C Difficile	0	0	0	0	0	0	0	2	0	2
MRSA	0	0	0	0	0	1	3	2	0	5
Ocular	8	5	4	9	9	7	11	7	9	69
Abscess Boil	4	1	1	2	0	2	1	3	8	22

A review of the 20 comprehensive records contained information of a diagnosed case of shingles for Individual #137, documented on 4/29/13, which was not reported or tracked on the quarterly infection control trends ending in June 2013. Although there was evidence of infection control surveillance identifying infections, and of providing education, there was a need to resume a much more in-depth analysis for underlying factors that contributed to the continued incidence of above infections.

<u>Wound Clinic</u>
The facility did not have a designated Wound Clinic Nurse certified in wound management. The recently hired Infection Control Nurse was assigned to conduct the clinic. The facility conducted a weekly wound clinic for individuals who were referred to wound clinic. Each week, the clinic sent out a list of individuals with set appointment

#	Provision	Assessment of Status	Compliance
		times to be seen by the Wound Team, which consisted of the Infection Control Nurse, a Physical Therapist, and a staff from HAB. Pictures were obtained for documentation of the wound or skin integrity site. The monitoring team attended the 7/10/13 Wound Clinic accompanied by the Compliance Nurse. The following individuals were seen in the Wound Clinic: Individual #540, Individual #223, Individual #437, Individual #46, Individual #542, Individual #27, and Individual #156. The latter two individuals, although scheduled, were not seen because one was receiving redirection during a behavior and one was to be rescheduled related to timing of the clinic visit. The monitoring team observed dressing changes, which followed usual standard of care in aseptic techniques. Of concern to the monitoring team, however, was Individual #540, who was observed to have large amounts of bile colored drainage from the g-tube stoma site after the binder and dressing were removed. The stoma site was measured and a picture taken. A referral was made to the gastrointestinal specialists due to the severity of the drainage. The monitoring team reviewed two records from the wound clinic of 7/10/13 (Individual #540 and Individual #542); the findings were as follows: • Two of two (100%) had a corresponding IPN for the wound clinic • One of two (50%) had documented the date and time • Two of two (100%) were documented in the SOAP format • Two of two (100%) described the wound to include measurements • Two of two (100%) had physician written orders for follow-up and or referral • One of two (50%) were not monitored for Intake and Output given the large amount of drainage observed from the g-tube stoma, coupled with drainage from the stoma documented in the individual's IPN. In the last report, the monitoring team noted the absence of a Skin Integrity Committee. The Infection Control Meeting on 7/10/13 included discussion of the development of (a still not yet developed) Skin Integrity Committee. Much work is needed here. <u>Infirmary</u> The facility had an infirmary with a bed capacity of 14. The unit had two rooms designated as isolation rooms. Reportedly, the infirmary was utilized to support individuals who required closer observation, such as after returning from hospitalization or a postoperative surgical day procedure, or for receiving special prep for a diagnostic test. The monitoring team toured the infirmary on 7/10/13 with the direct care nurses. The census was six. The individuals were supported by a Direct Support Professionals present in the room. The monitoring team was pleased to see the interaction with the Direct Support Professional anticipated the individual's personal preferences while recovering in the infirmary. One individual had a TV at the bedside and was watching a favorite TV program. The monitoring team reviewed the document request for the	

#	Provision	Assessment of Status	Compliance
		number of infirmary admissions, length of stay and diagnoses for infirmary admissions from 11/1/12 through 5/31/13. There were: • A total of 228 admissions • Average daily infirmary census over the seven month period was nine • Total days of stay in the infirmary ranged from one to 60 days • 46 of the 228 (20%) were documented as post special procedure or a hospitalization • Six of the 228 (2%) had five admissions The infirmary should continue its practices of admission for those individuals identified through hospital discharge, emergency room visits, and/or planned pre-diagnostic procedures that require more frequent assessments and/or treatments. The infirmary had the capacity to provide a higher nurse to individual ratio, during the immediate convalescent period. <u>Emergency Response</u> The monitoring team made unannounced visits to various units accompanied by the CNE or Compliance Nurse, inspected emergency equipment, and reviewed the Emergency checklist. All equipment was found to be in acceptable working order and the checklists contained dates and initials for the required checks. The pool area and the adjacent gym, however, did not house any emergency medical equipment. The monitoring team was informed by the CNE that "buildings across the road were designated sites" with emergency equipment. In order to respond with emergency equipment, one would have to run across the street, to one of two buildings, one of which was locked at 5:00 p.m. The monitoring team reviewed the facility's data for the number of drills completed and the overall pass rate for December 2012 through May 2013. In addition, the monitoring team reviewed the Emergency CPR Drill Summary December 2012 to May 2013, which included documented concerns, such as "staff continues to express concerns with emergency equipment being located at house 533 in the event of an actual emergency occurring at homes 529, 539, or 542."	

	Dec.	Jan.	Feb.	Mar.	Apr.	May	Overall
Number of Mock Drills	40	33	32	34	32	34	205
Overall Pass Rate	78%	91%	94%	91%	97%	88%	90%

#	Provision	Assessment of Status	Compliance
		The facility had two committees that overlapped in the review of mock drills: the Nursing Monthly Safety Meetings and the Environmental Safety Meetings. The monitoring team reviewed both of these documents, but was unable to discern what action steps were put in place to ensure staff's concerns were sufficiently addressed. Furthermore, after this concern was brought forward by the monitoring team, the facility said that meetings were not held from December 2012 to April 2013. <u>Quality Enhancement Efforts</u> Since the monitoring team's last review, the following activities had been initiated. • The Nursing Department developed a process where nursing leadership and the nurse managers met to review and discuss inter-rater reliability findings. The monitoring team attended a meeting held by nursing to discuss nursing audits on 7/8/13. The meeting was led by the Compliance Nurse, who shared information as to inter-rating reliability findings from the audits. In the discussion, the nurses were committed to this type of process to assist them in learning how to conduct audit, review audits, and how to recognize where the auditors were not consistent. There was also discussion of indicators, such as having vital signs have separate indicators. The Compliance Officer addressed the inter-rater reliability disagreements with the group and provided clear and concise verbal and written instructions for conducting the audits. • The Nursing Department updated the audit/schedule/assignments on 6/4/13 from the previous 3/13/13 schedule of audits. It now included the Hospital Liaison Nurse and Day Infirmary Supervisor, while removing the vacant Immunization Nurse. • The Nursing Department had also instituted tracking tools to monitor how each of the nurses had performed in documentation scores. Nurses having an individual average of 90% or higher were acknowledged and recognized through communication posting on their respective units. • Changes in the QA Department included the vacancy of two RNs. The Infirmary Nurse Manager transferred to one of the positions. In an interview with the QA Nurse on7/11/13, the QA nurse reported roles and responsibilities primarily have been focused on the completion of death summaries and tracking recommendations from the death reviews, given the open vacancy. The monitoring team reviewed the following table of monitoring data entitled Nursing Action Plans and Trend Data submitted for the period of for December 2012 - June 2013.	

#	Provision	Assessment of Status	Compliance

Monitoring Tools	Dec.	Jan.	Feb.	Mar.	Apr.	May	Jun.	Overall
Constipation	70%	69%	85%	80%	71%	83%	85%	90%
UTI	60%	77%	66%	72%	72%	66%	80%	82%
Vomiting	73%	79%	76%	83%	85%	85%	77%	93%
Acute Illness Injury	Initiated April 2013				64%	100%	85%	83%
Pain				64%	60%	75%	54%	63%

The data were presented in bar graphs and had each question scored on the monitoring tool as separate percentages. The data indicated problems in the following trends:

- Constipation: Question #9 on the tool, "any changes in appetite or meal changes," for January 2013- April 2013
- Urinary Tract Infection (UTI): Question #3 "abdominal assessment for tenderness, guarding, suprapubic distention, rebound pain, and for masses. For January 2013- April 2103
- Vomiting: Question #18, "does the assessment reflect close monitoring of the individual until stability, resolution and/or transfer if applicable?," April 2013- June 2013
- Pain: Question #4 "Quality (i.e., stabbing, gnawing, aching, burning, dull) if individual can identify, for March 2013-June 2013

The Nursing Department should investigate these items to determine what is problematic with regard to the question, responses, and or services provided, given the low scores for these questions.

The monitoring team reviewed the Nursing Corrective Action Plans from 1/23/13 through 6/10/13 on the Vomiting Audit Tool. The data captured the auditor, home, individual, nurse, score, and action plan for each of the audit tools. The Corrective Action Plan included counseling of the nursing staff. More often, the action plan steps had notations of omissions of the lung sounds not documented, questioning the presence of nausea, and abdominal assessments. The Nursing Department should consider the development of case scenarios as lessons learned from the omissions. Even with protocol training/skills training, nurses who have not worked in the field of developmental disabilities will need a considerable amount of mentoring to help better understand the need for more in-depth assessments, given that vomiting can be a symptom of a serious illness not yet diagnosed.

<u>Assessment and Documentation of Individuals with Acute Changes in Status</u>
Since the last monitoring team report, the facility continued to make progress by the implementation of various activities to enhance assessments and management of individuals with acute changes in health status. These activities included:

#	Provision	Assessment of Status	Compliance
		• Clinical Services Meetings and Morning Reports that included disciplines from Medical, Nursing, Infection Control, Psychology, Pharmacy, Reparatory, Psychiatry, Dental, HAB, and RN Hospital Liaison. The Morning Meeting was attended by the monitoring team on 7/9/13 and on 7/11/13. Campus calls, emergency room visits, hospitalization, and information on admissions and discharges were presented along with in-depth review of the individuals' health status. The meetings also served as a place for any team member who had concerns about an individual to bring the concerns forward for an open discussion. An example of this was Individual #437 who was sent out by 911 on 7/8/13 after experiencing altered mental status and low blood pressure. The CNE at the meeting discussed the individual's medication regimen and requested the team to conduct a review of Individual #437's medications. The monitoring team reviewed the meeting notes of the last five Clinical Services Morning meeting reports, 7/1/13 through 7/9/13. The monitoring team was impressed by the recordkeeping notes of the Clinical Services Morning Meeting Reports. They included detailed information on individuals' vital signs, diagnoses, current symptoms, PRN medications, laboratory tests, hospitalizations and infirmary stays. This was an excellent formatted document that also included information as to what other interdisciplinary health services individuals were receiving or may be necessary to support their health needs. Across the sample of 20 comprehensive records, there was evidence that physicians responded to nurses' notification of significant health problems requiring their attention through sick call, or by carrying out immediate orders to transport to a tertiary care facility. There was less evidence, as in the cases of Individual #588 and Individual #517, (see elsewhere in this section M of this report), of recognition that the symptoms the individuals experienced were signs of a changes in status. The nursing assessments often did not contain detailed information about the individual signs and symptoms and were deficient in an analysis as to underlying problems, and relationship to the individual's current active problem/diagnosis. Although the facility reported that all Nursing Protocols had been implemented, there remains much work to do here, to ensure the protocols transitioned in to sufficient nursing assessments for individuals experiencing a health care status change. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The facility should support the Nursing Department with activities that promote retention and recruitment, conduct in depth reviews as to the underlying problems of nursing staff turnover, and, as necessary, utilize an	

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		independent/objective source to evaluate turnover rates. The continued vacancies of nursing staff had direct impact for the individuals supported at LSSLC. Given that many individuals with intellectual and developmental disabilities have communication and other deficits and given that they are reliant on those who provide care to be their voice, a stable nursing staff is essential. 2. Develop a more refined quality management system for the specialty areas, for example, infection control and emergency response. 3. The facility should contract with a certified Infection Control Preventionist experienced with long term care facilities to address the significant number of occurring and reoccurring infections and assist in the direction of the overall infection control program, while mentoring the newly hired nurse for the Infection Control Program.	
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.	The monitoring team, as detailed below, conducted its own review of the requirements for this provision. A review of completed Nursing Discharge Summaries for Individual #216, Individual #99, Individual #340, Individual #263, and Individual #431 found: • Five of five (100%) allergies were documented • Three of five (60%) were complete for End of Life Planning • Three of five (60%) included completion of the RN signature block • Five of five (100%) identified nursing problems and level of risk • Five of five (100%) contained information about personal preferences and special instructions, some more explanative than others • Two of five (40%) nursing summaries were in depth and provided information about the individual's ongoing health surveillance needs While the summaries were consistent in providing day to day information about individuals, including risks, the summaries did not have a place holder to describe what an emergency might look like for the individual. Also, one documented that a diagnostic test result was pending, but did not provide for how the reporting LSSLC RN would follow-up or ensure the health information was communicated to others. One nursing summary was explicit in providing information regarding the individuals past behavior which included the statement that the individual "has behavior issues, including fixation on a case manager that work on the Oak Hill Unit." Nursing Summaries provide valuable information about the individual and are important in the process of transitioning care and services. Discharge summaries are considered important documents for supports and services when individuals are transferring or being discharged to other community settings. Written guidelines for nursing discharge planning did not appear to be available.	Noncompliance

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		The monitoring team selected a sample of records to review for the Admission, and for the Annual and/or Quarterly Comprehensive Nursing assessments completed over the last three months for Individual #488, Individual #437, Individual #422, Individual #542, and Individual #243. • Five of five (100%) were completed in accordance with the facility's policy • Five of five (100%) were completed in accordance with the ISP schedule • Five of five (100%) contained the RN signatures and completion dates • Five of five (100%) contained a completed Braden Scales • Three of three (100%) quarterly assessments were completed in accordance with the ISP schedule Annual and/or quarterly Comprehensive Assessments, Section I through IX showed improvement since the last monitoring visit. Nursing summaries remained problematic, however, as most contained a listing of dates, rather than summary statements. Although improvements with timeliness of the summaries was improved upon, overall most nursing summaries did not contain sufficient information in relation to whether the individuals and their health statuses were improving, maintaining, or regressing, as well as the effectiveness of their health care plans. There were problems associated with the facility's electronic systems of uploading data in a timely manner, related to changes made in the nursing assessment form. The CNE and QA Nurse worked collaboratively to quickly rectify the issues identified. The Tracking Log by Clinical Discipline Reports for the assessments contained information regarding the issues in the "May 2013 Notes" that "96% of the assessments were actually completed, but only 26% of them were uploaded to the S: Drive in time to meet the criteria on time." Notably, this also affected the percentages as this problem began in April 2013. A document entitled Settlement Agreement Compliance Report 11/1/12 through 6/30/13, Annual Nursing Assessments and Annual Nursing Care Plans provided the following in bar graphs: • Annual Nursing Assessments for January 2013, March 2013, and June 2013, achieved a rating above 90th percentile. In February 2013 they were noted at the 80th percentile. The document did not contain data for the months of November 2012 and December 2012, April 2013, or May 2013. • Annual Nursing Care Plans for 2013, for the months of January 2013 showed 70% compliance score, February 60% compliance score, March 70% compliance score, May 35% compliance score, and June 58% compliance score. No data were available for April 2013.	

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		Self-Rating The facility's self-assessment indicated "progress without substantial compliance. We do not have the data to represent full compliance at this time." Activities to support this self-assessment were: • Revised Annual/Quarterly assessment forms were implemented for implementation by 6/1/13 • Two audits were conducted on Annual Nursing Assessment in 1/13 with an overall compliance of 97% • One audit completed 2/13 - 79% • One audit 3/13 - 94% • Four audits 6/13 – 96% Although the RN Case Management staff had been stable, the facility experienced a number of recent revised changes in policy, procedure, and process with regard to nursing assessments and health care plans. The changes in process were to begin with the June 2013 ISP for Nursing Assessment and Health Care Plans, therefore, the facility had not had enough time to evaluate progress, but had been proactive in the promotion of self-help through the offering of technical assistance in the writing of nursing care plans for nursing staff. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Continue to ensure RN Case Managers and Direct Care Nurses continued to be trained in physical assessment skills; and those skills are transitioned to have sufficiently identified and documented the individual's health care problems.	
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.	The monitoring team interviewed the RN Case Manager Supervisor, accompanied by the CNE, and the state Director for Nursing Services, on 7/11/13. The RN Case Manager Supervisor reported a consistent staff of 23 RN Case Managers. The RN Case Manager Supervisor provided information that the RN Case Managers were a very collegial group and, as their supervisor, she had not experienced issues with time and attendance. The RN Case Manager Supervisor reported a need for an additional staff person to assist in fostering the RN Case Management process. The state Nursing Director discussed with the CNE and RN Case Manager Supervisor the current ratio of nurse to caseload and suggested excellent options of having a RN Case Manager float or assist with reviewing completed nursing assessments. The RN Case Manager Supervisor held monthly meetings. She reported a challenge was time management regarding completion of quarterly and annual nursing assessments.	Noncompliance

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	Nursing interventions shall be implemented promptly after they are developed or revised.	Reportedly, when a physical assessment was approaching a due date, the RN Case Manager requests assistance from the Direct Care RN to complete the assessment. The RN Case Manager Supervisor also voiced concern of an expected increase in meetings the RN Case Manager will be expected to attend, and additional data requirements with regard to the planned changes in the facility's new QA process for risks. Although the RN Case Manager Supervisor had expressed concerns of the new QA Risk process, the RN Case Manager Supervisor should also re-evaluate case management activities for duplicative/inefficient practices with the team of RN Case Managers, with regard to the utilization of how another RN Case Manager could be utilized (e.g., as a floater). The monitoring team reviewed the last six months of the RN Case Management meeting minutes and was impressed by the guiding principles used to encourage peer-to-peer assistance for absences and for integrated collaborative processes with the psychiatric department (i.e., for having MOSES and DISCUS on the same schedule as the nursing assessments). The minutes also reflected RN Case Mangers conduct of peer review on quarterly nursing assessments and caseloads to identify individuals with chronic pain or diagnoses/conditions that would like result in pain to determine if the individual had a plan of care for the management of pain or risk of pain. Findings from the reviews were reported to the RN Case Manager Supervisor. The format used for the minutes or meeting notes, however, did not lend itself to discussion of what was working, what was not working among staff, problems staff were experiencing, and supports staff needed. The RN Case Manager Supervision should consider using a format that produces a positive productive meeting with disposition of issues/concerns, and feedback to staff from lessons learned in the arena of case management. Throughout the week, in various units and at different times of the day, RNs were not visible on the various units interacting with individuals and or the Direct Support Professionals. These included the RN Case Mangers. The Nursing Department should come up with ways that provide opportunities for the RNs to engage in active treatment measures and RN Case Managers to make observations about their caseloads across all settings the individual may participate in. In this way, they gain more first-hand knowledge of how the individual's health care needs impacts work, play, and preferences. The monitoring team reviewed four of the most recently completed Health Care Plans/Acute Health Care Plans, and Integrated Progress Notes for acute illness/injury for Individual #542, Individual #46, Individual #308, Individual #542, and Individual #488. • Three of four (75)% had sufficient information to identify the reason for Health Care Plan • Four of four (100%) had sufficient goals that were measurable	

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		• Three of four (75%) Health Care Plans interventions addressed the acute illness or injury • Three of the four (75%) IPNs had documentation the protocols were followed • Four of the four (100%) included a NANDA diagnosis • Four of four (100%) had documentation Direct Support Professionals had been trained on the Health Care Plans, although it was difficult to ascertain if all shifts had been trained • Four of four (100%) Health Care Plans had documentation included staff instructions that were easily understandable • Two of four (50%) were for infections The monitoring team's review indicated progress in the assessment, development, and implementation of the plans of care, although some were noted as Acute Care and others in the same time periods were identified as Health Care Plan. <u>Self-Rating</u> The facility's self-assessment indicated, "progress without substantial compliance. We do not have the data to represent full compliance at this time." Activities to support this self-assessment were: • Weekly Volunteer Care Plan Class to discuss health care plans, and the assessment, held 4/10/13, 4/17/13, 6/5/13, 6/11/13, and 6/19 /13 • Two Annual Nursing Care Plan audits completed 1/13 with an overall compliance of 85% • One Annual Nursing Care Plan audit completed 2/13 scored at 62% • One Annual Nursing Care Plan audit completed 3/13 scored at 37% Additionally, the facility self-assessment reported that no audits were conducted in April 2013. The Action Plan had a recommendation to implement Corrective Action Plans for areas of compliance below 80% with a start date of 11/1/12, and a projected date to complete by 8/1/13, of which the completion status documented "Not started." This was assigned to the CNE/NOO. The facility had not had time to show compliance in this provision because the revised Comprehensive Nursing Review/Quarterly Nursing Review/Quarterly Physical Assessment Guidelines, and associated forms, were coordinated with the June 2013 ISPs. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Continue its systems approach with training opportunities, to include one-on-one competency based nursing summaries, to ensure that health risks factors	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>and health risk indicators are appropriately assessed, and also that they are folded into the nursing assessment to accurately match the individual's' characteristics to the ratings in determining level of risk.</td><td></td></tr>
<tr><td>M4</td><td>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.</td><td>Policies, Procedures, Protocols, and Guidelines
The Nursing Department reported they were in receipt of revised policy/protocol changes from the state office on the following: SSLC Nursing Services 010.2: Effective: 6/17/13and SSLC Enteral Nutrition Revised May 2013. They had developed and implemented the following new guidelines/protocols:
• Nursing Guidelines for Reporting Elevated Blood Pressure, Dated: 4/15/13
• Nursing Protocol: Gastrostomy Tube: Insertion by a nurse, Dated: 6/1/13

Education/Training/Inservices
• Protocol and 24 hour log, 1/31/13
• Pain Assessment Protocol, 3/1/13
• New Restraint Forms, 2/28/13
• 24-hour report, 4/30/13
• Hospital Transfer/Discharge, 5/1/13
• Emergency Drill Bags (Medical ER Response)
• Blood Pressure Guidelines, 5/31/13
• Re-insertion of G-Tube, 6/7/13
• Mosby's Quarterly Class Musculoskeletal System (December2012, January 2013, and February 2013)
• Mosby's Quarterly Class Neurologic System (January 2013, February 2013, and March, 2013)
• Acute Care Plans Class, 5/31/13
• SOAP Documentation Class
• Medication Administration Class, 5/31/13
• Initiated last five Protocol Cards,

Since the last visit by the monitoring team, 24 nurses had been hired. Twenty (83%) completed the orientation. In addition the facility had an ongoing Preceptor training program. As reported, 8 of 36 (22%) were recertified.

As reported from the document entitled: Nursing Action Plans and Trends, Combined Protocol Monitoring Audits from January 2013 – June 2013, showed:

<table><tr><td>January 2013</td><td>February 2013</td><td>March 2013</td><td>April 2013</td><td>May 2013</td><td>June 2013</td></tr><tr><td>70%</td><td>74%</td><td>81%</td><td>70%</td><td>76%</td><td>77%</td></tr></table></td><td>Noncompliance</td></tr>
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		On a positive note, the facility continued to make progress given the vast amount of required education/training that had taken place since the last review and the absence of a full complement of nursing staff. The Nursing Department was commended on the design and use of auditing flow chart forms for conducting audits on initial assessments addressing protocols. The monitoring team was provided two examples of completed audits in May 2013 and June 2013. These examples were excellent training examples. In addition, the form contained a comments and corrective action plans sections. During a visit to one of the units on 7/9/13, the monitoring team, accompanied by the CNE, found the following: Individual #588 had the presence of dried blood surrounding his pinky finger from reportedly, "picking at skin around the nail bed."' Individuals'#517 had a visible scalp injury and reportedly "had returned from getting a haircut; and had dried blood on the scalp." The CNE immediately put in place corrective action plans for both individuals' to be assessed by nursing staff. The monitoring team, with the CNE, reviewed the individuals' records and dually noted omissions of completed incident reports, or notifications to the nurse with regard to assessments and treatments for their discovered injuries, occurring prior to the monitoring team's direct observation. The CNE made the necessary contacts for the initiation of injury reports. A follow-up onsite review by the monitoring team, accompanied by the CNE, occurred on 7/10/13, which included observations of Individual #588 and Individual #517, as well as a review of individuals' records; both of whom now had a completed incident report and corrective actions taken by nursing to document assessments and administered treatments for the injuries. The documentation also included instructions for the Direct Support Professionals. Nonetheless, the reviewed assessments did not address the underlying reason or previous history as to how the injury occurred for Individual #517. In the monitoring team's review of the documentation requested for Individual #517 and Individual #588, the following issues were found to be problematic regarding the recent care of these individuals. Some of these problems included: • Medical records from 5/2/13 through 7/7/13 contained six episodes of vomiting, none of which involved placing the individual on sick call for vomiting or notification to the physician for the vomiting. • Two of the vomiting episodes documented a large amount of vomitus. One, described as a cup of brown vomitus; one, two cups (documentation was absent for the color).	

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		• Two vomiting episodes were documented as occurring "when the individual was in the bed, on awakening. " • Quarterly Nursing Record Review 4/29/13 through 7/1/13 had omissions for acknowledgement and analysis of vomiting episodes relevant to the individual's gastrointestinal track function. • ISP Goal: indicated the individual "will be free of indigestion or vomiting." • Omission of trigger sheets for May 2013, June 2013, and July 2013 • Omission of the nursing protocol being followed, including (a) description of the color of the vomitus (b) Hemoccult results if indicated, with regard to the brown vomitus. • Omission of the indication the individual gastrointestinal issues were being addressed with the IDT team. Since the prior monitoring team's review, the Nurse Educator had done an outstanding job in working with the nursing teams having accomplished the required training. The facility's action steps, while a direct response to the last review, were dispersed across provisions M1-M6. For this provision, the previous review included a recommendation for a meeting between the CNE and QA Director to discuss QA Nurse and the Nursing Department's nurse assignments, to include monthly audits for the purpose of inter-rater reliability checks. As of this review, this corrective action had not been acted upon. In the monitoring teams' interview with the QA Nurse, attended by CNE, this was confirmed. As the CNE returned 6/1/13, reportedly, there had not been ample time to set up meeting for these discussions. The QA Director and CNE reported the work relationship for identifying and reporting problems in nursing. Nonetheless, the facility should include in the collaboration with the QA Department, a nursing a process to conduct their own nursing audits when identifying problems. Although there were notable improvements in M4, as exampled by many of the education activities, the monitoring team was not in agreement with the facility's self-assessment. Recent changes in nursing policies, procedures, protocols, and processes had not had sufficient time to put processes in place in order to adequately assess substantial compliance. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Expand efforts focusing on integrated assessments and health care practices across the facility ensuring health care needs are addressed.	

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M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	Of 20 records reviewed, eight had completed Integrated Risk Rating Form (IRRFs) and Integrated Health Care Plans (IHCPs). The review found: • Eight of eight (100%) had comprehensive interdisciplinary assessments completed • Eight of eight (100%) IRRFs provided baseline data that helped to identify risk ratings, though some were more detailed and explanative than others • Four of eight (50%) IHCPs identified relevant clinical indicators • Four of eight (50%) IHCPs were clinically sufficient to meet the needs of the individual's identified risks • Three of eight (37%) were sufficiently integrated for all disciplines • One of eight (12%) IHCPs sufficiently addressed the inclusion of the Direct Support Professional in the participating of reducing risk through prevention activities, detailed observations, and reporting, as opposed to others that were more task oriented for the Direct Support Professional • Three of eight (37%) IHCPs included preventative interventions to minimize individuals risk rating health conditions • Four of eight (50%) contained functional and measurable objectives in the ISP to measure the efficacy of the individuals plan • Two of three (66%) IHCPs and IRRFs relevant to a change of health care status, were appropriately updated • Example: Individual #517: Review of the Individual Support Plan (ISP), IRRF, and IHP dated found that the Individual #517 was assessed at low risk for gastrointestinal (GI) based on no reported nausea or vomiting or constipation events. The 3/11/13 IHCP documented Individual #517 was receiving, before meals and before bedtime, a medication for the treatment of gastritis. Gastritis and Helicobacter pylori (H. pylori a bacterium found in the stomach) were listed as inactive problems on the medical problem list. Weight loss and constipation were noted to be active problems on the medical problem list. The ISP indicated that he had begun refusing medications March 2012. On 4/12, the ISP documented the medication to treat gastritis was discontinued. Over the last quarter (through June 2013), Individual #517 experienced a weight loss of 7 pounds, and from July 2012 through February 2013, a significant weight loss of 35 pounds. An appetite stimulant was prescribed. Over a six-month period, the individual had 39 meal occurrences/episodes of meal refusal. In addition, the ISP reported the individual had a 75%increase in target behaviors over the last six months. Combined with the meal refusals, weight loss, discontinuation of the medication for gastritis, an increase in target behaviors, history of positive for H. pylori, and gastritis, the IDT should have considered Individual #517 to be at high risk for gastrointestinal (and for need for intervention).	Noncompliance

#	Provision	Assessment of Status	Compliance
		Self-Rating The facility's self-assessment indicated "progress without substantial compliance." Activities to support this self-assessment were: • Review of 26 audits completed by the ADOP yielded a 25% compliance rating for At Risk process." To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Nursing Department should place emphasis on the development of a system of assessing, documenting, evaluating, monitoring, and re-evaluating health risk and integrated risk plans for the individuals that include understanding the health risks and a risk indicator for individuals with intellectual and developmental disabilities.	
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.	Administration of Medications The monitoring team conducted 23 unannounced medication administration observations and interviewed eight nurses during various times of the day and evening 7/8/13 through 7/11/13. The monitoring team was accompanied by a member of the nursing leadership team for all medication passes. These observations included administration of oral, crushed medications, medications via tube, medications given with different mediums, such as pudding, applesauce, and thicken liquids. The observations included (as per the individuals Physical Nutritional Management Plan) use of adaptive equipment, such as a nosey cup. One observation included application of external medication. The observations were measured against the facility's Medication Administration Guidelines. Findings from the Medication Administration Observations were as follows: • Two of 23 (9%): Omissions of the use hand sanitizer between administration of medications o 21 of 23 (91%): washing of hands after the third administration of medication, even though facility practice (not policy) was after the fifth administration. • One of 23 (4%): Omission to observe individual to ensure medication was swallowed • One of 23 (4%): Omission to provide privacy during medication administration • One of 23 (4%): Omission to follow accepted standards of care in the application of an external medicated powder Notably, the attending Compliance Nurse prompted and re-directed the nurse and other support staff with regard to hand hygiene and privacy. The monitoring team was troubled by the application of an external medicated powder because the nurse had an	Noncompliance

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		omission in appropriately assessing the area prior to the administration of a powder to the perineal area. The nurse applied the powder pulling the individual's brief to the side, rather than removing the brief completely prior to application. This was the same individual who was not provided sufficient privacy. One individual was observed having difficulty in arousing for medication administration. The individual had reportedly been asleep and had placement of respiratory equipment to support positive pressure respirations. During the observation, the nurse removed the respiratory equipment and obtained a washcloth to try and arouse the individual. Reportedly, per the medication administration nurse, this had been a consistent problem in arousing the individual to administer medications on the evening medication pass for several days. The monitoring team pointed out to the Compliance Nurse that the individual was extremity cool to the touch and the inability of staff to arouse during the observation. The Compliance Nurse prompted the nurse to obtain vital signs. Within minutes, another nurse, who also was familiar with the individual, came to the room to assist with the assessment. A physician was called and orders were received to transport the individual to the hospital emergency department via 911. Overall, however, the nurses administering medication were familiar with the individuals, the staff who supported the individuals, the individuals' preferences to mediums or liquids. During the medication pass there was much interaction between individuals, the Direct Support Professional, and the nurses. <u>Documentation</u> • 23 of 23 (100%) of the observed medication passes were accurately recorded in the medication entry box and there was a corresponding signature for each of the initials • 22 of 23 (95%) had no blanks on the Medication Records for July 2013 <u>Storage and Security of Drugs</u> All units where medication passes were observed included a focused physical inspection of the locked medication drawer located on the medication cart, and cabinet stock of external and internal medications. • Infirmary: expired medicated foot powder • Unit 523: oral rinse placed in with external medications • Unit 523: hydrogen peroxide opened, not dated As reported, the CNE, Nurse Managers, Compliance Nurse, Nursing Operation Officer, in addition to the administering nurse, had access to the Medication Administration Rooms. The monitoring team was unable to discern from the interviews if this extended beyond	

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		to the Medication Rooms, for example the after-hours medication box, or medication carts, as to facility user access. <u>Oversight and Monitoring</u> The monitoring team attended the Medication Variance Committee Meeting on 7/9/13. The meeting was chaired and the data presented by the CNE. The NOO was present as well as the attending nurse managers who were familiar with the data and were able to discuss and respond to questions about specific occurrences of variances, as well as what corrective actions were put in place to mitigate medication variances. During the review and discussion of data, a category displayed in bar graph, known as "other," had a significant increase from May 2013 to June 2013 by 18%. This was later explained by the attending pharmacist as "as dispensing errors categorized as other." This was further confused by the bar graph node, which captured dispensing as 0% for May 2013 and 2% for June 2013. The meeting was attended by state Office Nursing Coordinator, to which the monitoring team expressed a concern regarding the capturing of medication variances, specifically related to the discovery and counting of transcription medication variances, as one variance rather than a multiple variances based on the number of days of omission the caused by the variance. Review of minutes from the last six months of Medication Variance Committee Meetings showed an absence of documentation of the presence of a physician at any of the meetings. This was problematic given that a medical director (or representative physician) is an integral member of the committee. To the credit of Nursing Department, greater presence of nursing personnel from each of the units was consistently documented. Notably, the pharmacist was in attendance at each meeting. The 5/16/13 Medication Variance Committee Minutes reflected the pharmacy and nursing " will meet to review and discuss Medication Variances and look at identifying factors causing medication variances and discuss how they can be avoided." Because this was a new process, sufficient data were not available to review as to the outcomes of the process change. The monitoring team reviewed the Pharmacy and Therapeutics Committee minutes for 1/19/13 and 5/9/13. The Pharmacy and Therapeutics Committee was attended by the CNE. The January 2013 Pharmacy and Therapeutics Committee Minutes indicated the agenda item, "Medication Variance was deferred as this date has already been held." The May 2013 Pharmacy and Therapeutics Committee Minutes denoted, "next quarter nursing and pharmacy to present overall presentation." Later it was learned the meeting	

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		between pharmacy and nursing to reconcile medication variances was cancelled due to the NOO being on leave. Also see section N8 of this report. Per a document request by the monitoring team for the last month of medication variances, a spreadsheet of raw data entitled "fiscal Yr 12-13" was provided. The document provided detailed information as to the discovery date, variance date, node, type, category, home, generic drug name, and involvement of pharmacy, nursing, or physician. The findings by the monitoring team were as follows: • 12 of 60 Variances (20%) were transcription variances, for June 2013 • Eight of 12 (66%) transcription variances were discovered within 24 hours; one was 12 days later, and one was seven days later, for June 2013. Transcription variances reporting were problematic as they did not represent the significance of the error, as exampled by the one medication variance that continued for 12 days, but was counted only as one variance. The facility should re-assess its practice's for documenting/counting transcription variances. The monitoring team requested the most current 20 medication variances, IPN, Medication Variance form, and count sheets. The results are as follows: • 17 of 20 (85%) of the Medication Variance forms were completed as applicable. Two were incomplete as to the time and location of variance; for one, the second page of the form was absent. • Ten of 20 (50%) were discovered within 24 hours of the variance. One was discovered after 17 days, using the first date noted on the medication variance form; two variances were recorded on one form. The individual received medication for high blood pressure, contraindicated by the MAR Parameters for Nursing Interventions for pulse. One, a transcription variance was not discovered for 12 days, where the individual did not received an accurate dose of an injectable medication for the treatment of a chronic anemia with Chronic Kidney Disease Stage IV (CKD IV). One, individual received medication for "palpitations" contraindicated by the MAR Parameters for Nursing Interventions for pulse. • Seven of 20 (35%) did not include notification to the physician. Four included omissions where the individual did not receive their medications. • 14 of 20 (70%) medication variances described how the variances occurred. • Seven of 20 (35%) contained corrective actions included supporting the nurse through mentoring • Medication Trends by unit: 561A, six of 20 (33%)	

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		Self-Rating: The facility self-assessment indicated that: "progress without substantial compliance". Activities to support this self-assessment included: • Development of an integrated process to the implementation of adaptive equipment, with special instructions on the PNMP • Medication Nurses completed integrated training on 5/31/13 • Conducted 121 medication pass observations, with no documented occurrences of missing PNMPs on the MARs • Implementations of a new medication pass observation form in 1/13 includes essential elements • Conducted 121 medication pass observation December 2012- May 2013 • LSSLC nurses administer medications in a designated private area • Conducted surveillance with regard to 24 of 29 medication variances occurring in the first week of December 2012 • Discontinued the practice of rotating medication carts and re-instituted counting as a result of the surveillance • Revised Local Medication Variance Policy to include Category C and D variances (per facility director) • Reviewed Medication Variances with the Medication Variance Committee Although not clearly defined in the self-assessment, there were some indications from the onsite interviews and observations that a significant amount of time was devoted to ensuring the appropriate storage of medications and ensuring medications were not outdated. Many of the nurse managers' reported this task requiring eight hours. The facility self-assessment indicated the percentage of compliance for medication room inspections were as follows for November 2012 through May 2013. November: 92%; December: 50%; January: 50%; February: 92%; March: 92%; April: 100%; May: 100% The Nursing Action Plan and Trends Synopsis of Inter-Rater Reliability review dated 6/10/13 self-reported that during the document preparation it was discovered medication administration observations were 40% delinquent in the first quarter and 60% delinquent in the second quarter. Reportedly, there were two medication pass observations that were conducted and completed on an "outdated form." The facility had developed a corrective action plan to become compliant with medication administration observations. Since the previous monitoring team report, improvements were made in medication	

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		practices, exampled by collaboration and integration with other health related disciplines in some aspects of Medication Safety. Despite these corrective actions there remained the need for improvement in the following practices: • Improved interaction between pharmacy, prescribers, and nurses to resolve discrepancies observed in written and verbal medication orders • Anticipate and address problems with the administration of medications • Continue to improve upon a more coordinated system of ownership, that can collect, report and analyze meaningful data; inclusive of all disciplines that prescribe, transcribe, and administer; as the Nursing Department should not be viewed as the sole owner of medication processes • Invest in some simple measures to encourage reporting of both potential and actual variances to address under reporting • Ensure lessons learned from medication variances ensure that they are fed back into practice • Continue to foster the importance of system-related causes rather than of individual actions • Consider the top percentages of drugs being utilized, consider using a minimum and maximum products when stocking medication rooms/medication carts To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The facility must have systems in place for administering, transcribing and monitoring, components of safe medication processes.	

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o DADS Policy #009.2: Medical Care, 5/15/13 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, rev4/1/13 o LSSLC Lab Procedure Matrix, date unknown o LSSLC Moses Assessments – For General Medication Side Effects Monitoring, DISCUS Assessments For Tardive Dyskinesia and Extrapyramidal Side Effects Monitoring, 9/12 o LSSLC Operational Procedure, Pharmacy and Therapeutics Committee, 6/1/13 o LSSLC Policy: Pharmacy Medication Order Processing, Procedure or Filling and Verification, 11/12 o Pharmacy and Therapeutics Committee Meeting Minutes, 1/29/13, 5/9/13 o Medication Variance Committee Meeting Minutes, 12/20/12, 1/17/13, 2/21/13, 4/18/13, 5/16/13 o Adverse Drug Reactions Reports o Drug Utilization Calendar o Drug Utilization Evaluations o Bactrim, 1/27/13 o Phenobarbital, 4/28/13 o Trazodone, 7/10/13 o Quarterly Drug Regimen Review Schedule o Quarterly Drug Regimen Reviews for the following individuals: • Individual #484, Individual #93, Individual #380, Individual #170, Individual #46, Individual #44, Individual #352, Individual #172, Individual #191, Individual #580, Individual #290, Individual #479, Individual #238, Individual #101, Individual #60, Individual #130, Individual #500, Individual #402, Individual #64, Individual #129, Individual #91, Individual #504 o MOSES and/or DISCUS Evaluations for the following individuals: • Individual #28, Individual #85, Individual #574, Individual #484, Individual #340, Individual #215, Individual #465, Individual #411, Individual #20, Individual #202,

	Individual #284, Individual #22, Individual #321, Individual #320, Individual #507, Individual #375, Individual #584, Individual #453 Individual #189, Individual #99, Individual #532, Individual #221 Individual #477, Individual #562 Individual #11, Individual #521, Individual #388, Individual #108, Individual #467, Individual #202, Individual #361, Individual #131, Individual #130, Individual #500, Individual #402, Individual #129, Individual #504, Individual #238, Individual #101, Individual #64, Individual #91, Individual #60 Interviews and Meetings Held: o David Leeves, RPh, Pharmacy Director o Laura Luna, RPh, Staff Pharmacist o Andra Self, Clinical Services Director o Janis Rizzo, RPh, Contract Pharmacist o Dickerson Odero, MD, Primary Care Physician o Ronald G. Corley, MD, Primary Care Physician o Nelda Johnson, APRN, Family Nurse Practitioner o Tammy Nelson, LVN, Medical Administrative Assistant 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 pharmacy director 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 self-assessment did not necessarily align with the types of assessments completed by the monitoring team. For example, the review of the QDRRs by the monitoring team assessed timelines for completion. The content of the QDRRs was also assessed to determine if the required items were present. The clinical pharmacist assessed the compliance with laboratory monitoring, etc. However, there was no assessment of the content of the QDRRs. That is, did the clinical pharmacist actually include all of the required elements and make appropriate recommendations. For Provision N4, the self-assessment noted that 100% of recommendations either were accepted or had appropriate justification for rejection. This result was in stark contrast to the findings of the monitoring team and comments of the clinical pharmacist. This may have been attributed to the sample reviewed.

	Overall, based on the self-ratings, it would appear that additional work is needed in completion of the self-assessment. The facility found itself in substantial compliance with provision items N1, N2, N3, N4, N5, and N7. It found itself in noncompliance with N6 and N8. The monitoring team found the facility in substantial compliance with provision items N2, and N3. It found the facility in noncompliance with provision items N1, N4, N5, N6, N7, and N8.
	Summary of Monitor's Assessment: At the time of the compliance review, the pharmacy department was staffed with a pharmacy director, full time pharmacist, and four technicians. The clinical pharmacist resigned on 6/6/13. A contract pharmacist began working the following week. The facility indicated that she was a clinical pharmacist and she explained that she had extensive experience. A review of the credentials indicated that, unlike the other clinical pharmacists who worked at the facility during recent years, she did not hold a Doctor of Pharmacy degree. Her primary role was the completion of the QDRRs. This review was somewhat hampered by the fact that the clinical pharmacist who was responsible for addressing many issues related to the Settlement Agreement was no longer working at the facility and was not available to provide information. The pharmacists were documenting the communication with providers, but most communication appeared to occur with nursing staff. The resolution of problems was also not always documented. The facility had not properly implemented all of the Intelligent Alerts. Physician order writing improved, but there continued to be significant issues related to an excessive reliance on the use of verbal orders. Verbal orders frequently required clarification and some staff attributed medication errors to this practice. The facility made good progress in completion of the QDRRs. The clinical pharmacist completed the reviews in a timely manner and the content was improved. Most physicians reviewed the QDRRs within the required timelines. The MOSES and DISCUS evaluations were completed by nursing staff. The psychiatrist completed the required reviews and overall this was accomplished within the required timelines. The monitoring team found no evidence that the information was used by the primary providers nor was it reviewed by the neurologists. The facility was also not consistent in the forms utilized for reviews. The ADR reporting and monitoring system remained unchanged. Reporting of ADRs was scant and for those ADRs reported, the forms were usually not thoroughly completed. Many suspected ADRs were identified in the QDRRs and other documents, but no ADR form was completed. The facility completed three DUEs in a timely manner and presented the findings to the Pharmacy and Therapeutics Committee. The content was adequate, but for the most part, the medical staff was not present when the findings were presented at the P&T Committee meetings. Moreover, follow-up related to deficiencies was inconsistent. LSSLC continued to have significant issues related to the medication variance system. Variances continued

	to be under-reported. The accuracy of the information was also in question because assignment of the correct discipline and severity level for many variances seemed incorrect. The lack of a full time clinical pharmacist who was involved in all aspects of the delivery of pharmacy services was evident in several aspects of the compliance review. These are discussed in the various sections of this report. The clinical services director will need to ensure that the administrative duties of the department are fully executed. The monitoring team received minutes from the Pharmacy and Therapeutics Committee that were unsigned. The May 2013 minutes appeared to be a draft because the document included handwritten notes, changes, doodling, and strikethroughs resulting in minutes that could not be followed very well. The facility implemented a procedure for the Pharmacy and Therapeutics Committee in June 2013. This procedure essentially adopted the guidelines as set forth in Appendix A of the Health Care Guidelines. It did not specify the frequency of meetings.

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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	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 procedure related to medication order processing was revised in November 2012. The policy provided information on the requirements for writing medication orders and the responsibilities of the pharmacy staff. It did not provide any specific guidance on the Intelligent Alerts. The pharmacy director submitted a WORx generated report that included a total of 35 clinical interventions for the reporting period of October 2012 through May 2013. The majority of the interventions were related to drug-drug interactions. There were also several interventions related to medications that were prescribed when the individual had a documented drug allergy. The clinical interventions report indicated the problems and recommendations made to the prescribers, but the resolutions were inconsistently documented. In fact, approximately 50% of the clinical interventions had no well-delineated resolution. In addition to the clinical interventions report, the facility also submitted six pages of notes extracts that included information related to issues, such as stocking, order clarification, and other concerns that were primarily addressed with the nursing staff. The monitoring team reviewed the clinical interventions report and notes extracts with the pharmacy director, staff pharmacist, and clinical services director during the onsite review. Following discussions, the clinical services director presented an additional document related to review of physician orders. Each of the three reports submitted highlighted recurrent problems related to incomplete medication orders, therapeutic duplication, medication allergies, legibility of orders, and incorrect drug forms. The monitoring team confirmed, through a review of a sample of physician orders, that physician order writing remained problematic although the problems appeared less	Noncompliance

	literature.	extensive in comparison to the November 2012 review. In addition to the aforementioned concerns, it was observed that some physician order forms also failed to document medication allergies as required. The active records and order sample included many orders that were verbally given. Many of these orders occurred during normal work hours and addressed routine issues. Staff reported that verbal orders were associated with numerous medication variances. In spite of these problems, the pharmacy director could not provide additional information on how these problems were addressed. The data had not been organized in a manner to allow analysis to determine the issues that were most problematic. 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 eight drugs: carbamazepine, dilantin, valproic acid, phenobarbital, lithium, levothyroxine, potassium, and warfarin. LSSLC did not expand the list beyond the required minimum eight drugs. The pharmacy director provided a report of the Intelligent Alerts. It was clear to the monitoring team that several drugs, frequently used at the facility, were not included in the report. Upon further investigation, the pharmacy director determined that the Intelligent Alerts had not been implemented for drugs, such as lithium, phenobarbital, and dilantin. It was reported that this deficiency was corrected during the review. The clinical pharmacist, who participated in several of the interviews, reported that she had found a lack of monitoring for some individuals. <u>Compliance Rating and Recommendations</u> The lack of (1) adequate clinical interventions for medication order problems, (2) documentation of resolutions for the reported clinical interventions, (3) data review and analysis to assist in trending and implementation of appropriate corrective actions, and (4) proper implementation of the Intelligent Alerts module resulted in the monitoring team finding this provision item in noncompliance. To move in the direction of substantial compliance, the monitoring team recommends the consideration of the following: 1. The documentation of discussions that occur between the pharmacists and prescribers must be improved. There should be more documentation of the communication and clear identification of the resolution of issues. 2. The pharmacy director, clinical pharmacist, and medical leadership should work together to develop a plan to address medication order problems. 3. There should be collaboration between the pharmacy and the medical staff to identify additional drugs that require important lab monitoring prior to dispensing.	

		4. The pharmacy director should review the IA report frequently to ensure that the IAs occur as required. This information should be reviewed with the medical leadership of the facility.	
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.	Progress was seen in the facility's completion of the QDRRs. The records reviewed contained current QDRRs. A total of 24 QDRRs was reviewed. The monitoring team observed significant improvements in the QDRR process, both in timeliness of completion by staff and in the content of the evaluations. A number of noteworthy improvements in content were observed as well as some issues that require remediation: • The comments section of the QDRR report included the results of the required laboratory monitoring based on the lab matrix. Additional information could be obtained by review of the QDRR worksheets. The QDDR reports and worksheets were identified in all of the active records reviewed. • The anticholinergic burden of each medication was listed when appropriate. Additionally, the overall anticholinergic burden for the individual was addressed. The results of the MOSES and DISCUS evaluations were briefly summarized and mitigation of the risk and management of the side effects were also addressed. • Polypharmacy for psychotropic and seizure medications were discussed in the comments. • The criteria for metabolic syndrome were discussed for those individuals who were at risk due to the use of medications. • There was improvement in the identification of recommendations. There continued to be issues in the comments section that were worthy of formal recommendations because prescribers did not need to acknowledge comments. • The lab matrix reviewed did not include a revision history. Meeting minutes discussed changes related to phenobarbital monitoring and eye exams, but the matrix did not reflect those changes. There was no requirement for eye evaluations related to quetiapine use in the lab matrix. The aforementioned changes resulted in QDRRs that were more robust in content and provided more clinically relevant information in comparison to the previous review. Even with positive changes, the monitoring team noted that opportunities for improvement in the clinical content. The following are a few examples of problems related to content and clinical issues of the QDRRs: • Individual #93, 4/15/13, received 1400 mg of Seroquel which the pharmacist noted was above the maximum dose. The individual had a history of syncope, but there was no discussion related to the use of a Seroquel, which is known to cause orthostatic hypotension. The provider noted that the individual would be monitored. This individual also had a platelet count of 104k in August 2012, but no repeat value was documented and there was no recommendation to obtain a follow-up study. The eye exam was overdue, but no formal recommendation was made to complete the evaluation. The criteria for metabolic syndrome were met, but there was no review of a suspected	Substantial Compliance

		ADR. • Individual #191, 4/10/13: The results of the BMD testing indicated that the individual had osteoporosis. The clinical pharmacist made the recommendation to consider additional treatment. The physician responded, "no change needed" without any further explanation. The pharmacist did not make any additional recommendations, but noted the physician's response. In the absence of the lead physician and clinical pharmacist, the monitoring team had no information related to how responses, such as these, were managed if the pharmacist continued to believe that treatment should be considered. • Individual #91, 7/3/13: A recommendation was made to obtain a HbA1c since the last was dated 6/9/12. Zyprexa was indicated for autism. • Individual #336, 5/2/13: The pharmacist documented prolactin levels of 110,72 and 50. The hyperprolactinemia was associated with the use of Risperdal. This was not reported as an ADR. In addition to opportunities for addressing clinical issues, the monitoring team noted patterns related to completion of QDRRs by the medical staff. Fourteen of the 24 evaluations involved the use of psychotropic agents. According to the signature dates, the psychiatry staff generally reviewed the evaluations promptly. The QDRR policy required psychiatrist review the QDRR only when there was polypharmacy. It appeared that the psychiatrist reviewed the evaluations whenever the individual received psychotropic medications. Upon receipt, most primary providers also reviewed the QDRRs promptly. One primary provider consistently failed to include the date of review. Moreover, for the same provider, there were some QDRRs that included a date of review, but the dating was clearly not done by the provider who signed the document. The P&T minutes, dated 1/29/13, documented that this provider was not reviewing the QDRRs in a timely manner. Three of 24 QDRRs had delays of more than two weeks from pharmacy completion to provider review. Several QDRRs included comments from the clinical pharmacist stating that the QDRR from the previous review period was not filed in the records. <u>Compliance Rating and Recommendations</u> The monitoring team agreed with the facility self-assessment's rating of substantial compliance for this provision item. To maintain substantial compliance, the monitoring team recommends the consideration of the following: 1. The facility should date stamp each evaluation when it is returned to the medical services office prior to filing in the active records. 2. The QDRR must address polypharmacy for all medication classes and should not be limited to psychotropic polypharmacy. 3. The QDRR policy should be revised to include the requirement for psychiatric review whenever the individual receives psychotropic medications.	

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. There was improvement in most of the five areas monitored. Those improvements are discussed in further detail below. <u>Stat and Emergency Medication and Benzodiazepine Use</u> The use of stat medications and benzodiazepines was documented in the QDRRs. When chemical restraints were utilized, the dose of medication, effectiveness, and post-sedation monitoring were documented in the comments. Overall, the QDRRs were much improved in this area. 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 psychotropic polypharmacy occurred, the clinical pharmacist provided commentary on justification and monitoring. Some evaluations also included recommendations for reduction of polypharmacy. The LSSLC QDRRs addressed psychotropic polypharmacy and AED polypharmacy. The general polypharmacy requirement is discussed in section N2. Psychotropic polypharmacy and the Polypharmacy Oversight Committee are addressed in further detail in section J. <u>Anticholinergic Monitoring</u> Each of the QDRRs included the anticholinergic burden of relevant drugs as well as an overall assessment of the anticholinergic burden for the individual. Additionally, some QDRRs provided information from the MOSES and DISCUS evaluations regarding symptoms the individual experienced as well as recommendations to decrease the anticholinergic burden. This was a significant improvement from prior reviews. <u>Monitoring Metabolic and Endocrine Risk</u> The facility monitored individuals for the metabolic risks through the QDRRs. The worksheet included a section listing the criteria for diagnosis. This information was usually summarized under the comments section of the QDRR report form. An overall statement relative to risk was included in the comments. Greater attention must be given to ensuring that the laboratory requirements are completed in accordance with the lab matrix. <u>Compliance Rating and Recommendations</u> The monitoring team agreed with the facility self-assessment's rating of substantial compliance for this provision item. To maintain substantial compliance, the monitoring team recommends the consideration of the following: 1. The facility must continue to refine the review of the risk assessment process as it relates to monitoring for metabolic syndrome. The medical staff should identify in the Annual Medical Assessments when an individual is at risk. The risk assessment should include mitigation of risk as well as a plan of care when mitigation is not possible. 2. Laboratory studies should be completed within the defined timeframes.	Substantial Compliance

		3. The Polypharmacy Oversight Committee should continue to review individuals who receive multiple psychotropic agents. The facility needs to review the objectivity of this oversight process since the process is essentially administered by the psychiatry clinic.	
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. As discussed in section N1, the pharmacy department did not provide consistent or adequate information on the responses of the prescribers to the prospective reviews. Beginning in September 2012, the clinical pharmacist began tracking responses to recommendations in the QDRR Intervention Tracking Log. Each QDRR included comments from the clinical pharmacist on the response of the prescriber to the previous recommendations. The prescribers accepted many recommendations made by the clinical pharmacist. The decision to accept or reject pharmacy recommendations is a discretionary one. However, this provision item requires that the prescriber document in the individuals medical record, a rationale when recommendations are not accepted. State and local policy required documentation of the explanation on the QDRR report form. The monitoring team found little evidence that this occurred on a consistent basis for all prescribers. Many of the QDRRs reviewed documented the rejection of the recommendations as well as the lack of a rationale. The clinical pharmacist also documented in several QDRRs the failure to appropriately implement recommendations that were accepted. The monitoring team noted that this pattern was provider specific. In the absence of the lead physician and clinical pharmacist who completed the reviews, the monitoring team could not determine if the clinical pharmacist referred outstanding QDRR issues to the lead physician. Facility staff were aware of this problem because the medical audits indicated low compliance scores for this requirement. The lack of timely provider review is discussed in section N2. <u>Compliance Rating and Recommendations</u> The failure to demonstrate that providers consistently reviewed recommendations in a timely manner and document a rationale for not accepting recommendations resulted in this provision item remaining in noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The pharmacy staff must clearly identify the outcomes and resolution of the identified medication issues, both prospectively and retrospectively. Prospective clinical interventions should have clear documentation of the resolution. The lead physician/clinical services director should be notified when issues are not resolved in a prompt manner. 2. The clinical pharmacist should continue to follow-up on the recommendations in the QDRRs, ensuring that issues that require immediate resolution have proper attention.	Noncompliance

		The lead physician/clinical services director should be notified when issues are not resolved promptly. 3. The clinical pharmacist should provide data to the lead physician/clinical services director each quarter on the status of recommendations. These data should be utilized, as warranted, to address prescriber practice patterns and implement corrective actions.	
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.	This provision item addresses the requirement to have, at a minimum, a quarterly evaluation of side effects completed by facility staff. Achieving compliance requires timely and adequate completion of the evaluation tools. Moreover, the intent of the evaluations is to provide clinically useful information. This provision item does not specifically address the pharmacy department's assessment of compliance with the requirement. The facility utilized the Dyskinesia Identification System: Condensed User Scale to monitor for the emergence of motor side effects related to the use of psychotropic medications. The Monitoring of Side Effects Scale was completed to capture general side effects related to psychotropic medications. While nursing conducts the reviews, the evaluation requires review and completion by a physician. 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, were reviewed. The findings are summarized below: Thirty-three MOSES evaluations were reviewed for timeliness and completion: • 32 of 33 (97%) were signed and dated by the prescriber • 27 of 33 (82%) documented no action necessary • 3 of 33 (9%) lacked a prescriber conclusion (blank) Twenty-two DISCUS evaluations were reviewed for timelines and completion: • 22 of 22 (100%) were signed and dated by the prescriber • 18 of 22 (82%) indicated no TD • 1 of 22 (5%) indicated the presence of TD • 3 of 22 (14%) had no prescriber conclusion (blank) The completion of the evaluations by the prescribers represented significant progress. Notwithstanding this improvement, a number of issues were identified with the process. First, there was no evidence that the information was reviewed by the neurology consultants. The evaluations were not included in the information packet prepared for neurology clinic. The monitoring team observed this process prior to the clinic evaluations and it was clear that the neurologist did not review the information in clinic or comment on the information in the consultation notes. Second, none of the records and various documents provided any suggestion that the primary providers reviewed the evaluations apart from the comments noted by the clinical pharmacist in the QDRRs. Finally, the format of the MOSES evaluations varied. The prescriber review consists of three items: a conclusion related to the presence or absence of side	Noncompliance

		effects, actions, and comments. The prescribers did not indicate a conclusion (the presence or absence of side effects) for 17 of 33 (52%) of the evaluations because the conclusion was omitted from the form. The monitoring team would like to emphasize the importance of utilization of this information. To various degrees, psychopharmacologic medications are associated with side effects. Monitoring for these side effects is important in individuals with developmental disabilities for many reasons, but is particularly important because many individuals cannot verbally communicate the presence of side effects. <u>Compliance Rating and Recommendations</u> The monitoring team found this provision item in noncompliance due to (1) a lack of evidence that the evaluations were reviewed by the primary providers and neurologists, and (2) the failure to appropriately complete the evaluations due to the variation in the formats, specifically the lack of the correct prescriber review. To move in the direction of substantial compliance, the monitoring team recommends consideration of the following: 1. Evaluations should be appropriately and consistently completed in a timely manner with the appropriate version of the rating instruments. 2. Requirements for completion should be consistent among the various departments. 3. The information should be utilized in clinical decision-making. The information from the evaluations should be incorporated in the assessments completed by primary care providers and neurologists. Primary providers should review the information and acknowledge results. This could be in the form of an IPN entry, quarterly reviews, or annual assessments. The neurology consultant should be provided the data and <u>encouraged to review</u>.	
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 11 ADRs from August 2012 through April 2013. There was a total of 11 ADRs for 2012 and eight for 2013. The facility reported that training was provided to all direct care professionals. Additionally, four inservices were conducted between 12/1/12 and 5/31/13 to provide training to habilitation services staff, home managers, and members of the morning medical services team. There remained an outstanding need to ensure training of all nursing staff. Two additional ADRs were reviewed during the July 2013 P&T Committee meeting. Individual #519 was noted to have an elevated prolactin attributed to Risperdal which resulted in the discontinuation of Risperdal and initiation of Abilify. By and large, the assessment of this ADR was incomplete. The ADR report did not provide any information on the actual prolactin levels or clinical symptoms. Thus, the magnitude of the problem was unknown to the reviewers. The report also did not include a list of medications. The process required attachment of the medication profile which was needed to assess confounding factors, such as other drugs that could cause similar findings. Moreover, there was no follow-up prolactin level to indicate if drug	Noncompliance

		withdrawal resulted in improvement. After considerable discussion, the committee agreed to obtain additional information and review at the next quarterly meeting. The monitoring team had numerous concerns about the ADR reporting and monitoring system in place at LSSLC: • Generally, the reporting forms submitted for review did not include adequate information and most did not appear to have any review by the primary provider. The descriptions were not sufficient to allow a reasonable determination to be made. For example, skin findings (symptoms) associated with antibiotic use were reduced to one word "rash." Associating an antibiotic with development of a rash is dependent upon many factors, including the type of skin eruption that occurred. • 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. <u>Compliance Rating and Recommendations</u> The monitoring team agreed with the facility's self-assessment rating of noncompliance for this provision item. Overall, LSSLC did not maintain an adequate system for monitoring and reporting ADRs. The number of ADRs reported was relatively low and those that were reported, in many instances, lacked adequate review based on limited information provided in the ADR report. The system also lacked a mechanism for triggering adequate reviews of serious cases. Finally, the facility did not provide training to ensure that <u>all health care professionals</u> had adequate knowledge related to monitoring and reporting of ADRs. To move in the direction of substantial compliance, the monitoring team recommends consideration of the following: 1. There should be increased reporting by the medical staff. 2. ADRs should be reviewed by the primary provider, clinical pharmacist, and medical director/lead physician. All three should be required to sign the ADR reporting form. The form should indicate who initiated it (reporter). 3. All <u>suspected ADRs</u> 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. 4. There should be continuous monitoring of individual and aggregate data. 5. 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. 6. 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.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The facility'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. During the meeting held on 7/10/13, facility staff reported that the calendar being used was set in 2011. They were unaware of the rationale for the DUEs that were completed even though they indicated that the P&T Committee was responsible for setting the calendar. It was not clear that the calendar reflected the current medication issues at the facility or targeted high risk/high use drugs. DUEs on Bactrim/Septra and phenobarbital were conducted by the clinical pharmacist. The staff pharmacist completed a DUE on Trazodone. The DUE on Bactrim was completed and presented to the P&T Committee in January 2013. Sixteen of 41 individuals who were prescribed Bactrim were randomly selected and evaluated based on criteria determined by the committee: • Appropriateness of prescription for infection • Dosing guidelines • Presence of contraindications • Drug interactions • Reporting of adverse drug reactions The DUE concluded that Bactrim was prescribed for appropriate infections at the appropriate dose. One individual had a contraindication to use and two individuals had significant drug interactions. One individual had a possible ADR, although it appeared unlikely that symptoms were related to Bactrim. A number of recommendations were cited in the DUE including: • Ensuring that renal dosing was done when appropriate • Obtaining current EKG • Measuring folate levels for those taking folate depleting drugs • Reporting suspected ADRs The DUE on Pb was presented at the April 2013 meeting. The objectives were similar to those for Bactrim with the addition of lab monitoring. Eleven of the 46 individuals who received phenobarbital were evaluated. The DUE summarized the results, stating that Pb was prescribed and monitored correctly with only three individuals needing more frequent monitoring to meet the state of Texas Guidelines. The recommendation was made to change the lab monitoring parameters for individuals to every	Noncompliance

		six months per guidelines. The staff pharmacist completed a DUE on trazodone and presented it during the P&T committee meeting held in July 2013. She reported that this was her first attempt at completing a DUE. As previously noted, the committee members did not know why this drug was selected for review. The DUE concluded that trazodone was prescribed and monitored correctly. Consequently, there were no recommendations generated from the DUE. Generally, the content of the DUEs was adequate and the evaluations provided some clinically relevant information. Even so, the monitoring team had concerns regarding the dissemination and use of the information, the role of the medical staff in the process, and follow-up of the recommendations. The monitoring team reviewed the minutes of the Pharmacy and Therapeutics Committee meetings for January 2013 and May 2013 and noted that there was <u>no participation</u> by the medical staff in the January 2013 meeting. As discussed previously, the minutes for the May 2013 meeting appeared to be a draft which provided poor and confusing documentation of the meeting. It appeared that two members of the medical staff attended this meeting based on handwritten corrections. Neither of the committee minutes documented the outcomes of the discussions of the evaluations. The only comment was that the DUE was attached. The monitoring team requests attachments for the committee meetings as part of the original document request and made a second request following the compliance review. Attachments for the meeting minutes were not received. There was no documentation of the recommendations included in the evaluations. That is, it was not clear if the recommendations were accepted, rejected, or implemented. <u>Compliance Rating and Recommendations</u> The lack of evidence that (1) the prescribers of medications were consistently informed of the DUE findings and (2) DUE recommendations implemented were appropriately followed-up resulted in the monitoring team's agreement with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team recommends the consideration of the following: 1. The facility must ensure that the current DUE procedure is followed, including the requirements for drug selection and approval of data collections forms. 2. There should be evidence that the DUE information is reviewed with the medical staff. 3. The P&T Committee minutes should document some elements of the DUE, such as the conclusion, recommendations, and corrective actions, if any, that will be required to address the findings of the evaluation. Corrective actions should be documented through completion.	

N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances.	The facility continued to report medication variances. The medication data provided to the monitoring team are summarized in the table below. Medication Variances 2012 -2013 |	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
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Nursing	29	27	16	34	29	12	30	34	22	20	24	46
Wrong dose (%)	28	47	25	41	7	42	37	21	32	10	33	4
Extra Dose (%)	3	0	6	9	0	8	20	15	5	15	0	13
Omissions (%)	52	41	31	35	83	33	30	50	59	45	33	39
Pharmacy	27	19	30	4	11	12	5	18	6	19	15	17
Wrong Med (%)	8	10	18	0	1	4	2	12	0	3	4	4
Wrong Dose (%)	8	6	3	1	3	6	0	2	0	7	6	0
Provider	0	0	1	0	0	0	0	0	0	0	0	0
Total	56	35	27	38	40	24	35	52	28	39	39	63	 There was very little progress made in the medication variance system. The monitoring team attended the Medication Variance Committee Meeting conducted during the week of the compliance review and noted several problems during the conduct of the meeting: • The accuracy of pharmacy data remained questionable. Medication errors were categorized as "other" when it was clear that the errors were related to dispensing issues with the pharmacy. • Physician errors were under-reported. There were no prescriber errors reported for the period of October 2012 through June 2013. As noted throughout the sections of this review, the monitoring team reviewed documents which revealed that medications were prescribed when allergies were documented, and were provided in the wrong form and/or incorrect dose. The Bactrim DUE documented that dosing was inappropriate based on renal function. All of these issues occurred within the reporting period, but were not reported as variances. • While omissions were the most frequent variance noted, LSSLC had a significant problem with individuals being administered the wrong dosages of medications. Many of these variances involved the individuals receiving additional medications or extra doses which should have required increased monitoring or observation. This did not appear to occur and the variances were categorized as Level C variances. By definition, a Level D variance is one that results in the need to perform increased monitoring or observation, but results in no harm to the individual. • The facility's presentation of data remained somewhat problematic. Bar graphs continued to be utilized heavily for longitudinal data. While this is acceptable, the use of control charts might provide better insights to trends and special causation. Copies provided to committee members during the meeting were in an unacceptable font size for meeting distribution. The monitoring team also learned of other issues related to safe medication practices during the meeting:	Noncompliance

		• The annual state licensing survey cited deficiencies related to the presence of expired medications being available for use in the medication rooms. This occurred in spite of the requirements by several departments to complete audits. During the meeting, it was reported that nursing did not complete 50% of the required audits. The pharmacy and nursing departments were discussing a collaborative approach to completion of the audits as well as reconciliation of the departmental checklists. • Twenty-four hour chart checks were completed in the infirmary, but not in other clinical areas. Monthly MAR reviews compared the old MARs to the new MARs. This process did not have the ability to detect errors related to the failure to transcribe orders. Finally, a review of the committee meeting minutes indicated that participation in the committee by the medical staff was inconsistent. The lead physician did not attend any of the five meetings conducted from December 2012 to May 2013. The nurse practitioner was present at two of the five meetings. This was an unfortunate finding since the minutes reflected numerous issues related to the medical providers and medication prescribing. <u>Compliance Rating and Recommendations</u> The monitoring team agreed with the facility's self-rating of noncompliance. The monitoring team identified (1) problems related to data accuracy and under-reporting (2) incorrect assignment of discipline involvement and (3) inaccurate assessment of severity levels. The failure to appropriately identify and categorize the medication variances resulted in data that were not reliable. The lack of good data prohibits the analysis and trending that is needed in order to correctly identify systems issues and take the most appropriate actions. To move in the direction of substantial compliance, the monitoring team recommends the consideration of the following: 1. All variances must be captured and appropriately assigned to the disciplines involved. 2. 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. 3. All disciplines must maintain appropriate documentation of corrective actions related to medication variances. 4. The pharmacy director should ensure that there is reconciliation of all non-pill medications. Adequate documentation of the findings should be maintained.	

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 Physical Nutritional Management Policy o PNMT Staff list, back-ups, and Curriculum Vitae o Staff PNMT Continuing Education documentation o List of Medical Consultants to PNMT o Section O Presentation Book and Self-Assessment o Section O QA Reports o PNMT Evaluation template o PNMT Meeting documentation submitted o Individual meeting Minutes submitted o List of individuals on PNMT caseload o List of individuals referred to the PNMT in the last 12 months o Compliance Monitoring spreadsheet o Individuals with PNM Needs o Dining Plan Template o Compliance Monitoring template o Completed Compliance 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 Hospitalizations for the Past Year o ER Visits o List of individuals who cannot feed themselves o List of individuals requiring positioning assistance associated with swallowing activities o List of individuals who have difficulty swallowing 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 Individuals with Aspiration or Pneumonia in the Last Six Months 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 With Falls Past 6 Months

	o List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o Individuals with Chronic Dehydration o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance o List of Choking Events in the Last 12 Months 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 Individuals with 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 o PNMPs submitted o APEN Evaluations submitted o PNMT Assessments and ISPs submitted o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QDDP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, 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 #174, Individual #402, Individual #243, Individual #22, Individual #172, Individual #207, Individual #467, Individual #511, Individual #425, Individual #305, Individual #182, Individual #294, Individual #388, Individual #488, and Individual #114. o PNMP section in Individual Notebooks for the following: • Individual #174, Individual #402, Individual #243, Individual #22, Individual #172, Individual #207, Individual #467, Individual #511, Individual #425, Individual #305, Individual #182, Individual #294, Individual #388, Individual #488, and Individual #114. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #174, Individual #402, Individual #243, Individual #22, Individual #172, Individual #207, Individual #467, Individual #511, Individual #425, Individual #305, Individual #182, Individual #294, Individual #388, Individual #488, and Individual #114. <u>Interviews and Meetings Held</u>: o Dr. Danielle Perry, Habilitation Therapies Director o Melissa Huggins, RN o Peggilu Watkins, RD o Rhonda Hampton, SLP

	o Laura Kunstmann, OTR o Cristen Nerren, PT o Delisa Smiley, PNMPC o Various supervisors and direct support staff o PNMT meeting <u>Observations Conducted</u>: o Living areas o Dining rooms o Day programs o Work areas o Bathroom areas
	Facility Self-Assessment: The self-assessment completed by Danielle Perry, Habilitation Therapies Director, was improved over previous assessments. There were very clear and relevant activities conducted and most linked well to previous reports by the monitoring team. Findings reported were in measureable terms. Each provision listed the activities to conduct the assessment, results of the self-assessment, and a self-rating. There were some statements of actions planned to demonstrate attempts to move toward substantial compliance in the future, particularly related to the development of a monitoring system, due for implementation on 7/15/13. These were clearly described to the monitoring team during discussions with Ms. Perry onsite. These should be documented moving forward. Ms. Perry and her staff were on track to ensure continued progress was made for the next review. While there were overall improvements noted, delays in implementation of PNMT assessments upon referral, assessment content, other PNMT documentation, and the system of monitoring continued to be problematic. Benchmarks (in measurable terms) were not established; this may be an area to consider for future assessment over the next six months. These benchmarks may be used to establish targets for success and to track progress. Though much continued work was needed, the monitoring team acknowledges the strides that Ms. Perry made during the last six months. The facility rated itself as not in compliance with all eight items of section O. While the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team concurred with these findings.
	Summary of Monitor's Assessment: Progress was made towards substantial compliance with provision O. The PNMT was fully staffed, though there was turnover/gaps in the RN position and frequent changes in contract staff. Back-ups had been identified for PT and attendance at the meetings was generally consistent. All seemed well qualified and committed to the process and success of the PNMT.

	• Each of the assessments reviewed had not been completed in a timely manner from the date of referral, but once initiated, were completed promptly. • The content was often weak. There was limited evidence of hands-on assessment by the team, but rather record review of IDT actions and assessments completed by others. This needs to be addressed. • The meeting observed by the monitoring team was organized, but staff were handwriting notes that would need to be transcribed later. Availability of a computer and possibly a projector would permit the team to record minutes right then. The team had shifted to individual meeting documentation, which could then be filed in the individual records. • There needs to be at least marker notes to direct others to these notations to effectively communicate with the IDT in a timely manner. • Team members concisely and efficiently presented data for analysis and review relative to individual status. • No other IDT members or physicians were in attendance, though a couple of RN case managers stopped by to exchange information. • There appeared to be a holistic approach to problems and they appeared to look at issues comprehensively, though this was not well represented in the written assessments. • There was a concern for the potential influx of referrals with implementation of the Risk Threshold system currently under development. The PNMT appeared to be routinely and proactively reviewing individuals with a high risk of key PNM indicators. The status with regard to outcomes and exit criteria should be clearly established, routinely reviewed, and modified as needed to ensure that transition to the IDT occurred consistently. Documentation related to discharge should clearly state the rationale and plan for transition to the IDT. Mealtimes and position and alignment were notably improved in Lone Pine and Woodland Crossing. 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 do what is in the plan by supervisors? • Are staff doing the right thing even when they think no one is watching? A system of effectiveness monitoring was not well established and will be necessary for further progress with this provision. Areas, such as toothbrushing and oral sensitivity, should be addressed through assessment, supports, and monitoring. The therapists were encouraged to more objectively evaluate individuals for protective equipment. There were a large number of helmets and gait belts, for example. There was a disconnect between the identification of risk and the necessary supports to address these and the level of supervision required in some cases to ensure there is proper implementation. The therapists are encouraged to carefully, thoughtfully and functionally evaluate individuals and make recommendations for the least restrictive, yet

	most appropriate supports required on an individual basis. The least restrictive options should be selected. Decisions related to equipment should be data driven. There continued to see implementation errors and failure to update PNMPs/dining plans to represent recent changes, and others that required clarifications. The facility staff demonstrated that they can effect positive change. It is now time to create that same kind of initiatives to promote improvements in both Oak Hill and Castle Pines. DSPs reported that staffing was typically low during mealtime, yet during the evening meal observed by the monitoring team, there were 10 staff present for 17 individuals. There were still numerous errors and the process was disorganized and chaotic. In Oak Hill, there were a number of strategies used that, by report, were directed by QIDPs, unit directors, RNs and others, yet none were evident in the dining plans or PNMPs. Examples included changes in adaptive equipment, positioning, and even permitting an individual to eat with his fingers rather than use utensils. These documents are the primary references developed collectively by the IDT for staff use. All changes must be reflected there. <u>Samples for Section O:</u> Sample O.1 consisted of a non-random sample of 15 individuals who were chosen from a list provided by the facility of individuals identified as being at a medium or high risk for or experienced an incidence of PNM related issues (i.e., aspiration, choking, falls, fractures, respiratory compromise, weight [over 30 or under 20 BMI], enteral nutrition, GI, osteoporosis), required mealtime assistance and/or were prescribed a dining plan, were at risk of receiving a feeding tube, presented with health concerns and/or who have experienced a change of status in relation to PNM concerns (i.e., admitted to the emergency room and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. Sample O.2 consisted of the individuals who were assessed or reviewed by the PNMT over the last six months. Sample O.3 consisted of five individuals at SSLC who received enteral nutrition. Some of these individuals might also have been included in one of the other two samples.

#	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	<u>Core PNMT Membership</u>: The PNMT at LSSLC included the appropriate disciplines as defined in the Settlement Agreement. Each was a part-time team member who had other clinical duties, with the exception of the nurse, which was a full time position. Team members included the following with start dates: • Melissa Huggins, RN • Cheri Marini, RD • Rhonda Hampton, SLP • Laura Kunstmann, OTR • Cristen Nerren, PT • Delisa Smiley, PNMPC	Noncompliance

#	Provision	Assessment of Status	Compliance
	care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, 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.	This team had three new members since the previous review and back-ups for each position had been assigned. <u>Consultation with Medical Providers and IDT Members</u> Dr. Corley was listed as the physician consultant to the team, though there was no documentation of physician attendance at PNMT meetings held over the review period. <u>Qualifications of PNMT Members</u> The qualifications of the current PNMT members were as follows: 4 of 5 core team members (80%) were currently licensed to practice in the state of Texas, as verified online. It was not possible to verify the licenses for the dietitian per the license numbers provided. 4 of 5 core PNMT members (80%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. The CV for the OT presented no documentation of work experience with individuals with intellectual disabilities. She had other experience, in acute care and in inpatient and outpatient rehabilitation. The PT appeared to be a new graduate with a Doctorate of Physical Therapy (2012). Her start date at LSSLC was not known. The other three team members had a collective 30 years of experience in their respective fields and, together, more than 20 years with individuals with intellectual disabilities. <u>Continuing Education</u> 4 of 5 PNMT core team members (80%) had completed continuing education directly related to physical and nutritional supports and/or transferrable to the population served during the past 12 months. Courses attended by the team members included the following: • Annual Habilitation Therapy Conference (24 contact hours, Marini, Huggins, Nerren, and Hampton) • Operation of Baclofen Pump (16 hours, Nerren) The CV for the OT indicated that she attended two courses since December 2012 (Sensory Processing Disorder – Practical Solutions that Work and Self-Regulation in Children: Keeping the Body, Mind, and Emotions on Task in Children with Autism, ADHD, or Sensory Disorders). The dates or contact hours were not documented. The extent of continuing education obtained by this group of clinicians was acceptable. Ongoing continuing education related to PNM and transferrable to the population served	

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		is essential to ensuring that an adequate level of expertise is maintained for all team members, individually and collectively via cross-training. <u>PNMT Meetings</u> Meeting minutes were submitted for 9/5/12/12 to 5/30/13. The meetings held from 9/5/12 through 11/28/12 did not have sign-in sheets, but attendance was tracked in the minutes. From 12/12/12 to 5/30/13, sign-in sheets were submitted for 20 meetings, though minutes were not submitted for six of these (1/16, 2/27, 3/6, 3/20, 3/27, and 4/11). There were minutes submitted for 1/23/12, 1/30/12, 5/2/12, 5/9/12, 5/16/12, 9/5/12, and 9/26/12, but these were well outside the scope of this review period and, as such, were not included for review. There was documentation related to a meeting held on 5/1/13, but there was no evidence of attendance for that meeting. Overall, complete documentation was submitted for 22 times. The team generally met one time weekly, though there were additional weeks during that period for which no meeting was documented. Based on review of the minutes, attendance by core PNMT members for 22 meetings conducted during this time frame was: • RN: 19/22 (86%) attendance by core member or back-up. • PT: 21/22 (95%) attendance by core member or backup. • OT: 22/22 (100%) attendance by core member or back-up. • SLP: 22/22 (100%) attendance by core member or back-up. • RD: 20/22 (92%) attendance by core member or back-up. • PNMPC: 20/22 (92%) attendance Attendance was acceptable. Personnel changes resulted in less consistent attendance by the nurse, but with a permanently assigned nurse at the time of this review and consistent use of back-ups, there should be further improved representation in the future. There was no evidence of physician participation in any of the PNMT meetings. Section O requires that the PNMP 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. Also, the PNMP is to be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. This aspect of O.1 is reviewed in O.3 below. There was no evidence of physician consultation throughout this period. While attendance at the meeting is an excellent method to gain the input of the medical staff, alternate methods to demonstrate their availability to the PNMT is advised for compliance with this aspect of O.1. The current PNM policy lacked clear procedural guidelines to	

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		address the PNMT assessment process, such as monitoring. The monitoring team concurs with the self-assessment for noncompliance with this provision of Section O. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Establish a consistent method of documenting the activities of the PNMT to include the actions taken, plans and dates due and completed related to all individuals, as well as, individual progress and status. 2. Ensure that evidence of participation by medical providers is clearly documented.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	<u>Identification of PNM risk</u> All individuals at LSSLC identified with PNM needs (321 per the list submitted) were provided a PNMP, thereby ensuring that, as per the Settlement Agreement, each individual who could not feed himself or herself, who required positioning assistance associated with swallowing activities, who had difficulty swallowing, or who was at risk of choking or aspiration, collectively, "individuals having physical or nutritional management problems") were reported to be provided a current PNMP. There were 29 individuals, however, identified with no PNMPs. Based on lists of individuals with identified PNM concerns, including those requiring positioning assistance associated with swallowing (226 individuals), who were dependent on others to eat (112 individuals), had difficulty swallowing (180 individuals), and/or considered to be at medium or high risk of choking (approximately 230 individuals) or aspiration (approximately 152 individuals), Of those identified as requiring positioning assistance associated with swallowing, there were eight individuals who were not listed with a PNMP or a PNMP that had been discontinued (Individual #344, Individual #473, Individual #430, Individual #66, Individual #93, Individual #317, and Individual #490). Of those identified as not able to eat independently, only one was not listed with a PNMP (Individual #490). Of those identified with difficulty swallowing, two were not listed with a PNMP (Individual #475 and Individual #490). There were no choking incidents documented since the previous review per the documentation submitted. Approximately 98% of individuals who presented with PNM concerns were provided a PNMP. The identification of other PNM concerns was via the at-risk system. Improvements were noted in the completion of the risk rating tools. Action plans were not provided in the same manner as during the previous review. Rather, the plans to address specific health risk issues were included in the IRRF and IHCP (integrated plans developed collaboratively with IDT members).	Noncompliance

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		PNMT Referral Process Criteria for IDT referral were included in the LSSLC Operational Procedures, Physical Nutritional Management (Client Management 26), effective 6/1/13 as follows: • Two choking incidents in one year • Two aspiration pneumonia diagnoses in one year • Results of PNMT nurse Post-Hospitalization Assessment for individuals diagnosed with any of the following: • Aspiration Pneumonia • GI Issues • Fractures • Skin Integrity • Seizures • New or proposed enteral feeding • Unresolved vomiting (>3 episodes in 30 days not related to viral infection) • Significant/unplanned/verified weight loss or gain of: • > 5 pounds in one month • 3 or more pounds per month for 3 consecutive months, or 7.5% of body weight for 3 consecutive months • 10% of body weight in 6 months • Any stage III or IV decubitus, or any stage II with delayed healing • Fracture of a long bone, spine, or hip The PNMT received some referrals from the IDTs, though some individuals followed by the team were self-referrals. From 5/9/12 to 5/30/13, there were 48 individuals referred to the PNMT. It could not be determined how many of these were self-generated. Individual #172 was listed as on the active PNMT caseload, but was not listed as a referral. The date and reason for his referral was not known. Reasons for referral of the others listed included the following: • PNE (3) • New gastrostomy tube (6) • Weight loss (12) • Fracture (2) • Falls (15) • Cough and Swallow (1) • Weight (1) • Diarrhea (1) • Skin breakdown (1) • Weight gain (1) • Weight loss/aspiration (1)	

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		• Pneumonia (1) • Meal refusals (1) • Falls/weight loss (1) • Unknown (1) It was difficult to determine which of these met the guidelines outlined above, though all were referred prior to implementation of these guidelines. While these were developed as guidelines for the PNMT, other individuals may be followed as deemed necessary by the team based on individual circumstances per policy. There were 13 individuals on the current active caseload for the PNMT per the documentation submitted. Reasons for referral included the following: • Falls (Individual #336, Individual #382, Individual #351, Individual #151, Individual #306, Individual #27, and Individual #101) • Weight gain (Individual #361) • Pneumonia (Individual #258) • Falls/weight loss (Individual #542) • Weight loss/aspiration (Individual #298) • Unknown (Individual #294 and Individual #172) Incidence of conditions in various PNM-related risk areas were tracked by the team based on data derived from a variety of sources and entered into the PNMT meeting minutes through 4/10/13. This practice was intended to identify needs for supports and interventions early, rather than waiting for significant health issues to occur before action was taken. Issues tracked included the following: • Other (Weight) • Fractures • Falls • Skin Breakdown • Pneumonia • Choking • Hospitalizations/Change in Health Status • New Enteral Tube Placement As of 4/17/13, the format of the documentation was changed to Individual Meeting Records. This format appeared to be a good way to readily track the status and actions of individuals, however, the information to be included in these was incomplete (e.g., chronic medications, reason referred, pertinent diagnoses, assessment start and completion dates,	

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		frequency of review/date of next review, exit criteria, and discharge dates) and there was no evidence of discussion of individuals related to the incidence of PNM concerns listed in the facility-wide episode tracker for individuals not yet referred to the PNMT. If the PNMT has identified this individual method of documentation as preferred, they should ensure that the forms are all complete with the necessary information and that there was documentation of PNMT review of individuals with PNM-related concerns not yet referred in order to identify the need for referral as soon as possible. A PNMT meeting was observed by the monitoring team. No other IDT members were present, though two nurses stopped in briefly for updates. The PNMT had significantly improved its process for review (with the exception of documentation as stated above). Additionally, there were a number of team members taking written notes that would then need to be transcribed later. It would be beneficial to have a computer and a projector available for use, allowing the documentation to be readily available to all team members throughout the meeting and to save time outside the meeting to accurately document the meetings. The discussion was thorough and the team members appeared to be very familiar with the status of the individuals discussed. The facility should address facility trending of occurrence of PNM-related concerns, for specific individuals, facility wide, and over time. Collaboration across departments was indicated, including incident management, risk management, QA, and others. This is another area where specific benchmarks may be tracked in an effort to reduce the occurrence of some of these key indicators. <u>PNMT Assessment and Review</u> The assessments completed by the PNMT should be comprehensive, including specific clinical data reflecting an assessment of the individual's current health and physical status, with an analysis of findings, recommendations, measurable outcomes, monitoring schedule, and criteria for discharge. Based on review of the assessments in the last two months, the comprehensiveness of the PNMT assessment components was as follows: • 0 of 9 PNMT assessments submitted (0%) were initiated at a minimum within five working days of the referral; • 0 of 9 PNMT assessments (0%) were completed in less than 30 days of the referral; • 7 of 9 (78%) contained date of referral by the IDT (or self-referral); • 8 of 9 (89%) contained date assessment was initiated; • 5 of 9 (56%) contained evidence of review and analysis of the individual's medical history; • 4 of 9 (44%) identified the individual's current risk rating(s), including the current rationale. Those listed in the assessments were deemed relevant to the	

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		reason for referral, while others were deemed unrelated and, as such, were not addressed. PNM is a comprehensive approach to the assessment and provision of supports and services to address an individual's health concerns. Individuals with significant needs that warrant referral to the PNMT typically have complex issues that are interrelated and should be evaluated with regard to this interrelatedness. Antecedents to concerns in one area may result in health changes in other areas and should be addressed in that context. One important purpose of the PNMT is to model for IDTs that they must consider all factors when addressing health concerns. Typically, only the obvious is addressed, which often leads to a failure to identify the root cause or failure to recognize how clinical indicators are interrelated. It also helps in establishing a baseline of health prior to PNMT supports and services in order to evaluate changes and improvements. The PNMT should consider each of the current risk ratings and determine if the individual's clinical indicators were consistent with the IDT's ratings of risk. If the PNMT looks only at those factors that are medium/high or only those typically associated with PNM, they may overlook a key factor for an individual. For example Individual #101 was referred to the PNMT on 1/25/13 for falls, yet her assessment was not initiated until 5/8/13. An ISPA conducted on 5/17/13, prior to the completion date listed for the PNMT evaluation, reported that she had a 36-pound weight loss over the past year and experienced frequent vomiting. Though it appeared that the PNMT was aware of these issues they did not document any actions related to assessment of these concerns in the interest of a comprehensive PNM approach. It was reported that the IDT and PNMT were to meet related to weight loss and recommendations, but there was no evidence of an ISPA. • 0 of 9 (0%) included recommended risk ratings based on the PNMT's assessment and analysis of relevant data; • 9 of 9 (100%) contained evidence of discussion of the individual's behaviors on the provision of PNM supports and services, including problem behaviors and skill acquisition; • 3 of 9 (33%) contained assessment of current physical status, yet even these were only partial. Frequently, the PNMT only reported the findings of others. There was no evidence of a nursing physical examination, for example, in any of the assessments reviewed. The purpose of the PNMT is not merely to review the supports provided by the IDT, but also to present a new perspective on the individual's status, history, issues and supports; • 2 of 9 (22%) contained assessment of musculoskeletal status; • 5 of 9 (56%) contained evaluation of motor skills; • 0 of 9 (0%) contained evaluation of skin integrity; • 3 of 9 (33%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, or indicated that the individual was independent with	

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		mobility and repositioning. There was no evidence that the PNMT addressed positioning that may impact PNM status including during bathing and oral hygiene (Individual #172); • 3 of 9 (33%) contained evaluation of current adaptive equipment; • 4 of 9 (44%) contained nutritional assessment, including but not limited to, history of weight and height; intake, nutritional needs, and mealtime/feeding schedule; • 7 of 9 (78%) contained a list of medications with potential side effects listed. None reflected potential or actual drug/drug and drug nutrient interactions. Few addressed actual or suspected side effects, or ruled this out if it was not an issue; • 1 of 9 (11%) identified residual thresholds, if enterally nourished. For example: o Individual #172 presented with frequent vomiting, but there was no current nutrition assessment to review volume of his enteral feedings, but rather only a recommendation that this should be done. That should be an aspect of the assessment process. o Individual #101 had experienced frequent vomiting and weight loss of 36 pounds in the last year per the ISPA dated 5/17/13. Though she was prescribed 3420 calories per day and she only required 1550 to 1800 calories per day for weight gain, there was no evidence of observations at mealtime or a calorie count per the assessment submitted; • 1 of 9 (11%) contained a tableside oral motor/swallowing assessment, including, but not limited to, mealtime observation; • 1 of 9 (11%) contained information about the individual's current respiratory status based on a physical assessment that included, but not limited to, respiratory rate, heart rate, lung sounds, breathing patters, or oxygen saturation levels. • 4 of 9 (44%) contained evidence of review/analysis of lab work, though how this was done was inconsistent; • 2 of 9 (22%) contained evidence of review/analysis of medication history over the last year and current medications, such as dosages, administration times, and side effects. Changes in medications and/or doses were not reported consistently, nor was the start date for current medications prescribed; • 4 of 9 (44%) contained discussion as to whether existing supports were effective or appropriate; • 1 of 9 (11%) contained oral hygiene status. None documented observation of oral hygiene/toothbrushing by the team. Not only is oral hygiene status an important element to consider, position and other techniques related to toothbrushing should also be investigated to rule out any concerns that potentially increased the individual's risk of aspiration. o For example, Individual #172 was referred to the PNMT for increased	

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		episodes of aspiration pneumonia. While his oral hygiene was reported as good, there was no evidence that the PNMT conducted observations to determine if this was done correctly and in appropriate position and alignment. Further, the PNMT recommended that the IDT monitor oral care to determine if signs and symptoms were noted. This should be as aspect of the assessment process; • 6 of 9 (67%) contained evidence of observation of the individual's supports at their home and/or day/work programs; • 6 of 9 (67%) contained evidence that the PNMT conducted hands-on assessment; • 4 of 9 (44%) identified the potential causes of the individual's physical and nutritional management problems; • 6 of 9 (67%) identified the physical and nutritional interventions and supports that were clearly linked to the individual's identified problems, including an analysis and rational for the recommendations; • 0 of 9 (0%) contained recommendations for measurable skill acquisition programs, as appropriate; • 4 of 9 (44%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status; • 0 of 9 (0%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT. The outcomes were identified, but only criteria for re-assessment were outlined rather than clinical indicators for when nursing staff should contact the PNMT. The criteria for re-assessment or review were often occurrences of negative outcomes (such as additional fracture, for example), rather than specific indicators that may require attention prior to actual occurrences; • 3 of 9 (33%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP); • 5 of 9 (56%) contained recommendations for monitoring, tracking or follow-up by the PNMT; and • 0 of 9 (0%) contained signatures of all core team members (or alternate), but dates were included inconsistently. Compliance with each of the 33 elements outlined above was 100% for 3% of the elements. Only one other was rated at over 80% (reflected the date initiated) and two were rated at 78% (included the date of referral and medications and potential side effects). All others were below 70%. There was little change in the quality of content in the assessments. Many were lists of information, but there was little analysis of the data reported to guide the development of the PNMT recommendations. Much of the data was what was already provided by the IDT. • In some cases, it was reported that the individual was to have the head of the bed	

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		elevated, but there was no evidence that the PNMT verified that this was done routinely and correctly (Individual #294). • Oral hygiene was reported to be good for one individual, but there was no evidence of observations conducted by the team to look at position and alignment (Individual #172). • Individual #351's team identified numerous physical issues related to ambulation. There was a recommendation to the IDT to address the use of her walker, but there was no evidence that they had explored any options themselves. There were measurable outcomes, monitoring schedules, criteria for discharge and criteria for review/re-assessment outlined in 8 of 9 assessments reviewed. There was no frequency of monitoring by the PNMT for Individual #361. Objective clinical indicators should be established for individuals followed by the PNMT as part of the assessment recommendations that may serve as clues for potential change in status. These should be integrated into the individuals' IHCPs, as well as, clinical data that individually define health and wellness. The IHCPs for individuals with physical or nutritional management difficulties require effectiveness monitoring of individual-specific objective clinical data to determine the efficacy of the IHCP interventions (of which PNMT interventions are a part). PNMT review would be necessary to determine if the plan was being implemented as written, staff were adequately trained, etc. If the team determined interventions were not effective, the IDT/PNMT should revise these interventions. Plans should be revised within 24 hours, or sooner if the concern was critical, when a change was indicated. This should be collaborative between the PNMT and the IDT. <u>Integration of PNMT Recommendations into IHCPs and/or ISPs</u> There were no IHCPs, ISPAs or ISPs submitted that reflected integration of any findings by the PNMT for the seven individuals for whom assessments were submitted. In the case of Individual #351, there was an ISPA dated 2/28/13 that documented she had been referred to the PNMT on 1/18/13, but as of that time they had not provided an assessment. It was reported that she was on the schedule for that week. Per the assessment, it was not initiated until 5/17/13 (four months after the referral) and not completed until 5/21/13. The ISPAs documented a history of frequent falls prior to the referral to the PNMT since at least 8/1/12. <u>PNMT Follow-up and Problem Resolution</u> It was not possible to track recommendations and implementation based on the documentation submitted. Most of the evaluations had been completed in May 2013. Intervals of PNMT review were monthly or quarterly. Meeting minutes were not submitted after 6/3/13 to assess consistency of follow-up. A system that addresses implementation of recommendations and other actions should permit the team and others	

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		to readily review this information. It was not clear if the individual meeting records were to be filed in the active records. If this was intended, it will continue to be difficult for IDT members to follow the PNMT actions on a routine basis. The IPNs are the primary location for written communication among team members and this should not be ruled out as a method for the PNMT to keep others informed. <u>Individuals Discharged from the PNMT</u> There was evidence in the meeting minutes that two individuals were discharged from the PNMT during the last six months: • Individual #425 (4/10/13) • Individual #323 (4/24/13) Individual #425 had been referred to the PNMT on 1/22/13 due to a fractured fibula, yet there was no documentation in the IPNs related to any actions by the PNMT. The meeting minutes, dated 1/23/13, indicated that the PNMT would consult with follow-up due 2/13/13. There was no evidence of this, and the next review was scheduled for 2/20/13. Again there was no evidence of review or actions by the PNMT. A subsequent review was scheduled for 2/27/13. There was no evidence of meeting minutes until 4/10/13. Though there was no evidence of assessment by the PNMT, an entry on 4/10/13 in the meeting minutes (weekly summary) indicated that he had met exit criteria and was to be discharged on that date. There was no evidence of an ISPA held to review his status, recommendations, or need for further follow-up upon discharge. Individual #323 was listed as referred to the PNMT on 10/29/12 for weight loss. There was no evidence of PNMT review related to this referral. Then on 11/28/12, he was listed for consult in the meeting minutes related to disruption of gastrostomy tube feedings. It was documented that the team would complete an evaluation for him. There was no new information on 12/12/12 and he was scheduled for review on 12/19/12. On that date, there was no new information/update and he was scheduled for review on 1/9/13. On 1/9/13, it was documented that the PNMT would continue to follow his weights and investigate refusals (what he was refusing was not clearly stated). This continued in a similar manner through 4/24/13, at which time it was reported that he did not meet the referral criteria for the PNMT and would be discharged at that time. There was no evidence that the PNMT completed an evaluation as indicated in their plan on 11/28/12. This was not an adequate approach to address PNM needs for individuals referred to the PNMT. The IPNs are intended to provide a chronological record of any and all status updates, contacts, or actions taken and these should be consistently used by the PNMT to inform all other team members. Marker notes should be used by the team to refer others to additional documents, such as assessments. A discharge summary should be completed that provides objective clinical data to justify the discharge. This may be via a report or	

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		IPN by the PNMT. All outstanding recommendations should be integrated into the IHCP with specific criteria established for referral back to the PNMT. An ISPA should be held to discuss the terms of discharge. Meeting minutes should reflect status updates and actions taken by the team for each individual they review. This should provide them with an easy method to review their work and individual status without having to sort through IPNs. As stated in previous reports, an effective PNM program requires that the referral to the PNMT must occur in a timely manner, so as to capitalize on the collective expertise of the team members. There is urgency to complete PNMT assessments. Even so, some interventions may need to be implemented immediately, before the written report is finalized. It is critical that the assessments be completed in a timely manner. At this time, the LSSLC PNMT appeared to understand this responsibility and the assessments were conducted in a very timely manner, a significant and important improvement from previous reviews. The team is commended for its hard work, expertise, and follow-up. That being said, consideration should be given to individualize follow-up at more frequent intervals. In some cases, the IDT had failed to completed specific key actions related to the agreed upon plan. This was not known until the 30 day follow-up. That being said, the PNMT was moving substantial toward compliance with this aspect of O.2. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Assessments should be initiated within five days of referral and completed within 30 days. 2. A system of audits should be conducted to address consistency and comprehensiveness of PNMT assessment content. 3. PNMT recommendations should be addressed by the IDT and documented via the ISP process, generally with an ISPA to integrated all findings. While all recommendations may not be implemented by the IDT/PNMT, each should be discussed with rationale documented to accept these or not. The PNMT should identify actions to be implemented by themselves as well as the IDT, rather than merely direct the IDT. 4. Address toothbrushing and bathing position via actual observations in the PNMT evaluations and OT/PT evaluations.	
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	<u>Identification of Individuals Requiring a PNMP</u> In section O.1, the Settlement Agreement requires that PNMPs be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team, as appropriate. Per current state office policy, each individual's team should decide which team members should attend the annual meeting. For individuals with therapeutic needs, teams will need to provide clear justification if they decide that therapists involved in the individuals' care and treatment do not need to attend.	Noncompliance

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	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.	Attendance by key IDT members for review and approval of the PNMP included the following for current ISPs with signature sheets (11/15 ISPs included signature sheets): • Medical: 0% (0/11) • Psychiatry: 18% (2/11) • Nursing: 100% (11/11) • RD: 9% (1/11) • Physical Therapy: 27% (3/11) • Communication: 27% (2/11) • Occupational Therapy: 55% (6/11) • Psychology: 73% (8/11) • DSP: 73% (8/11) • Dental: 0% (0/11) • Pharmacy: 0% (0/11) 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 key team members is present to participate in that process. The new pre-ISP process will identify which team members are required to attend the ISP meeting and the needs for review of the PNMP should be considered when making this determination. <u>PNMP Format and Content</u> Review of findings for PNMPs of individuals included in Sample 0.1: • PNMPs for 15 of 15 individuals (100%) were current within the last 12 months. This was consistent with the previous review. • PNMPs for 15 of 15 individuals (100%) included a list of PNM risk levels. This was consistent with the previous review. • In 15 of 15 PNMPs (100%), there were large and clear photographs with instructions. The photos were presumed to be in color in the plans available for staff use. This was consistent with the previous review. • 15 of 15 PNMPs (100%) identified the assistive equipment required by the individual, though rationale or purpose was not consistently identified. • In 15 of 15 PNMPs (100%), positioning was adequately described per the individuals' assessments or the individual was described as independent. This was consistent with the previous review. • In 15 of 15 PNMPs (100%), the type of transfer was clearly described, or the	

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		individual was described as independent. This was consistent with the previous review. • In 12 of 15 PNMPs (80%), bathing instructions were provided. This was a decrease from 100%. • In 15 of 15 (100%) PNMPs, toileting-related instructions were provided, including check and change. This was consistent with the previous review. • In 13 of 15 (87%) of the PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning. Each of the others was described as independent. This was a decrease from 100%. • In 15 of 15 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. This was consistent with the previous review. • 15 of 15 individuals' (100%) Dining Plans were current within the last 12 months. This was consistent with the previous review. • 7 of 15 individuals had feeding tubes with no oral intake. 7of 7 PNMPs/dining plans (100%) indicated the individual was to receive nothing by mouth. This was an increase from 73%. • In 15 of 15 PNMPs/dining plans (100%), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. This was consistent with the previous review. • In 8 of 8 PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. This was consistent with the previous review. • In 4 of 8 PNMPs/dining plans for individuals who received liquids orally (50%), the liquid consistency was clearly identified. This was consistent with the previous review. • In 8 of the 8 PNMPs/dining plans 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 or used regular dining utensils. This was consistent with the previous review. • In 9 of 15 PNMPs (60%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. This was an improvement from 0%. • In 8 of 15 PNMPs (53%), oral hygiene instructions were included. Positioning was most often omitted. This was an improvement from 0%. • 6 of 15 PNMPs (40%) included information related to communication (how individual communicated and how staff should communicate with individual). Most did not offer strategies for staff use as a communication partner.	

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		The PNMPs reviewed were generally very good with comprehensive content in most areas. PNMP audits were conducted and attention to the areas described above will ensure greater consistency and improved content. Additional findings included the following: • 68% of the elements were noted in 100% of the plans • 79% of the elements were noted in 80% or more of the plans • 100% of the plans reviewed included 70% or more of the essential elements • 93% of the plans included 80% or more of the essential elements There were a limited number of IDT members present at the IDT meetings in which PNM risk was established and the elements of the PNMP should be reviewed. The PNMPs were generally improved and continued to move toward the criterion of 100% of the elements in 90% of the sample plans. The monitoring team concurred with the facility that they were not in compliance with this provision. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Determine how the PNMP will be effectively reviewed by the IDT and how to accurately reflect that in the ISP. 2. IDTs need to consider review of the PNMP when determining who is required to attend the ISPs. 3. Ensure that any changes to the plans are included immediately, rather than communicated by word of mouth.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	<u>Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs</u> Dining Plans were readily available in the dining areas. 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. Based on observations conducted by the monitoring team, it was noted that: • 53 of 73+ individuals' (73%) dining plans were implemented as written. • 63 of 78+ individuals' (81%) PNMPs related to positioning and mobility were implemented as written or alignment and support were consistent with generally accepted standards. Based on additional observations: • 3 of 3 (100%) individual's oral hygiene plans were implemented appropriately. • 1 of 2 (50%) individuals' transfer plans/repositioning were implemented appropriately. • 1 of 2 (50%) individuals' bathing plans were implemented as written.	Noncompliance

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		• Individual #258 was observed to fall very hard straight backward on the concrete outside his home. He had a Reebok helmet on and a gait belt, but no staff were outside providing supervision or assistance. His PNMP dated 3/7/13 stated that he was independently ambulatory at home, with use of the gait belt for staff handhold when he was unsteady. He was to use a wheelchair for off home transportation (for now). The surface was uneven and there was a ramp from the door that he had to be navigated to exit his home. Some additional comments are below: • Individual #306 was reported to have an increase number of falls, yet was outside by himself wearing a helmet and gait belt. His PNMP indicated that he was to wear the gait belt with stand by assist (within arm's reach) and contact guard with gait belt when unsteady. It did not address ambulation outside of his home, whether unsteady or not. If there are no staff nearby, whether or not he was unsteady and required contact guard could not be determined. • On the other hand, Individual #114 was observed seated in a wheelchair (transport chair). Staff reported that he was not supposed to walk by himself. The PNMP stated that he was to ambulate independently at home and use the wheelchair off the home if he wanted to. He was noted to have lower extremity edema and his feet were not supported on the footrests. There was no seatbelt fastened and he was leaning to toward the right with his right arm down inside the armrest. There was documentation on 6/18/13 by the nurse that he was to use a wheelchair for safety. There was no evidence that his PNMP had been revised to reflect this change in status. As of 7/1/13, he was to participate in direct PT, three times a week for three weeks. • There appeared to be an extensive use of gait belts and helmets. Many individuals were observed to be wearing gait belts with no staff within arm's reach to effectively use them to attempt to slow the fall and/or lower the individual to the floor. These supports should be carefully considered to ensure that they are necessary and effective. They should not, however, set the occasion for staff to forego appropriate supervision and assistance. <u>Choking/Aspiration Events</u> There were approximately 29 individuals identified at high risk for choking and approximately 202 others considered to be at medium risk. There were no choking incidents reported in the last six months. This was an important achievement again this review period, representing hard work related to staff training and continuing to improve compliance with the Dining Plans prescribed for all individuals.	

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		Many staff continued to require prompts to answer questions related to risks, though others did an excellent job of describing the individual's risks, food consistency, and adaptive equipment. Staff should not routinely need to refer to the plans to answer these types of questions. Review of the plans and risks should be done when the staff are initially assigned for the day, but even so, staff should have an active knowledge of the individuals to whom they are assigned on any given day: • The staff were assigned as responsible for the individual. • The staff should have already reviewed the plan prior to taking on that responsibility. • The staff should be trained to competency to work with that individual. • Staff should know many, if not most, of the risks and rationale for the supports they provide. It is critical that they know what to look related to potential triggers or clinical indicators so that any necessary action may be taken promptly. The monitoring team concurred with the facility that they were in noncompliance with this provision. While improvements were noted, as described below there was no system of monitoring in place at this time and, as such, it was not possible for the facility to accurately assess their own level of compliance with the dining plans and PNMPs. Recommendations: See O.6 below.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	<u>NEO Orientation</u> Habilitation Therapies provided new employees with classroom training on foundational PNM-related skills. Class time was extended since the previous review to address the PNMP, orientation and mobility, communication/deaf awareness and AAC, lifting and transfers, and dining plans and eating skills. The times were limited to one day for mealtimes and one day for lifting and transfers. Only one hour was allotted for communication and a full hour was to review hearing aids, though the number of individuals who used these was very limited. As described in section R, time should be available related to general communication and AAC. It was reported that there was a presentation of foundational skills, with modeling by the trainers to new employees. Practice time was provided with coaching by the trainers and then new employees were required to take a combination of written tests and were checked off on specific skills, using the checklists. Staff who did not pass were required to repeat the check-offs. A second failure resulted in a re-check with a different instructor with the staff supervisor observing. If they did not pass that time, they were not hired or are terminated. There were a number of core competencies including: • Mechanical lift • Stand pivot transfer	Noncompliance

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		• Gait belt use • Two person manual transfer • Bed positioning • Positioner and wheelchair positioning • Mealtime safety • Thickening liquids • Food textures • Adaptive dining equipment • Communication There was no consistent method to establish and maintain competency for staff who provided the training. There was no system to audit the trainers at the time of this review. NEO training was provided by licensed therapists with assistance from PNMPCs. During the eating skills class observed by the monitoring team, some information presented was inaccurate and, by report, had been taught in that manner for some time. The Habilitation Therapies Director identified this and intended to address it. This emphasized the need for routine audits of all training provided to ensure consistency and accuracy. The PNM-related core competencies (i.e., foundational skills), included in the NEO training appeared to be comprehensive. There were a number of associated knowledge and skills-based competency check-offs for most of this content. <u>PNM Core Competencies for Current Staff</u> Refresher courses for all existing staff were required annually for lifting and transfers and eating skills. Skills-based competencies were also required for this. Consideration for an additional refresher course related to communication should be considered. This was an area of support that was provided to every individual living at LSSLC and, as such, staff should be provided more extensive and ongoing training to ensure that competency of performance in was maintained. <u>Individualized Non-Foundational Training</u> The facility was in the process of implementing a system to identify and provide specialized training for unique supports provided to individuals that were not taught in NEO (red dot system). At this time, there were approximately 15 individuals that would require this for implementation of their PNMPs. The monitoring team looks forward to review of this during the next onsite visit. While progress was made in this area, the facility self-rated non-compliance with this provision and the monitoring team concurred.	

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		To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Implement routine audits of all training provided to ensure consistency and accuracy. 2. Consider the addition of a communication-related annual refresher course.	
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>Facility's System for Monitoring of Staff Competency with PNMPs</u> LSSLC utilized the Universal Compliance Monitoring Form developed by the state. The elements of the form were very general and it made it difficult to identify more discrete issues for tracking and analysis. For example, the form stated that "materials/equipment are present, working and utilized." If there was a "no" finding, there was no method to clearly identify which of these had been a concern. This was also true of a number of other elements monitored. Instructions for use of these forms were not submitted. A monitoring form that included more discrete measures should be considered, so that specific issues could be more readily identified for individual and/or systemic change. There was no clearly established frequency to conduct staff compliance monitoring. While the department had the ability to track staff names, these were not used to ensure that all staff were routinely monitored. It was likely that some staff were not monitored routinely for continued compliance plans for which they were deemed to be competent. The monitoring team requested compliance monitoring forms that were completed in the last month by OT and PT, and monitoring forms completed for individuals included in Sample O.1 for the last three months. There were 30 Compliance Monitoring Forms submitted as completed by OT/PT for 25 individuals and 29 forms submitted for only 8 of the 15 individuals in this sample. These two forms differed somewhat. The PNMP Monitoring Form contained more elements, while the Compliance Monitoring Form contained a system to calculate a compliance score. Compliance Monitoring designated a time that the monitoring had occurred and a description of the activity monitored; the other form did not. Both contained a mechanism for follow-up related to issues identified during the monitoring. All of the forms had been completed from April through June 2013. Compliance monitoring was completed as follows: • 7 forms (12%) were marked as completed between 2:00 pm and 8:00 pm. • 17 forms (29%) were completed between 12 noon and 2:00 pm. • 19 forms (32%) were completed between 8:00 am and before 12 noon. • 5 forms (8%) were initiated prior to 8:00 am. • 11 forms (19%) had no time designated.	Noncompliance

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		Compliance scores were calculated for only 68% of the forms submitted. Five forms were scored incorrectly due to completion of the calculations using the "N/A" answers as "no" answers. Only 37% of the forms identified any "no" responses, indicating that a concern was noted. These included the following indicators: • Plan was being performed as written/instructed (5). • Materials/equipment was present, working and utilized (3). • Staff identified individual triggers from dining plan/PNMP (2). • Staff had been or reported being trained on the individualized program (19). • PNMP/DP/instructions are present and/or easily located (3). • Staff communicated with individual before and during activities (2). • Staff explained plan rationale, goal(s), desired outcome(s) (1). • Staff explained risks associated with not implementing the program (1). • Staff entered data correctly in appropriate location (1). Compliance scores ranged from 20% to 100% as follows: • 100%: 15 • 90%: 15 • 80%: 8 • 60%: 1 • 20%: 1 • Compliance score not calculated: 19 The average compliance score was 89%. This was not consistent with general observations by the monitoring team. Documentation of actions related to these was not consistently documented on the forms. The PNMP monitoring process did not consistently cover all areas that were likely to provoke swallowing difficulties or increase PNM risk, including bed position, bathing, medication administration, and oral care, though some of these were noted. In most cases, the monitor did not identify the position the individual was in at the time of the observation. Monitoring was conducted as follows: • Meal/Snack: 31 • Positioning: 4 • PNMP/Equipment: 3 • Positioning/PNMP Equipment: 5 • Lifting /Transfers: 4 • Communication: 9 • No designation: 3	

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		Monitoring occurred across a limited variety of activities and times of day (only 12% occurred after 2:00 pm). It was not clear how the activities or times were determined. Trending of the findings from monitoring was not reported in the self-assessment, but rather that the system was undergoing revision and that was in process at the time of this review. <u>Individual-Specific Monitoring</u> While the type of monitoring described above focused on staff performance, it was tracked per individual rather than per staff, though staff names were a data point. It was not possible, however, to ensure that all staff were monitored for continued and consistent compliance with the current system and likely not realistic to do so. 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, as well as effectiveness. This should be a key element in an effective PNM system and is reviewed in O.7 below. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Establish a procedure for implementation of an effective monitoring system. Ensure that monitoring staff are trained to address issues related to consistency of scoring and follow-up. 2. A monitoring form that included more discrete measures should be considered so that specific issues could be more readily identified for person-specific and/or systemic change.	
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 specific system of routine effectiveness monitoring of the PNMPs and dining plans by the professional staff established at LSSLC based on risk, individual factors, or the need for special instructions in the PNMP. The current monitoring form did not permit the clinician to review the individual's overall health status to determine if the supports provided were effective in mitigating identified risks. Effectiveness monitoring should address this to determine if the interventions were effective, that the interventions observed should continue to be needed, and that no modifications or additional interventions were needed. Effectiveness should be addressed in addition to compliance monitoring conducted with staff. It was a concern that not all strategies would necessarily be reviewed using the current approach. For example, at the time of the observation, the therapist might observe positioning, but not necessarily transfers. In the current manner, effectiveness of	Noncompliance

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		the strategy as implemented is addressed, but effectiveness related to health and/or safety concerns are not. Review of specific health concerns for which the specific strategy was intended to address should also be addressed. These should include any health occurrences since the last review and whether the strategy continued to be the right one. This was done more consistently in the annual assessments, but routine review should also occur in the interim. The monitoring forms were not included in the individual's active record and, as such, there was no record of review. There was IPN documentation by therapists related to direct interventions or contacts for equipment or other troubleshooting, but none routinely done to review <u>all</u> interventions for effectiveness related to the occurrence of health concerns. These reviews should also report on compliance with implementation of plans by staff. Effectiveness monitoring should include programs across all environments and not only in the home. The self-assessment addressed only follow-up by the PNMT, but the intent of the Settlement Agreement in this provision was related to all individuals with physical nutritional management difficulties. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. There was IPN documentation by therapists related to direct interventions or contacts for equipment or other troubleshooting, but none routinely done to review <u>all</u> interventions for effectiveness related to the occurrence of health concerns. These reviews should also report on compliance with implementation of plans by staff. Effectiveness monitoring should include programs across all environments and not only in the home.	
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.	<u>Individuals Who Received Enteral Nutrition</u> There was a list of individuals who received non-oral intake that identified approximately 78 individuals (and two others, now deceased) who received enteral nutrition (22% of the current census). Individual #328, Individual #235 Individual #243, Individual #30, Individual #521, and Individual #27 were listed as having received new tube placements since the previous review. Twenty-two individuals were listed with some level of oral intake. Sixteen individuals were listed with poor oral hygiene at least one or more times since December 2012, increasing their risk for aspiration pneumonia. Twenty-six individuals were noted with at least one incidence of pneumonia in the last six months. Seventeen of these received enteral nutrition. Two had multiple incidents of pneumonia (Individual #172, four and Individual #243, two), with at least one categorized as aspiration pneumonia. Only two others were listed with aspiration pneumonia (Individual #22 and Individual #402), while the others were listed as bacterial	Noncompliance

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		pneumonia. <u>Evaluation of Individuals who Received Enteral Nutrition</u> Ten APENs were requested and 10 were submitted. • 8 of 10 individuals (80%) who received enteral nutrition in the sample were evaluated at a minimum annually. Two assessments submitted were not completed (Individual #68 and Individual #42). • 8 of 8 individuals evaluated and included in the sample (100%) had an at least a partial evaluation to determine the medical necessity of the tube, though assessment of oral motor status by the SLP and/or OT did not provide comparative analysis and safety of intake or development of an oral motor treatment plan, as appropriate for any assessment based on the APENs submitted. No one admitted to LSSLC since the previous review received non-oral intake, so the following metric did not apply: • ____ of the ____ individuals who received enteral nourishment and were admitted since the last review had a review of the medical necessity of the feeding tube within 30 days. <u>Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition</u> • 8 of 8 individuals who received enteral nutrition had been evaluated by the IDT to determine if a plan to return to oral intake was appropriate, though these were generally incomplete. Most did not clearly reflect assessment by the SLP and/or OT regarding oral motor status with a clear determination of whether the individual was a candidate for an oral motor treatment program to improve potential not only for by mouth (PO) intake, but for improved saliva control. Justification for/or against oral motor treatment or potential PO intake should be included as a part of assessment findings. Two of these individuals already received ongoing oral intake. • None of the APENs reflected an adequate assessment by the dietitian regarding current formula and schedule of feedings with a determination if the feeding schedule was the least restrictive or there were potential modifications needed in preparation of transition to oral intake. Plans for individuals identified as potentially benefitting from oral motor intervention or cleared to return to some form of oral intake require a comprehensive plan outlining the treatment or return to PO process. These plans should be: • Integrated into the IHCP, ISP, and/or an ISPA.	

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		• Implemented in a timely manner. • Staff responsible for implementation of these oral intake plans trained to competence by a licensed clinician with specialized training in PNM. • Monitored as outlined in the plan. <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. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Proceed with plans to establish protocol related to the completion of assessments on an annual basis to determine the medical necessity of all individuals with enteral nutrition.	

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 and Curriculum Vitae o Continuing Education documentation o Section P Presentation Book and Self-Assessment o Section O and P QA Reports o OT/PT Tracking o Individuals with PNM Needs o Dining Plan Template o Compliance Monitoring template o Completed Compliance 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 Individuals with Aspiration or Pneumonia in the Last Six Months 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 With Falls Past 6 Months o List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o Individuals with Chronic Dehydration o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance o List of Choking Events in the Last 12 Months 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 Individuals with 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 o PNMPs submitted o PNM Maintenance Log o Wheelchair evaluations submitted o List of Individuals Who Received Direct OT and/or PT Services o OT/PT Assessment template and instructions o OT/PT Assessment Log o Sample OT/PT Assessments OT/PT Assessments for individuals recently admitted to LSSLC**:** Individual #522, Individual #588, Individual #220, Individual #59, and Individual #594. o OT/PT Assessments and ISPs for the following individuals: • Individual #23, Individual #401, Individual #424, Individual #311, Individual #108, Individual #240, Individual #129, Individual #454, Individual #117, Individual #404, Individual #262, Individual #1, Individual #191, Individual #383, Individual #151, Individual #306, Individual #248, Individual #170, Individual #27, Individual #361, Individual #351, Individual #258, Individual #101, Individual #382. o OT/PT Assessments, ISPs, ISPAs, and other documentation related to OT/PT intervention for the following individuals: • Individual #305, Individual #238, Individual #522, Individual #323, Individual #240, and Individual #97 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 #174, Individual #402, Individual #243, Individual #22, Individual #172, Individual #207, Individual #467, Individual #511, Individual #425, Individual #305, Individual #182, Individual #294, Individual #388, Individual #488, and Individual #114. o PNMP section in Individual Notebooks for the following: • Individual #174, Individual #402, Individual #243, Individual #22, Individual #172, Individual #207, Individual #467, Individual #511, Individual #425, Individual #305, Individual #182, Individual #294, Individual #388, Individual #488, and Individual #114. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #174, Individual #402, Individual #243, Individual #22, Individual #172, Individual #207, Individual #467, Individual #511, Individual #425, Individual #305, Individual #182, Individual #294, Individual #388, Individual #488, and Individual #114.

	Interviews and Meetings Held: o Dr. Danielle Perry, Director of Habilitation Therapies o Gail Harris, PT o Cristen Nerren, PT o Laura Kunstmann, OTR o Various supervisors and direct support staff o ISP Meeting for Individual #278 Observations Conducted: o Living areas o Dining rooms o Day programs o Work areas o Wheelchair clinic for Individual #16 o ISP for Individual #549
	Facility Self-Assessment: The self-assessment completed by Danielle Perry, Habilitation Therapies Director, was improved over previous assessments submitted for this section. There were very clear and relevant activities conducted and most linked well to previous reports by the monitoring team. Findings reported were in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was no actual analysis of the data to support the self-rating, though most were obvious. There were no statements of actions planned to demonstrate attempts to move toward compliance in the future in the self-assessment document. These were, however, clearly described to the monitoring team during discussions with Ms. Perry onsite. These could be documented moving forward. Ms. Perry and her staff were on track to ensure progress would be made for the next review. While there were overall improvements noted, on-time assessments, assessment content and the system of monitoring continued to be problematic. Benchmarks (in measurable terms) were not established; this may be an area to consider for future assessment over the next six months. These benchmarks may be used to establish targets for success and to track progress. Though much continued work was needed, the monitoring team acknowledges the strides that Ms. Perry made during the last six months. The facility rated itself as not in compliance with all four items of section P. While the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team concurred with these findings.

	Summary of Monitor's Assessment: There was continued progress towards substantial compliance in several aspects of provision P. The majority of the assessments, though completed, were completed after the ISP. A late assessment creates a void in the development of an ISP in an integrated team manner. It requires that extra time from all IDT members because it requires that they then meet (again) for an ISPA to ensure that all recommendations are addressed. That is not fair to the individual and to other team members. There were improvements in assessment content related to 48% of the elements and at least six of the elements were present in more than 80% of the assessments. Most, however, were consistently well below 80%. Only 15% of the assessments reviewed contained over 60% of the required elements. The average for all 13 assessments was approximately 45%. This was a slightly higher average than that identified by the department consultant (35%) who reviewed a small sample of assessments as well. Both of these averages were lower than the average of 69% reported in the self-assessment. The assessments continue to focus primarily on the clinical aspects of health and safety, with rather limited focus on skill acquisition or motor skill improvements. There were some notable exceptions, particularly with an increase noted in OT services and direct therapy overall. It is critical, however, that these interventions be based on sound rationale, with measurable and functional objectives with clearly stated performance criteria. Documentation should consistently review the individual's status related to the objectives and this should drive the continuation or termination of services. Though improvements were evident, the OT/PT supports and services were not consistently integrated into the ISPs. Guidelines for use during the ISP meetings with prompts from the clinicians in attendance may assist the QIDPs with properly and adequately documenting these.

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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	Assessments were submitted for 35 individuals. Of those, 34 of the assessments were current within the last 12 months. The samples of assessments used for review included the following: • Sample P.1 = 13/15 individuals. An assessment current within the last 12 months was not submitted for Individual #174. The most current assessments for Individual #207, Individual #425, Individual #243, Individual #294, and Individual #22 were identified as Assessments of Current Status. Each of these, with the exception of Individual #425 (6/11/13, date of signature), included the corresponding comprehensive assessment. The current status updates were not stand-alone assessments, thus, only with the comprehensive was the information complete. In its absence, the information could not be analyzed in full and, as such, was excluded from the sample for review. • Sample P.2 = 5/5 individuals newly admitted to LSSLC in the last six months for whom a current assessment was submitted.	Noncompliance

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	mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	• P.3 = 6/24 individuals who were provided direct OT and/or PT services per the list submitted. <u>Screenings</u> Eight individuals were admitted to LSSLC between 11/1/12 and 5/31/13. Comprehensive Evaluations were submitted for five of these (Individual #594, Individual #588, Individual #220, Individual #522, Individual #59). The facility may want to consider developing a strong, but brief, screening to rule out a need for assessment for individuals newly admitted rather than this lengthier document to determine if a comprehensive assessment was indicated. Based on the compliance reported in the spreadsheet submitted: • 3 of 5 individuals in Sample P.2 (60%) received an OT/PT assessment within 30 days of admission based on the Admission Activity list and the signature dates on the assessments. It was reported that electronic versions were generally made available sooner than the signed copy, but there was no evidence of when these were submitted. None of these was included in the assessment tracking log that listed data processing dates for the assessments submitted. The following metric was not applied because LSSLC did not use an OT/PT screening at the time of this review: • If screenings were completed, ___ of ___ individuals (%) identified with therapy needs through a screening (%), received a comprehensive OT/PT assessment within 30 days of identification. <u>OT/PT Assessment</u> Only current and complete assessments included in Sample P.1 (13) were included in the following analysis: • 0 of 13 individuals had comprehensive assessments that contained each of the 22 elements outlined below. The elements listed below are the minimum basic elements necessary for an adequate comprehensive OT/PT assessment. The state assessment format and content guidelines generally required that these elements be in the assessments. Based on review of Sample P.1, the analysis for comprehensiveness of the OT/PT assessments was as follows: • 1 of 13 OT/PT current assessments (8%) for individuals in Sample P.1 were dated (dates of signatures) as completed at least 10 working days prior to the annual ISP. o Additionally, there were 169 assessments listed in the tracking log for ISPs dated 12/17/12 through 6/14/13. This list documented the dates that the assessments were electronically submitted (data processing date). Based on this log, only 19% of the assessments were performed	

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		on or before the designated due date. At least 22 of these assessments were not completed at all at the time of this review. • 9 of 13 individuals' OT/PT assessments (69%) were signed and dated by the clinician upon completion of the written report. This was a decrease from 81% in the previous review. In most cases, at least one of the clinicians dated the signature, but others did not. All clinicians need to date their signature. • 8 of 13 assessments (62%) included diagnoses and relevance to functional status. An improvement from 0% in the previous review. • 1 of 13 assessments (8%) included previous medical history and relevance to functional status. While the medical history was generally described, there was no reference to the manner in which these impacted functional status. Minimal improvement from 6% in the previous review. • 7 of 13 assessments (54%) addressed health status over the last year. An improvement from 31% in the previous review. • 10 of 13 assessments (77%) listed medications and potential side effects relevant to functional status. A slight improvement from 75% in the previous review. It was noted, however, in most cases, a plethora of side effects were listed, many of which may not related to functional skills or the provision of OT/PT. There were no statements as to whether the individual experienced any of the side effects. • 13 of 13 individuals' OT/PT assessments (100%) included individual preferences, strengths, and needs. An improvement from 64%. Some of these were limited and there was no evidence that this information was used to guide the selection of supports and interventions. • 2 of 13 assessments (15%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work). Improved from the previous review, but decreased from 31% in the review prior to that. • 3 of 13 assessments (23%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. The majority of descriptions were very clinical in nature rather than functional. Functional descriptions promote better use of the information by the therapists and the IDT. In many cases, the assessment did not clearly describe posture in various positions, or sitting and posture. There were notable improvements in the fine motor, sensorimotor function and activities of daily living areas. Overall, this was a decrease from 40% in the previous review. • 9 of 11 assessments provided a description of the current seating system for those requiring a wheelchair (82%). An improvement from 67% in the previous review. There was usually only a general statement that an individual had a wheelchair for support and mobility, but specific elements of the device were not outlined with a sufficient rationale. In many cases, it was not clearly stated that the device did or did not meet the individuals' needs.	

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		• 5 of 13 assessments (38%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. This was an improvement from 0% in the previous review. This was typically noted in the Risk Assessment related to specific risk areas. • 4 of 13 assessments (31%) included discussion of the expansion of the individual's current abilities. An improvement from 17% in the previous review. • 1 of 13 assessments (8%) included discussion of the individual's potential to develop new functional skills. This was consistent with the previous review. There was essentially little that identified potentials for improvements in functional status for the individuals included in this sample. o In the case of Individual #511, he did not use the grasp cuff toothbrush listed on his PNMP and it could not be located. It was stated that it would be removed from his PNMP rather than investigate why he did not use it and whether another option would have been more successful, particularly because he had functional fine motor abilities. • 4 of 13 assessments (31%) included a comparative analysis section that clearly analyzed the individuals' level of functional status with previous assessments. A decrease from 75% the previous review. It was not consistently identified whether the health status over the last year had impacted the individual's functional performance. • 5 of 13 assessments (38%) included documentation of the relationship between the individual's risk levels and their performance of functional skills. An improvement from 13% in the previous review. • 13 of 13 assessments (100%) identified need for direct or indirect OT and/or PT services, and provided recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs. An improvement from 77% in the previous review, though all identified indirect supports only. o For Individual #243, the sensorimotor section noted a need to evaluate her for sensory swings when orders for bed rest were lifted, but this was not included in the list of recommendations. o Individual #388 was identified as appropriate for the Calming Sensory Group, and further assessment was recommended when the Sensory room in 550 was set up. Specific sensory equipment was identified as appropriate for use with her. The only recommendation was that OT/PT would continue to follow-up with sensory as appropriate. By not translating this into the recommendation section, it was likely that they would be overlooked by the IDT and/or clinicians. • 0 of 13 assessments (0%) included a monitoring schedule. Consistent with the previous review. There was essentially no reference to a need to monitor the	

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		indirect supports provided to each of the individuals in this sample. • 13 of 13 assessments (100%) included a re-assessment schedule. Consistent with the previous review. The assessments should clearly and consistently state the plan for re-assessment, and whether they were comprehensive or updates only. • 13 of 13 individuals' OT/PT assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. This was now a required element in all IDT assessments. • 2 of 13 assessments (15%) provided a statement detailed the supports and services needed for successful community living. A decrease from 50% in the previous review. • 13 of 13 assessments (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. Consistent with the previous review. Further findings were as follows: • There were improvements in 48% of the elements. • There was regression in 24% of the elements. Others were consistent with the previous review, though three of these were consistently well below 80%. • Only 15% of the assessments reviewed contained over 60% of the required elements. The average for all 13 assessments was approximately 45%. This was a slightly higher average than that identified by the department consultant (35%) who reviewed a small sample of assessments as well. Both of these averages were lower than the average of 69% reported in the self-assessment. Assessments for individuals newly admitted (5/5) were completed within 30 days, though other assessments were consistently late, often well beyond the date of the ISP. There was continued progress related adequacy of the OT/PT assessments. There was a noted improvement in the availability of the comprehensive assessment for an associated Assessment of Current Status. There was a lack of consistency across therapists with regard to the content and organization of the assessments. While most followed a similar format, the location of key information varied greatly, making them non-user friendly for use by the IDT, as well as for new contract therapists. The analysis of assessment data continued to be weak and did not clearly establish needs and rationale for supports provided. Establishment of clinical competence of the therapists and review of their continued compliance with the elements of the OT/PT assessments may be accomplished via an expanded audit system. The monitoring team concurred with the facility in finding this provision to be in noncompliance.	

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		To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. In order to ensure that key information was available for reference, while reducing the time required to complete the annual updates, it is recommended that the comprehensive evaluation continue to be retained in the record until such time as a new one was completed. The updates for current status can then be limited to health and functional changes since the previous evaluation, and the changes required and effectiveness of supports provided in the last year. Specific statements should be included that refer to the original evaluation and that it remained accurate with the exceptions described in the update. 2. Clearly stated content guidelines or guiding questions for each section may be useful to ensure consistency of information included in the assessments and integrated into the audit process. Establishment of clinical competence of the therapists and review of their continued compliance with the elements of the OT/PT assessments may be accomplished via this system. 3. The assessments should clearly state the plan for re-assessment, whether they are comprehensive or updates only. This should be distinguished from the recommended intervals for monitoring for compliance and effectiveness of any supports and services 4. The facility may want to consider developing a strong, but brief, screening to rule out a need for assessment for individuals newly admitted rather than this lengthier document to determine if a comprehensive assessment was indicated. 5. Establish benchmarks for more timely completion of assessments.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing	<u>Direct OT/PT Interventions:</u> The records of individuals in Sample P.4 were reviewed with the following findings: • 6 of 6 individuals' direct intervention plans (100%) were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety. Though initiated in a timely manner, intervention plans for PT and/or OT services were not routinely established as follows: o There was no OT intervention plan and there were no measurable objectives for desensitization for wearing a helmet for Individual #305. o The OT/PT assessment for Individual #238 (12/20/13) recommended that OT evaluate and provide sensory programming to address toe walking and SIB to prevent falls. Direct OT was initiated on 12/27/12, but there was no intervention plan or measurable objectives. Based on the progress note 1/3/13, it was likely the initial contacts were for the purposes of assessment. As of 1/3/13, measurable objectives were stated, but they were very broad with insufficient performance criteria. For example, one objective stated that he would stay on task for three to	Noncompliance

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	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.	five minutes with minimum room distraction. The criteria as stated would require that he only perform that task one time to meet the objective. An OT progress note form identified an individual program plan with different objectives, but without rationale for the changes. o Though direct OT appeared to be initiated on 1/30/13 for Individual #522, there were no measurable objectives until April 2013. These changed several times across the next two months without clear rationale. OT continued at the time of this review. o Measurable objectives were not clearly stated related to direct PT intervention initiated on 11/30/12 for Individual #240. PT was placed on hold on 12/5/12 due to a wound. It appeared that PT was again initiated on 1/3/13. He was hospitalized on 1/8/13. There was evidence of initiation of PT again on 4/15/13, but he appeared to be seen inconsistently. There were no clearly stated measurable objectives. He was assessed on 5/2/13 for ambulation and again PT was initiated. This time there were clearly stated objectives and routine documentation by the PTA. A re-assessment of status was conducted monthly by the PT with revised objectives outlined on 6/14/13. This continued through 7/9/13, at the time of this review. o An OT sensory assessment was conducted over several sessions for Individual #97, though there was no clearly stated rationale. Direct intervention was initiated on 3/4/13 with no intervention plan or measurable objectives, though he was seen routinely by the OT. A monthly summary note was written on 6/3/13, but did not refer specifically to measurable functional outcomes, but rather only that he tolerated the interventions. The program plan goals were modified in May 2013 with no clear justification. Data collection identified the activities used only rather than progress toward objectives. OT appeared to be continued at the time of this review. • For 5 of 6 interventions for individuals (83%), the current OT/PT assessment or consult identified the need for OT/PT intervention with rationale. • For 0 of 6 individuals' records (0%), there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. • For 1 of 4 individual's record (25%), whose therapy had been terminated (Individual #305), termination of the intervention was well justified and clearly documented in a timely manner. An OT discharge summary for Individual #238, dated 4/30/13, did not address the status of all of the stated objectives and, as such, discharge was not clearly documented. PT was initiated and terminated for Individual #238 and Individual #240 on several occasions and none were clearly justified or documented.	

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		The system for documentation was not consistent for each of the six individuals reviewed. There was an assessment or consult to identify the need for OT or PT intervention, but the rationale and plan with measurable and functional objectives was not noted in all cases. There was no associated SAP associated with these services. Data sheets were used inconsistently and IPNs were generally used to document intervention sessions. In the case that the COTA or PTA provided the intervention, evidence of review or monthly progress notes completed by the OT or PT was noted in one case only (Individual #240). Though he had been seen several times for direct PT, this was noted only for the most recent round of direct therapy that continued at the time of this review. Documentation appeared routine, but did not consistently effectively close the loop on the direct services provided. Review of progress notes should be considered with the following elements: • Information regarding whether the individual showed progress with the stated goal(s), including clinical data to substantiate progress and/or lack of progress with the therapy goal(s); • A description of the benefit of the program; • Identification of the consistency of implementation; and • Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. • A comprehensive progress note was completed on at least a monthly basis that offered a comparative analysis to progress made the previous month or across a quarter. • Termination of the intervention was well justified and clearly documented in a timely manner. Each of these elements was noted for 0 of the 6 (0%) individuals in Sample P.4. <u>Indirect OT/PT Interventions:</u> The primary indirect OT/PT intervention provided to individuals was the Physical Nutritional Management Plan. Refer to section O.3 above regarding PNMP format and content. Implementation of PNMPs is addressed in section O.5. In most cases, it appeared that the PNMP was updated within 30 days of the ISP, though this could not be consistently tracked across all the individuals in Sample P.1. In some cases, the ISP was not current, the assessment was not current, the recommendations were very general, and were not reflected specifically in the ISP. Generally, it appeared that the ISPs addressed each of the recommendations for indirect supports outlined in the current OT/PT assessment, including the PNMP. In some cases, however, though recommendations were listed in the ISP when presenting the OT/PT	

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		information, these were not consistently listed as services, supports, or actions in the plans. Also, the ISP generally stated only that the PNMP had been reviewed and approved, rather than reflecting a discussion of any proposed changes to the plan. <u>Integration of OT/PT Supports and Services in the ISP</u> Attendance by either OT or PT or both disciplines was noted for approximately 73% of the ISPs included in Sample P.1. Review of the ISPs submitted was as follows: • 73% (11 of 15) of the ISPs submitted were current within the last 12 months. • 100% (11 of 11) of the current ISPs had attached signature sheets. • 9% (1 of 11) of the current ISPs with signature pages submitted were attended by both the OT and PT. • 18% (2 of 11) were attended by PT only. • 45% (5 of 11) was attended by OT/COTA only. • 27% (3 of 11) of the current ISPs had no representation by an OT or PT. The new system of pre-ISPs will designate which disciplines will be required to attend the ISP. The monitoring team looks forward to review of this system during the next review. o The Pre-ISP for Individual #207 identified that the most appropriate therapist was to attend the meeting. The OT attended. In the case of Individual #243, the Pre-ISP indicated that both OT and PT should be in attendance. Only the OT was present. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Rationale for therapist attendance in the pre-ISP process needs to be sound and clearly supported. 2. Develop guidelines for documentation to address the essential elements to ensure that these effectively close the loop on the direct services provided. Review of progress notes may be considered via an audit system to ensure that the necessary improvements were made.	
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.	<u>Competency-Based Training</u> 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.5 above. Substantial compliance with O.5 is the standard for compliance with this element. This element was self-rated to be in noncompliance at this time and the monitoring team concurred with the self-assessment. See section O.5 above for recommendations related to staff training.	Noncompliance

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P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	<u>Monitoring</u> 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. This was addressed in section O.6 and O.7 above. There was limited evidence of effectiveness monitoring by the therapists. There were 30 PNMP monitoring forms submitted for May 2013 by OT or PT. These were focused on compliance for implementation with no indication that the plans, equipment or other non-PNMP supports were effective to address the identified needs. There were approximately 122 individuals seated in wheelchairs as their primary means of mobility and approximately 54 who required wheelchairs for distance and transport. It could not be determined from the maintenance log that monthly maintenance checks were conducted for wheelchairs or other assistive equipment to ensure that these were in proper working condition. There was no completed date to determine if these were done in a timely manner. Over 1100 entries were included in the log submitted with dates ranging from 9/5/12 through 5/30/13. There were approximately 18 entries listed as cancelled for a variety of reasons. There were approximately 100 entries listed as "pending," some as far back as September 2012. There was no reason for the delay in resolution of these identified problems and no projected completion dates were documented for any of these. This element was self-rated to be in noncompliance at this time and the monitoring team concurred with the self-assessment. See section O.5 and O.6 above for recommendations related compliance monitoring. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: Establish a consistent method for OT and PT clinicians to conduct routine effectiveness monitoring. 1. Adjust tracking of maintenance activity to reflect routine maintenance checks as well as problem-oriented work orders with dates received and dates completed in order to effectively track the timeliness of completion.	Noncompliance

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o LSSLC Dental Procedures Manual, 5/31/13 o LSSLC Procedure, Oral Suction Toothbrush, 1/1/12 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: o Individual #319, Individual #584, Individual #144, Individual #34, Individual #62, Individual #88 o ISPAs for the following individuals: o Individual #50, Individual #279Individual #522, Individual #400, Individual #539, Individual #160 Individual #76, Individual #44, Individual #332, Individual, #524Individual #70, Individual #255, Individual #138, Individual #175Individual #485 o Annual Comprehensive Assessments for the following individuals: o Individual #279, Individual #567, Individual #539, Individual #357, Individual #568, Individual #301, Individual #126, Individual #132, Individual #380, Individual #544 o Emergency Documentation for the following individuals: o Individual #301, Individual #430, Individual #95 o Oral Surgery Consultations for the following individuals: Individual #301, Individual #594, Individual #424 Interviews and Meetings Held: o Ahmad Jiri DDS, Dental Director o Tina Murray, DDS, Facility Dentist o JoAnne Lancaster, RDH o Marill Gerth, RDH o Frances Tucker, RDH o Nancy DeVore, Dental Clerk

	Observations Conducted: o Dental Clinic o Dental Clinic Observation of treatment for Individual #130 and Individual #101 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 self-assessment, updated on 6/27/13, provided data for each of the activities, but the data did not include the May 2013 data; the dental director reported that the data were not yet completed at the time of the submission of the self-assessment and documents to the monitoring team. The results of the standard 23 items were presented. However, the monitoring team noted that the methodology for some assessments was questionable. For example, in determining the compliance with completion of annual assessments, the facility should note the number that were completed within the required timeframe in addition to those that were current at the time of review. To take this process forward, the monitoring team recommends that the dental director review this report, and the recommendations included in the report, and ensure that the self-assessment includes a review of items similar to those reviewed by the monitoring team. 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 several areas since the last compliance review. The new dental director assumed the position on 3/1/13. He had worked as a locum tenens dentist since mid-December 2012. The post-graduate training he completed allowed him to offer additional services to the individuals supported by the facility. Clinic continued to be conducted daily. In addition to seeing individuals in clinic, several were seen in their homes as part of the Dental Outreach Program. Each week, both dentists and the two part time hygienists evaluated and provided treatment to individuals in their homes. Portable equipment gave them the ability to provide prophylactic services in the homes. This appeared to be beneficial for some individuals who preferred to receive treatment in a familiar environment. The facility was able to provide endodontic treatment onsite due to newly purchased equipment. In addition to the onsite treatment, more advanced services were provided by a local oral surgeon. Very few individuals were referred to the oral surgeon. Referrals were usually made for individuals who required

	extensive restorations and/or multiple extractions. 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. The facility made considerable progress in the reduction of failed appointments. The number of missed appointments decreased significantly and the facility did not report any missed appointments due to a lack of staff. Individuals who refused dental services were referred for assessment by psychology. There were a number of individuals who went to clinic and could not receive treatment. In most instances, this appeared to be an inability of the individuals to cooperate for various reasons. However, it was noted in several ISPAs that some individuals simply refused treatment, but were not listed on the reported refusal list. Generally, the review of records and documents indicated that most individuals were receiving basic dental services. The monitoring team observed the treatment of individuals in clinic as well as treatment provided in the homes through the Dental Outreach Program. Discussions with the dental director clearly indicated that there were ongoing efforts to improve the dental services provided. The outcomes of these efforts, such as treatment in the homes, plans to implement new clinic scheduling, and a decreased clinic failure rate were seen during the review. The monitoring team encountered some difficulty in reviewing other elements of care due to problems with the documentary evidence of care. The document submission for this provision was incomplete and the document requests were not appropriately fulfilled in some instances. The original document request indicated that the May 2013 data would be provided onsite. Even with a written request to update the data, the monitoring team received updated data only for oral hygiene and failed appointments. That being said, this was the new dental director's first Settlement Agreement compliance review and the monitoring team appreciates the efforts of the new dental director and his staff in preparing for this review.

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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	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 full time dental director, full time hygienist, two part time hygienists, a part time dental clerk, and a full time dental assistant. The part time dentist worked Monday through Friday mornings for a total of 20 hours each week. <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	Noncompliance

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	disabilities shall satisfy these standards.	anesthesiologist who provided services two days each month. Individuals who required treatment that was more extensive were referred to a local oral surgeon, but very few individuals were referred. The facility purchased equipment so that the dental director could provide endodontic treatment in the clinic, usually during TIVA. The total number of clinic visits and key category visits are summarized below.	

Dental Clinic Appointments 2012 – 2013						
	Dec	Jan	Feb	Mar	Apr	May*
Preventive	43	58	83	77	13	43
Emergency	1	1	1	0	0	0
Extractions	2	1	3	3	2	2
Restorative	2	4	2	3	4	3
Total	97	118	137	133	176	79

*Data through 5/17/13

The total appointments represented the number of scheduled appointments. The dental director reported that every individual was seen at least two times a year and most individuals were seen every three months.

Emergency Care

Emergency care was available during normal business hours. The facility did not maintain an on call schedule for the dental department. The dentists were not required to be available by phone after hours. It was explained that the PCP handled dental issues after hours and referred individuals to the emergency department if necessary. This practice was not consistent with the requirement to have continuous availability to dental care/consultation. During interviews, the dental director stated that he could be available by phone.

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 records of the three individuals reported to require emergency care were reviewed. It appeared that the care was timely and appropriate, although the consultation notes of the oral surgeon were incomplete. Entries in the IPN were not in the required SOAP format and legibility of some entries was poor. The documentation of pain management for these individuals was not clear. Documentation in the record is discussed in further detail in section Q2.

Oral Surgery

The facility continued to refer individuals to the oral surgeon who completed procedures at a local surgery center. Three individuals were referred to the oral surgeon during the reporting period. The facility submitted the original consultation, but not the subsequent

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		notes. The monitoring team, therefore, had no information regarding the actual treatment rendered and the timeframes within which the treatment occurred. <u>Oral Hygiene</u> Oral hygiene ratings were documented during annual exams and clinic visits. The table below summarizes the quarterly ratings.	

Oral Hygiene Ratings 2012 -2013			
Quarter	Poor %	Fair %	Good %
3rd	25	40	35
4th	21	45	34
1st	26	47	26
2nd	19	41	40

Overall, the percentage of poor ratings decreased. The percentage of individuals with good oral hygiene had a substantial increase for the last reporting period. Given that the dental clinic did not report complete data for most data sets for the month of May 2013, the monitoring team believes the accuracy of this data should be reviewed.

The Oral Health Maintenance Program was expanded to include the dentists. The revised program was known as the Dental Outreach Program. Each week, both dentists and the two part time hygienists saw individuals in their homes. A cordless dental polishing unit was purchased in March 2013. The purchase of this unit the clinic staff to provide prophylactic services in the homes. This appeared to be beneficial for those individuals who preferred to receive treatment in a familiar environment.

Suction toothbrushing was provided for 56 individuals. Individuals were identified by their primary care providers. 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 a collaborative effort of the dental clinic hygienist and CTD staff. Training occurred two times a month.

Current employees received ongoing individualized training through the outreach program. Additionally, all direct care professionals were required to complete the Oral Care refresher course annually through iLearn.

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		Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The facility must ensure appropriate access to dental services is available after hours. 2. Efforts to improve oral hygiene status should continue. 3. There should be a clearly documented plan of care for individuals with poor oral hygiene and those who experience a deterioration in hygiene status. 4. Continued work is needed to improve compliance with the requirement for annual assessments.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current 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.	Policies and Procedures The facility maintained policies and procedures related to the provision of dental services. The Dental Procedures Manual was updated in May 2013. Annual/Comprehensive Assessments 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 end of the anniversary month were considered to be in compliance. The data reported did not reflect the actual assessments completed each month, but were listed based on ISP dates. An overall compliance score was, therefore, calculated. The list provided to the monitoring team included dates for 175 individuals. The exams were completed within 12 months of the previous exam for 148 of 175 (84%) of individuals. For the 27 individuals whose exams did not occur within the required timelines, 16 were current. The facility reported the compliance rate as 93%. However, for 164 of 175 (93%) individuals who had current annual assessments, only 84% completed the evaluations within the one-year timeframe. Nonetheless, this was an improvement compared to the 68% compliance score seen during the previous onsite review. The comprehensive assessments for 10 individuals were reviewed. The documentation submitted was for individuals who received treatment with TIVA. For each individual, the facility submitted a copy of the TIVA-Assessment for and IPN entry.	Noncompliance

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		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 • 7 of 10 (70%) assessments documented the risk rating • 10 of 10 (100%) assessments documented x-rays were completed. Overall, the documentation found in these assessments was not adequate with the following problems identified: • The IPN entries, related to clinical encounters, were not consistently done in SOAP format. • The IPN entries of the dentists were not always timed and dated and many appeared as an addendum to that of the RDH, even though the RDH had signed the entry and drew a line indicating the end of documentation. • Many IPN entries were difficult to read, as was the documentation on the assessment forms. • The content was minuscule. In some cases, the dentist entered four lines with minimal comments. • The assessment form required the dentist to circle the appropriate items. Many of the forms included no recommendations for future treatment. The risk rating was blank in many. • Although x-rays were documented as done, the monitoring team could not determine the results of the x-rays. State guidelines required a review of the x-rays and with an entry in the individual's record. The assessment forms were not signed by the provider. Instead, the name of the dentist was circled. Following the onsite review, the facility reported that these documents were not legal documents and did not require a signature. To the monitoring team, they appeared to be valid documents. For the next onsite review, the monitoring team would appreciate clarification from the facility. The monitoring team was unable to determine if the IDT was provided adequate information as required. The content of the IPN entry and assessment form clearly did not provide the IDTs with dental records "sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions" because many notes were illegible, risk ratings were missing, and recommendations for	

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		future treatment were frequently not provided. This information may have been included in the annual ISP summary, but that information was not provided as part of the document submission. Nonetheless, the annual assessment documentation is the legal record of the annual exam that is included in the active records. It should be fully completed. While the records reviewed were generally inadequate, it should be noted that they were provider specific. That is, legible IPN entries in SOAP format that included adequate information were identified depending on the provider rendering treatment. Management of assessments is discussed further in section H1. <u>Initial Exams</u> The facility submitted data for six individuals admitted since the last onsite review. Five of the individuals completed initial dental evaluations within 30 days. <u>Dental Records</u> 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. As discussed above, many IPN entries were not appropriately timed and dated and many were not in SOAP format. The quality of documentation was provider specific. <u>Failed Appointments</u> The facility reported data on refusals, failed, and missed appointments. The numbers <u>as identified and reported</u> by LSSLC in the document request are summarized in the table below: |	Dec	Jan	Feb	Mar	Apr	May* | | Refused | 15 | 14 | 9 | 10 | 9 | -- | | Missed | 8 | 5 | 1 | 3 | 3 | -- | | Failed | 23(24%) | 19(16%) | 10(7%) | 13(10%) | 12(8%) | 14 | | Total | 97 | 118 | 137 | 133 | 176 | -- | *Data reported through 5/17/13 The failure rate for the reporting period was 20%, and most of the missed appointments were attributed to illness. In fact, 4 of 20 (20%) missed appointments were due to issues other than illness. This was an improvement because during the previous compliance review, many missed appointments were due to a lack of clinic and non-clinic staff and	

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		the overall failure rate was 28%. The clinic staff reported that scheduling was assisted by the monthly publishing of the dental clinic schedule which allowed for most scheduling conflicts to be resolved. The monitoring team noted that the data reported in the various documents were not consistent. Dental Restraints The facility continued to utilize oral sedation and TIVA to facilitate dental treatment. The use of both modalities required the approval of the Human Rights Committee. A board certified dental anesthesiologist conducted TIVA 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						
	Dec	Jan	Feb	Mar	Apr	May
Oral Sedation	0	6	7	3	6	8
TIVA	7	6	7	7	8	8
Off-Campus Gen. Anesthesia	--	--	--	--	--	--
Total	7	12	14	10	14	16

The monitoring team did not receive the oral surgery notes to determine the use of sedation and anesthesia during off campus appointments.

Strategies to Overcome Barriers to Dental Treatment
The dental director reported that failure rates were decreasing as a result of the Dental Outreach program. The facility continued the process of referring individuals, based on previous need for sedation for routine care and/or behavior, to psychology for assessment for completion of the Dental Desensitization Assessment Tool and/or Appointment Preference Assessment. Treatment plans, based on these assessments included dental education and toleration, dental support plans, simulation plans, desensitization plans, and SAPs.

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 list of individuals for whom the IDTs had met to develop strategies. The list included 29 individuals. A review of the ISPAs showed that many of these individuals went to clinic, but refused to allow staff access to render any treatment. Other individuals, such as Individual #221, refused to attend clinic appointments. None of these individuals on the list was counted as refusals. In most cases, the review was completed because sedation was requested by the dental clinic.

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		For individuals who refused treatment, the facility submitted six treatment plans, which were a mix of the various treatment plans described. One formal desensitization plan was identified. Overall, each of the plans targeted the particular problems that were determined to be the obstacles in the provision of treatment. The dental desensitization workgroup continued to meet regularly to foster mechanisms to decrease the use of sedation. The monitoring team attended this meeting where discussions included assigning each unit one day each week for clinic, scheduling use of dental simulation room, and expanding the use of checklists for toothbrushing monitoring. Overall, it appeared that the facility made good progress in decreasing failed appointments and addressing the barriers encountered in the provision of dental services. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. Considerable work is needed in the areas of documentation and record management and the accuracy of refusal data requires review. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. Continued work is needed to improve compliance with the requirement for annual assessments. 2. The state dental services coordinator should review the facility's documentation process and ensure that there is a clear understanding of the requirements. 3. Required annual assessments forms should be fully completed even when other documents such as the annual dental summary include relevant information. 4. All documents completed by the dentist should be signed. If completed electronically, an appropriate electronic signature is acceptable. Circling the name of the dentist is not verification that the dentist completed the document. For the next onsite review, the facility should clarify for the monitoring team where electronic signatures, circles, and actual signatures are used. 5. The clinical serves director should ensure that the clinic staff is aware of all requirements of documentation and consider including them on documentation inservices provided to the medical staff. 6. Per facility requirements, documentation of all clinical encounters with the individuals should be in SOAP format. 7. Consideration should be given to using electronic documentation for clinic services.	

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		8. In accordance with policy, there should be a legible entry in the records of the results of x-ray findings. 9. The annual assessment should include the recommendations for further care. If there are none, that should be stated. The entry should not be left blank. 10. The clinic should ensure that refusals are accurately recorded.	

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 Section R Presentation Book o Facility Self-Assessment, Action Plans and Provision of Information o Current SLPs, license numbers, caseloads o Continuing education and training completed by the SLPs since the last review o Facility list of new admissions since the last review o Master Plan o Tracking log of SLP assessments completed since the last review o SLP/Communication assessment template o Speech Language Pathology Screening template o List of individuals with behavioral issues and coexisting severe language deficits o List of individuals with PBSPs and replacement behaviors related to communication o PBSP minutes and attendance rosters for the past six months o List of individuals with Alternative and Augmentative communication (AAC) devices o AAC-related database reports/spreadsheets o List of individuals receiving direct communication-related intervention plans o Communication monitoring forms submitted o Summary reports or analyses of monitoring results o Communication Assessment for individuals recently admitted to LSSLC: Individual #20, Individual #59, Individual #522, Individual #588, and Individual #594. o Communication Assessments and ISPs for the following individuals: • Individual #151, Individual #68, Individual #582, Individual #535, Individual #471, Individual #519, Individual #34, Individual #258, and Individual #194. o Communication Assessments, ISPs, ISPAs, SAPs and other documentation related to communication for the following individuals: • Individual #285, Individual #258, Individual #592, Individual #126, Individual #20, Individual #59, Individual #360, Individual #68, Individual #34, Individual #151, Individual #369, Individual #542, Individual #128, Individual #326, Individual #502, and Individual #535. 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 #174, Individual #402, Individual #243, Individual #22, Individual #172, Individual #207, Individual #467, Individual #511, Individual #425, Individual #305, Individual #182, Individual #294, Individual #388, Individual #488, and Individual #114. o PNMP section in Individual Notebooks for the following: • Individual #174, Individual #402, Individual #243, Individual #22, Individual #172, Individual #207, Individual #467, Individual #511, Individual #425, Individual #305, Individual #182, Individual #294, Individual #388, Individual #488, and Individual #114. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #174, Individual #402, Individual #243, Individual #22, Individual #172, Individual #207, Individual #467, Individual #511, Individual #425, Individual #305, Individual #182, Individual #294, Individual #388, Individual #488, and Individual #114. <u>Interviews and Meetings Held</u>: o Dr. Danielle Perry, Director of Habilitation Therapies o Kristi Hodges, MS, CCC-SLP o Maegan Melton, MS, CCC-SLP o Amber Hodges, SLP Assistant o Various supervisors and direct support staff o ISP Meeting for Individual #278 <u>Observations Conducted</u>: o Living areas o Dining rooms o Day programs o Work areas o AAC clinic o ISP for Individual #549
	Facility Self-Assessment: The self-assessment completed by Danielle Perry, Habilitation Therapies Director, was improved over previous assessments submitted for this section. There were very clear and relevant activities conducted and most linked well to previous reports by the monitoring team. Findings reported were in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was no actual analysis of the data, however, to support the self-ratings, though most were obvious. There were no statements of actions planned to demonstrate attempts to move toward compliance in the future in the self-assessment document, but these were clearly described to the monitoring team during discussions with Ms. Perry onsite. These could be documented moving forward. Ms. Perry and her communication services staff were on track to ensure that progress is made for the next review. While there were overall improvements, on-time assessments, completion of assessments, and the

	system of monitoring continued to be problematic. Benchmarks (in measurable terms) were not established; this may be an area to consider for future assessment over the next six months. These benchmarks may be used to establish targets for success and to track progress. Though much continued work was needed, the monitoring team acknowledges the strides that Ms. Perry made during the last six months. The facility rated itself as not in compliance with all four items of section R. While the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team concurred with these findings.
	Summary of Monitor's Assessment: There was continued progress toward substantial compliance in most aspects of provision R. The majority of the assessments were not completed 10 working days prior to the ISP and many assessments were not completed at all. This clearly created a void in the development of an ISP in an integrated team manner. Significant information related to communication was based either on very old assessments or none at all. The content aspect of assessments reflected progress with 100% of the assessments containing at least 50% of the elements and a majority containing at least 60%. Improvements from the previous review were noted in 82% of the elements. It is critical that clinicians use what they learn from observing individuals in home, work, and day program areas and in direct therapy into the documentation needed for completion of the assessments. The therapists are commended for the impressive quantity of direct services they provided on a weekly basis. Integration of communication into the ISP and real time coaching and modeling for staff are also keys to effective functional implementation. Maintaining equipment already provided to individuals was reported as an ongoing and costly problem. Clear expectations from administration and supervisory staff regarding the care of these is essential in order that they are always available to the individuals who need them. Further, there was a need to expand the time available for staff training related to communication to further emphasize its importance throughout the day for every individual who lives at LSSLC and an annual refresher course is necessary to ensure that this is recognized by all staff on an ongoing basis. <u>The following samples were used by the monitoring team:</u> • Sample R.1: Individuals included in the sample selected by the monitoring team. • Sample R.2: Individuals with assessments submitted by LSSLC as most current. • Sample R.3: Individuals admitted since the last compliance review. • Sample R.4: Individuals receiving direct speech services • Sample R.5: Individuals from Sample R.1 with indirect communication supports (e.g., skill acquisition plans not directly provided by the SLP/SLPA, Communication Dictionaries).

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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> There were three SLPs with responsibilities primarily related to communication: Chris Pedroni, CCC-SLP, Kristi Hodges, CCC-SLP, and Maegan Melton, CCC-SLP. Two other SLPs Rhonda Hampton, CCC-SLP and Vickie McCarley, CCC-SLP, were assigned to mealtime and dysphagia issues and were not included as staff in this review of Section R. There was one SLP Assistant assigned to the provision of communication services. There were five positions budgeted, and all were filled. Responsibilities of the three communication therapists included, but were not limited to, conducting assessments, developing and implementing programs, providing staff training, and monitoring the implementation of programs related to communication. There were some supports related to mealtime as required, but this was predominately covered by the other two SLPs. The SLPs were assigned caseloads as follows (totals based on individual list by home): • Chris Pedroni: Castle Pines, 523, 520B, and 533: approximately 108 individuals (8% with severe language deficits) • Kristi Hodges: Woodland Crossing and 524: approximately 124 individuals (only one individual listed with a severe language deficit) • Maegan Melton: Lone Pine, 520A, 529, 539, and 542: approximately 119 individuals (51% with severe or profound language deficits) • Amber Hodges: As assigned Despite the availability of the SLPA, these caseload assignments were significantly high and may impact the ability of the speech clinicians to appropriately provide adequate supports and services in each area as noted below. <u>Qualifications:</u> • 3 of 3 SLPs (100%) were licensed to practice in Texas as verified online. • 1 of 1 SLPAs (100%) were licensed to practice in Texas as verified online. • 3 of 3 SLPs (100%) maintained current ASHA certification per the documentation submitted. <u>Continuing Education:</u> Based on a review of continuing education completed in the last 12 months: • 3 of 3 SLPs staff (100%) had completed continuing education related to communication. A number of continuing education opportunities were listed by each of the SLPs. Some included in-house topics that were not specific to communication. Others related to AAC	Noncompliance

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		vendor contact or independent research, though the hours were not listed for these. Continuing education topics that appeared to be relevant to communication included: • Every Move Counts, 11 hours (Pedroni, Hodges, and Melton) This was sufficient to continue to expand the knowledge base and competence of the SLPs. The intent of ongoing continuing education is to ensure that the clinicians attain and/or maintain knowledge and expertise related to the provision of communication supports and services, particularly related to AAC. A system to track participation in continuing education was in place at LSSLC, per the self-assessment. The clinicians generally appeared to recognize the role of relevance, alternate access sites, environmental context, and meaningful contextual training opportunities as effective methods in the development of AAC for this population. They also appeared to understand the important role of the DSPs as communication partners, though staff training related to this was limited. As discussed below, there was only one hour available for communication in NEO and there was no communication-related refresher training for existing staff. The department was encouraged to address this. <u>Facility Policy:</u> There was no local policy related to communication. The local policy should provide clear operationalized guidelines for the delivery of communication supports and services, including the following components: • Roles and responsibilities of the SLPs (meeting attendance, staff training etc.). • Outlines assessment/update schedule including frequency and timelines for completion of new admission assessments (within 30 days of admission or readmission), timelines for completion of comprehensive assessments (within 30 days of identification via screening, if implemented), and timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (within 5 days of identification as indicated by the IDT). • Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment. • Addressed a process for effectiveness monitoring by the SLP. • 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, problem resolution.	

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		There was insufficient allocation of speech clinician resources, as evidenced by assessments not completed 10 working days prior to the ISP and by very limited progress with the completion of communication assessments (see below). The facility concluded that they were not in compliance with this provision and the monitoring team concurred. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Develop a plan to address the completion of comprehensive assessments for individuals in a timely manner, while not reducing the current supports and services provided. 2. Continue to develop local policy and procedures to include the essential elements outlined above.	
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> A Master Plan was submitted (undated). This plan indicated that 34 individuals identified as Priority 1 (27%), 10 individuals identified as Priority 2 (8%), two individuals identified as Priority 3 (3%), and one individual identified as Priority 4 (2%), had been provided a comprehensive communication assessment, that is, a total of 47 assessments were completed since 2010 (13% of those included in the list of 352). Of the 47, only 12 assessments by three clinicians were completed since the previous review in October 2012. It was noted, however, that only 10 individuals were listed with assessments completed since 10/12 per the assessment log submitted. The clinicians elected to develop communication plans for AAC, rather than focus solely on completion of assessments, as previously discussed with, and encouraged by, the monitoring team. While this was certainly appropriate for a time, it was of concern that there appeared to be little focus on further progress toward completion of assessments at the time of this review. Updates were completed for nine individuals since the previous review, two of whom had not been provided previous comprehensive assessments. Six individuals were provided screenings, at least three of whom were newly admitted to LSSLC. The tracking log listed 10 assessments as completed since October 2012. Seven of these were completed after the designated due date. A communication assessment audit process was in place, though it appeared that only one was monitored per month. This small sample size would skew the findings and would not be as effective in the establishment of competency for the clinicians.	Noncompliance

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		Assessments Provided Communication assessments were submitted as requested for the following: • Sample R.1: 12/15 individuals. Assessments for Individual #172, Individual #388, and Individual #114 were not submitted in their individual records. Assessments for 12 others were submitted as follows (per signature page when available): • Speech, Language and Audiology 1. Individual #488 8/14/09, (incomplete per copy submitted) • Admission Baseline Communication Skills Evaluation 2. Individual #402 (3/2/05) • Communication Skills Evaluation 3. Individual #402 (3/11/08) 4. Individual #511 (4/4/12) • Communication Skills Evaluation Baseline 5. Individual #467 (4/4/03) • Communication Skills Evaluation Update 6. Individual #467 (3/18/09) 7. Individual #174 (7/24/08) 8. Individual #182 (11/26/08) 9. Individual #22 (3/31/09) 10. Individual #294 (6/16/09) • Communication Skills Evaluation Admission 11. Individual #305 (7/17/08) • Speech Language Screening Summary 12. Individual #425 (5/10/91) • Communication Skills Habilitation Therapies Evaluation 13. Individual #207 (9/1/00) • Communication Skills Evaluation Update/Admission 14. Individual #243 (5/8/08, incomplete per copy submitted) • Communication Skills Baseline Update 15. Individual #243 (5/16/05) None was current within the last 12 months and, as such, were not included in the analysis below. • Sample R.2: There were nine individual assessments completed by three clinicians submitted. All nine were considered to be current as follows: • Communication Skills Evaluation 1. Individual #151 (4/9/13) 2. Individual #68 (3/4/13)	

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		3. Individual #582 (12/18/12) 4. Individual #535 (11/15/12) • Speech, Language and Audiology 5. Individual #471 (4/29/13) 6. Individual #519 (4/15/13) • Speech Language Evaluation 7. Individual #34 (1/28/13) 8. Individual #258 (2/24/13) 9. Individual #194 (3/21/13) Thus, 9 of 24 individuals in Samples R.1 and R.2 (38%) were provided a current communication assessment for analysis below. There were 8 individuals admitted to LSSLC since 11/1/12. Five of these individuals were listed with screenings completed per the Master Plan submitted. Screenings were submitted and included in Sample R.3. All were added to the Master Plan, but none were included in the assessment tracking log. • 5 of 5 individuals admitted since the last review (100%) received a communication screening/assessment within 30 days of admission, based on the screenings submitted. A screening was to be provided for individuals with a change in status or for individuals who were newly admitted to the facility, though this was noted only for new admissions during this review period. It was further noted, however, that: • 0 of 0 individuals identified with therapy needs through a screening (0%) received a comprehensive communication assessment within 30 days of identification. Only five screenings were submitted (Individual #20, Individual #522, Individual #59, Individual #588, and Individual #594), all completed for admission to LSSLC. Each was assigned a priority level and added to the Master Plan for assessments to be completed at some point in the future. The Master Plan was maintained to prioritize assessment completion and to document when assessments were completed, but there were no target dates identified for completion of assessments for any individual included in this plan for any of the other individuals. • 8 of 15 individuals (53%) in the sample of individuals who were provided direct communication supports and services (Sample R.4) were provided an assessment current within the last 12 months. Individual #20 and Individual #59 were provided screenings only upon admission, though each was engaged in direct communication therapy. Though incomplete per the copy submitted, the tracking log indicated that an assessment for Individual #519 was completed	

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		on 4/15/13. Though no assessment was submitted for Individual #285, the Master Plan listed that an assessment was completed for him on 2/22/13. <u>Communication Assessment:</u> Based on review of the sample of current assessments submitted and included in Samples R.1 and R.2, it was noted that only one was identified as an update (Individual #360), and as such, the monitoring team presumed each of the others were intended to be comprehensive. There was no evidence of a previous comprehensive assessment for Individual #360, so the update submitted could not be reviewed below. Also, only those with current ISPs submitted were included. Individual #471's evaluation was removed from review because his ISP was not current within the last 12 months (5/16/12). None of the comprehensive assessments contained <u>all</u> of the 24 elements outlined below. These are 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 generally required that these elements be contained within the assessments. The comprehensiveness of the communication assessments were as follows: • 8 of 8 individuals' communication assessments (100%) were signed and dated by the clinician upon completion of the written report. • 1 of 8 individuals' communication assessments (13%) was dated as completed at least 10 working days prior to the annual ISP. This was a decrease from 21%. A number of the ISPs identified an ongoing need for assessment. In other cases, the IDT appeared to adjust the recognition of need in order to accommodate the priority established by the Master Plan. Neither of these was acceptable. • 8 of 8 individuals' communication assessments (100%) included diagnoses and relevance of impact on communication. This was an improvement from 64%. • 8 of 8 individuals' communication assessments (100%) included individual preferences and strengths. This was an improvement from 93%. Though these were listed in most assessments, they were rarely used to guide the development of meaningful communication strategies or AAC systems. • 6 of 8 individuals' communication assessments (75%) included medical history and relevance to communication. This was an improvement from 0%. Though some listed medical history, none identified the impact on communication. • 7 of 8 individuals' communication assessments (88%) listed medications and discussed side effects relevant to communication. This was an improvement from 64%. • 5 of 8 individuals' communication assessments (63%) provided documentation of how the individual's communication abilities impacted his/her risk levels.	

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		This was an improvement from 17%. • 8 of 8 individuals' communication assessments (100%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day. This was consistent with the previous review. • 5 of 8 individuals' communication assessments (63%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work). This was an increase from 36%. • 3 of 8 individuals' communication assessments (38%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required. The dictionary was recommended, but most assessments did not discuss whether it required modifications. This was an improvement from 0%. • 7 of 8 individuals' communication assessments (88%) included discussion of the expansion of the individuals' current abilities. This was consistent with the previous review. • 8 of 8 individuals' communication assessments (100%) provided a discussion of the individual's potential to develop new communication skills. This was an improvement from 64%. • 2 of 8 individuals' communication assessments (25%) included the effectiveness of current supports, including monitoring findings. This was an increase from 0%. • 7 of the 8 individuals' communication assessments (88%) assessed AAC or Environmental Control (EC) needs, including clear clinical justification and rationale as to whether or not the individual would benefit from AAC or EC. This was an improvement from 71%. • 2 of 8 individuals' communication assessments (25%) offered a comparative analysis of health and functional status from the previous year. This was an improvement from 0%. • 6 of 8 individuals' communication assessments (75%) gave a comparative analysis of current communication function with previous assessments. This was an improvement from 8%. • 6 of 8 individuals' communication assessments (75%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. This was an improvement from 36%. • 5 of 8 individuals' communication assessment (63%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff. • 8 of 8 individuals' communication assessments (100%) had a reassessment schedule. This was an improvement from 86%.	

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		• 2 of the 8 individuals' communication assessments (25%) supplied a monitoring schedule. This was an improvement from 0%. • 8 of 8 individuals' communication assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems. This was an improvement from 93%. • 8 of 8 individuals' communication assessments (100%) made a recommendation about community referral and transition. This was an increase from 0%. • 4 of 8 individuals' communication assessments (50%) included specific recommendations for services and supports in the community. This was an improvement from 0%. • 5 of the 8 individuals' communication assessments (63%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. This was a decrease from 100%. Additional findings related to the communication assessments were as follows: • 1 of 8 assessments contained more than 80% of the elements listed above. • 5 of 8 assessments contained more than 70% of the elements listed above. • 7 of 8 assessments contained more than 60% of the elements listed above. • 8 of 8 assessments contained 50% or more of the elements listed above. • 0 of 8 assessments contained less than 50% of the elements listed above. • 8 of 24 (33%) of the elements listed above were noted for 100% of the assessments reviewed. • Improvements from the previous review were noted in 82% of the elements. Decreases were noted for only two elements. There were no content guidelines used by the clinicians to ensure that the required content was addressed in each assessment and should be considered. A system of assessment audits implemented by the department for the establishment of competency of the speech clinicians was established in December 2012. External review was also implemented to promote further progress in this area. However, only one audit was conducted monthly and, at this point, would not adequately reflect the status of compliance with the elements described above. As significant improvements were noted since the previous review, expanding the audit system and the development of guidelines should promote further improvements over the next six months. <u>SLP and Psychology Collaboration:</u> There were approximately 193 individuals listed with PBSPs and 16 of these were included in the Samples R.1 and R.2 identified above. • 8 of 9 communication assessments reviewed for individuals in Sample R.2 (89%) addressed some aspect of the individual's behavior in the Behavioral	

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		Considerations section. Six of these individuals were identified as provided a PBSP. This section generally reported behaviors observed by the SLP during assessment and stated the target and replacement behaviors per the PBSP. Discussion of the communicative intent of these behaviors was limited. This section was not included in the assessment dated 4/24/13 for Individual #471. In the case of Individual #34, the clinician reported that there were no identified target behaviors, though Individual #34 was listed with a PBSP. • For 3 of 9 individuals (33%) in Sample R.2 for whom current assessments and ISPs were submitted (the ISP for Individual #471 was dated 5/16/12), communication strategies identified in the assessment were included in the ISP. The strategies in the communication assessments for staff use were not generally easily identified, so likely did not also translate to the ISP document for further reference. For those individuals included in Sample R.1, current ISPs were submitted for 11 of 15. PBSPs were included in the individual records as submitted for eight individuals, though three were expired at the time of the onsite review (Individual #182, Individual #22, and Individual #488). Of these, only Individual #22 was identified as currently provided a PBSP per the list submitted to the monitoring team. Though this list also indicated that Individual #511 had been provided a PBSP, none was included in his individual record. Since no current communication assessments were submitted for any of the individuals, the following metrics could not be applied for this review: • For __ of __ individuals (%), communication strategies identified in the assessment were at least partially included in the PBSP. • For __ of __ individuals (%) communication strategies identified in the assessment were included in the ISP. There were 24 meetings held to review PBSPs from 12/4/12 through 5/21/13 and a SLP attended 18 (75%) of the meetings held. Participation in the review of PBSPs during these meetings was one opportunity to promote collaboration between psychology and the SLPs. This should continue with an effort to improve frequency. It is understood that collaboration for assessment and development of PBSPs and communication plans may need to occur prior to the time of review by the Behavior Support Committee and, in that case, the facility is encouraged to document those efforts. This element was not yet in compliance as evidenced by assessments not completed 10 working days prior to the ISP, limited attendance at ISP meetings, and very limited progress with the completion of communication assessments. While improvements were noted with the inclusion of the essential elements in the completed communication assessments, further progress is still needed. A strength appeared to be related to the	

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		collaboration between speech and psychology, though the absence of assessments reflected on the application of communication strategies in the PBSPs and the ISPs. The facility concluded that they were not in compliance with this element of Section R and the monitoring team concurred based on the findings reported below. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Develop a plan, to include benchmarks, to address the completion of comprehensive assessments for individuals in a timely manner, while not reducing the current supports and services provided. 2. Consider the development of assessment guidelines consistent with the essential elements outline above. The use of guiding questions that are answered in the appropriate section of the written report is often helpful to the clinicians.	
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 ISPs for 15 individuals in Sample R.1 the following was noted: • 11 of 15 ISPs (73%) were current within the last 12 months (Individual #425, Individual #305, Individual #174, and Individual #511 were not). • In 2 of 11 ISPs reviewed (18%, for Individual #114 and Individual #294 only), there was evidence that a SLP attended the annual meeting. Each of these individuals had severe or at least significant communication deficits. o The pre-ISP for Individual #207 identified each of the three Habilitation Therapies clinicians, and stated that the most appropriate should attend. On 4/11/13, the IDT reviewed the previous communication assessment (7/1/10), which indicated that she should be re-evaluated for AAC following intervention from OT related to tactile defensiveness. The team identified this as a continuing concern, yet she did not receive OT service. It was of concern that three years later, this was still an unmet need. Per the ISP, there was no evidence that this had been addressed through assessment by speech or OT, discussion, or action steps. An OT was in attendance at the ISP, however. o In general, teams continued to identify the need for communication assessments, yet they were not completed in a timely manner. • In 8 of 11 ISPs for individuals with communication supports (73%), the type of AAC and/or other communication supports (e.g., Communication Dictionary, Communication Plan, strategies for staff use) were identified, though most of these were limited to the Communication Dictionary only. • Communication Dictionaries were reviewed at least annually by the IDT for 3 of 11 (27%), as evidenced in the ISP. These only documented IDT approval of continued use and stated that they were reviewed and updated, but did not	Noncompliance

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		address the accuracy of the content or identify any necessary changes. This appeared to be completed by the shift charges and home managers with no participation from the SLP. • 6 of 11 ISPs (55%) included a description of how the individual communicated. Some of these were very limited and most were based on a previous communication evaluation as far back as 2009 for Individual #172, 2008 for Individual #467, and 2010 for Individual #207 and Individual #488. • 1 of 11 ISPs (47%) contained skill acquisition programs to promote communication. Only one of these involved participation related to program development by the SLP (Individual #402), though the measurable objective was not stated. The functionality of a number of these other programs was questionable and all of these would benefit from collaboration with the SLP to develop appropriate and meaningful learning objectives, steps, and strategies: o Individual #207 was to indicate activities she would like to participate in as a leisure objective. The ISP specifically stated that she was not able to communicate her desires. It was not clear how this would be accomplished. There was no evidence of SLP involvement. o Individual #22 was to use a Big Mack Communicator and to use a pressure plate to say "I'm thirsty." There was no evidence that the SLP was involved in any way with this objective. o Individual #294 was to pick a hat from two choices. An action plan to have her communication wheel with her at all times was to be developed, but was not included in the ISP. Direct speech therapy, though recommended, was also not included. o Individual #467 was to choose between two types of music, but the ISP did not reflect how she might do that. There was no evidence of SLP involvement in this objective, though a current communication assessment was identified as needed per the ISP 3/8/13. o Individual #172 was to look toward the instructor when his name was called and to be encouraged to communicate through changes in behavior and vocalizations. • In 0 of 11 ISPs reviewed (0%) information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports or interventions involving the SLP were included.	

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		Individual-Specific AAC Systems: There were approximately 44 individuals who were provided some type of AAC per the Implemented AAC Database dated 10/31/12: • Big Mack switches (11), Go Talk (2), Express One (11), Talking Photo Albums (4), Dynavox systems (6), Spectronic switches (2), picture schedules (2), communication pictures (4), communication posters (3), communication wheels (3), communication boards 3), object boards (1), communication lapboards (8), activity vest (1), third arm switch (1), talking icons (2), talking watch (1), and Talkables II (1). It was not clear why this database had not been updated for the current review. During the last review, it was reported that 39 had AAC and this was consistent with the current Master Plan submitted. The AAC listed in the Master Plan (AAC implemented since 10/12) and the Implemented AAC Database did not match, so it was not clear how many individuals actually were being provided AAC. Individuals who used sign language were not included in either list. It was not known how many individuals were provided a Communication Dictionary or EC. There was no evidence of Communication Plans. The assessments completed were generally improved, though as stated above, did not contain all of the required elements. That said, informal assessment by the clinicians had occurred to establish the need for AAC and determine the type of AAC that was most appropriate for individuals. Because of this, a wide variety of AAC systems were provided for at least 44 individuals and others were engaged in direct communication therapy (41). This was all very good to see. Even so, this represented only a small percentage of the individuals identified as Priority 1 and 2 (a total of at least 245 individuals). While not all of these would necessarily benefit from AAC, an assessment to rule this out was indicated. In some cases, individuals listed as Priority 3 or 4 may also require AAC (another 107 individuals). The AAC Database identified the provision of AAC for 24 Priority 1 individuals, 16 Priority 2 individuals, and 4 Priority 3 individuals. There continued to be unknown needs in the area of communication. The majority of the assessments for the individuals in Sample R.1 (86%) provided an adequate assessment of the individual's potential for AAC use. Significant direct intervention and trials occurring in the natural environment (in situations that were most meaningful to the individual) were utilized to identify appropriate AAC for those not yet provided a formal communication assessment. The clinicians consistently used training/teaching models to expose and promote interest and use of AAC across settings with attempts made for use settings over time in order to spark interest, such as to request a favorite item, food, beverage, music, vibration or massage.	

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		General Use AAC Devices: Though general use devices were noted in some areas, these were not quantified. Communication books were developed and placed in meeting rooms to assist during an ISP meeting, for example. The meaningfulness and function of the other devices appeared to be very appropriate and many were noted to be in use and/or specific training was occurring to promote their use. The clinicians appeared to understand the application and integration of AAC as there were very excellent supports in place. Direct Communication Interventions: There were 41 individuals listed as participating in direct communication-related interventions provided by the SLP. Most of these pertained to AAC use. This was a notable improvement from the previous review when 26 were reported to receive direct communication therapy. This was impressive and the monitoring team commends the efforts of the clinicians in this regard, particularly as all were scheduled to be seen at least two to three times per month and others weekly (or more) for 15 to 30 minutes each. The focus of interventions described in the documentation appeared to be very functional, and each stated that measurable progress was expected, though none were stated in actual measurable terms. Generally accepted practice standards for comprehensive progress notes related to communication interventions include: • Contained information regarding whether the individual showed progress with the stated goal. • Described the benefit of device and/or goal to the individual. • Reported the consistency of implementation. • Identified recommendations/revisions to the communication intervention plan as indicated related to a comparative analysis of the individual's progress or lack of progress. Records related to the provision of direct intervention plans for six individuals were reviewed (Sample R.4). This included assessments, ISPs, ISPAs, SAPs and progress notes. • 0 of 6 individuals received direct therapy documented per generally accepted practice standards related to communication interventions. Some findings were as follows: o Individual #285: No assessment was submitted. There was no ISP or ISPA that addressed direct services being included in his annual plan. There was no SAP, but other forms indicated that there was an ISP goal to participate in programming to determine if he was a candidate for AAC. The first progress note was for January 2013. Specific measurable	

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		objectives were outlined, though the data presented in the progress notes were inconsistent. The progress notes did not meet basic generally accepted standards for documentation of direct intervention. Frequency varied greatly month to month through May 2013. o Individual #258: It was recommended that he participate in direct speech therapy to address articulation for 15 to 30 minutes four times per month for an indefinite period of time. Therapy sessions were provided consistently by the SLPA. Routine session notes were present and data were reported relative to the established objectives. There was no evidence, however, of review by the SLP to ensure that therapy was conducted as intended and that it was determined to be effective and appropriate. Thus, the progress notes did not meet basic generally accepted standards for documentation of direct intervention. o Individual #592: His most current communication assessment was an update on 1/29/13, the date of his ISP meeting. It indicated that he might benefit from consistent provision of direct speech therapy. This had been previously recommended, but not provided. Specific measurable objectives were outlined with a frequency of two to four times monthly for an unspecified duration. These were not reflected as an action step or objective. There was no evidence of implementation. Thus, the documentation did not meet basic generally accepted standards for the provision of direct intervention. o Individual #20: She was provided a communication screening at the time of her admission to LSSLC. Skilled therapy was deemed warranted to conduct in depth articulation testing. No SAP was submitted, but progress notes were submitted from January 2013 through June 2013. Therapy was generally conducted by the SLPA or graduate intern. Routine session notes were present and data were reported relative to the established objectives. There was no evidence, however, of review by the SLP to ensure that therapy was conducted as intended and that it was determined to be effective and appropriate. Thus, the progress notes did not meet basic generally accepted standards for documentation of direct intervention. There was inconsistency in the documentation and provision of direct intervention related to communication. Guidelines for the development of plans, documenting, and are staff training were needed. Routine review and audits of these is indicated.	

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		Indirect Communication Supports: Indirect communication supports for individuals included the communication dictionary only, though these appeared to be developed by the home managers and supervisors without specific input from the SLPs. The dictionaries were mentioned in some of the ISPs (but not described) and there was little evidence of annual IDT review. SAPs related to communication were developed by day program or home staff again without evidence of SLP participation. There was no evidence of documentation for the individuals related to the benefit and effectiveness of the supports, consistency of implementation, or recommendations related to necessary changes. Competency-Based Training and Performance Check-offs: New employees participated in NEO classroom training and completed competency check-offs for foundational skills related to communication. Per the schedule, content related to hearing aids was offered for one hour, despite the fact that there were only three individuals who wore these. There was only one hour related to AAC to present communication rights, permit an opportunity for new employees to explore the systems, and to present guidelines for use. It would not be possible to present all the information needed for DSPs to competently implement communication plans or to be communication supports as partners in this amount of time. No refresher training was completed in the area of communication. This was of significant concern to the monitoring team. This is an area that impacts all individuals who live at LSSLC and staff effectiveness is dependent on successful communication with individuals as well as their accurately interpreting and responding to individual efforts to communicate with staff and others. More time to address this critical area is needed for NEO, and communication should be addressed with annual refresher training. Lost and damaged equipment at the facility resulted in the unavailability of key supports for individuals who need them and great financial loss for the facility. Effective staff training and administrative support will be key to ensuring that staff understand the importance of these systems to the individuals and their quality of life. There was insufficient integration of communication supports and services into the ISP. In the ISPs submitted for review, there was a lack of focus on communication as evidenced by the limited descriptions of how the individual communicated and strategies for staff use to be effective communication partners. There were limited meaningful SAPS included in the ISPs and there was no evidence that the SLPs collaborated in the development of measurable objectives and effective strategies for implementation. The provision of direct communication therapy was a notable strength, though improvements were needed in the documentation of these interventions. The facility	

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		concluded that they were not in compliance with this provision of section R and the monitoring team concurred. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Establish a system to track SLP attendance as described by the pre-ISPs. Guidelines for IDTs should be provided to assist them in making the determination as to whether an SLP was needed at the meeting and how to address the identified needs for assessment. 2. Develop a plan to address the completion of comprehensive assessments for individuals in a timely manner, while not reducing the current supports and services provided. 3. Establish guidelines for the inclusion of communication supports in the ISPs to ensure that there is a clear description of how the individual communicates that includes AAC system where applicable and that there are specific strategies for staff to use as effective communication partners with the individuals they support. 4. Review the manner in which the Communication Dictionaries are developed and maintained to consider involvement by the SLPs. Ensure that these are reviewed for accuracy on an annual basis by the IDT. 5. Establish guidelines for documentation of direct speech therapy. 6. Promote increased participation in the development of communication-related SAPs implemented by staff other than the SLPs.	
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	<u>Monitoring System:</u> A system of monitoring was established at LSSLC using a universal monitoring form rather than one specifically related to communication. As such, it was not possible to discern discrete measures, such as the following: • Type of equipment or support monitored • Communication equipment was present • Equipment was found in the correct location • Equipment was in working condition • Staff response to use of the device • Staff were able to describe the purpose of the device. • Tracking of the effectiveness monitoring of AAC systems that was conducted by the speech therapists or the IDT with documentation in the IPN or ISP.	Noncompliance

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	shall be reviewed and revised, as needed, but at least annually.	Though this was reported to be in development, there was no local speech services policy for monitoring of communication supports to address: • Monitoring for the presence of communication adaptive equipment or other AAC supports/materials. • Monitoring for the working condition of communication adaptive equipment. • The frequency of monitoring. • Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work). • The process for identification, training, and validation for monitors. • The process of inter-rater reliability. • A process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic). The self-assessment reported that 120 monitoring tools were completed over a six-month period from December 2012 through May 2013. Average scores were reported as an aspect of the self-assessment, ranging from 63% in January to 95% in February 2013. The average across the six-month period was 81%. While this exceeded the 80% score established for substantial compliance, the Universal Tool allowed for the equipment to be missing, not in working order, and not used, and for the plan to not be performed as written… and still achieve a compliance score of 80%. Discontinuing use of this form was being considered. The facility monitoring data did not report on the following key compliance indicators: • Frequency of monitoring consistent with recommendations. • In the case a problem was identified, there was evidence of resolution (in the case that a problem was identified). • Compliance scores with specific elements across the facility and across homes to better determine training and monitoring needs. Completed forms for communication-related monitoring conducted in May 2013 (49) were submitted for review. These were completed by the PNMPCs. There was no way to determine what was monitored for most individuals. The equipment or supports were inconsistently written in at the top of the form. Compliance was scored as follows • 100%: 27 individual monitorings • 90%: 15 individual monitorings • 80%: 2 individual monitorings • 60%: 1 individual monitoring • 30%: 1 individual monitoring • Incomplete forms: 3	

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		In the case of the two monitorings found not to be in compliance, there was no evidence of actions taken to address the problems identified and there was no evidence that anyone else had been notified. There were two forms that were not scored despite the documentation that staff had to find the equipment (Individual #428) and that staff reported the equipment was in the trash in the other (Individual #490). • By not scoring these properly, inaccurate bias toward compliance occurs because these low scores were omitted from the data. There were four forms with a reported score of 100%, yet the majority of elements were marked "N/A." • The forms documenting 90% compliance included a variety of elements with a "no" designation, including that the plan was implemented as written (2), the plan was present and/or easily located (3), and staff were trained (8). • For the two forms scored at 80% elements scored "no" included two highly critical elements, (a) materials/equipment was present, working, and utilized, and (2) the plan was performed as written/instructed. • This was of significant concern to the monitoring team and impacted the validity of the compliance scores reported in the self-assessment. This was recognized by the Habilitation Therapies Director and she reported that she was working to remedy this process. At the time of this review, there was no effective mechanism in place to ensure an accurate assessment of AAC use at the facility. There was no evidence of a system for effectiveness monitoring by the professional staff at this time. Due to the ineffective monitoring system in place at this time, this R4 was not found in compliance by the facility and the monitoring team concurs with this finding. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Consider the development of a communication-specific monitoring tool with clear guidelines for its use. The elements should be more discrete and permit accurate analysis of the findings to permit system changes and to guide training and monitoring. Clear guidelines and staff training for effective implementation are indicated. 2. Include elements of monitoring in the development of local policy and procedures. 3. Frequency of individual monitoring should be outlined in the communication assessments. 4. Routine effectiveness monitoring should be outlined in the assessments and implemented by the speech clinicians. Standardize the procedures for conducting and documenting these.	

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o Individual Support Plans (ISPs) for: • Individual #106, Individual #108, Individual #467, Individual #380, Individual #444, Individual #402, Individual #249, Individual #176, Individual #142, Individual #300, Individual #45, Individual #151, Individual #285, Individual #138, Individual #332, Individual #129, Individual #124, Individual #304, Individual #294 o Skill Acquisition Plans (SAPs) for: • Individual #106, Individual #108, Individual #467, Individual #380, Individual #444, Individual #402, Individual #249, Individual #176, Individual #142, Individual #300 o Monthly review of SAP progress for: • Individual #106, Individual #108, Individual #467, Individual #380, Individual #444, Individual #249, Individual #176, Individual #142, Individual #300, Individual #402 o Functional Skills Assessment (FSA) for: • Individual #402, Individual #249, Individual #176, Individual #142, Individual #300 o Personal Focus Assessment (PFA) for: • Individual #402, Individual #249, Individual #176, Individual #142, Individual #300 o Vocational assessments for: • Individual #402, Individual #249, Individual #176, Individual #142, Individual #300 o List of individuals with dental desensitization plans, undated o Section S self-assessment, 6/27/13 o Section S action plan, 6/21/13 o List of individuals who were eligible for educational services, including their assigned school and hours of attendance, School year ending June 2013 o IEPs, ISD progress notes/report cards, ISPs, and relevant ISPAs for • Individual #59, Individual #412, Individual #223 o Data and graphs showing number of returns to LSSLC from public school mid-day o Description of the summer camp program 2013 o A list of all instances of skill training provided in community settings, undated o Description of on-campus and off-campus day and work program sites, undated o A list of individuals who are employed on and off campus, undated Interviews and Meetings Held: o Luz Carver, QIDP Coordinator and LSSLC Liaison to LISD o Mary Gill, Assistant to Ms. Carver o Suzanne McWhorter, QIDP Coordinator Assistant

	o Delaina Dearing, RTT IV o Vicki Layrd, Active Treatment Coordinator o Robin McKnight, M.A., BCBA <u>Observations Conducted</u>: o Dental /medical desensitization meeting o SAP implementation for: • Individual #302, Individual #151, Individual #39 o Pre-ISP meeting for • Individual #116 o Observations occurred in various day programs and residences at LSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals.
	Facility Self-Assessment: LSSLC's self-assessment included many relevant activities in the "activities engaged in" sections that were the same as those found in the monitoring team's report, and represented an overall improvement over the self-assessment submitted in the last review. The monitoring team believes, however, that some items in the self-assessment could better reflect the activities that the monitoring team assesses as indicated in this report. For example, S1 includes many of the components of an effective SAP that are discussed in the monitoring report (e.g., rationale, operational definitions, training instructions), however, it does not include other components, such as a plan for maintenance and a plan for generalization. Additionally, S2 of the self-assessment focused on ensuring that functional skills assessments, vocational assessments, and preference and strengths inventories were completed for each individual. These are important topics, however, S2 in the monitoring team's report also reviews if assessments were clearly used to select individual skill acquisition plans. 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 teams report. LSSLC's self-assessment indicated that S2 was in substantial compliance, and all other provision items were in noncompliance. The monitoring team's review of this provision was that all items were in noncompliance. The reasons for this discrepancy for S2 are discussed below.

	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: • QIDP Coordinator Assistant enrolled in coursework to become a board certified behavior analyst (S1) • Modification of the SAP format (S1) • Improvements in the quality of SAPs reviewed (S1) • Improvements in individual engagement (S1) • Continuous progress in pretreatment sedation reduction (S1) • Improvements in the documentation of how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans (S2) 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) • Consistently 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 item includes an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at LSSLC. Although there had been progress since the last review, more work is needed to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance. Specific recommendations are detailed below. <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 QIDPs (qualified intellectual 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 previous reports, 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. There were efforts, since the last review, to improve the overall quality of the SAPs at LSSLC. One was that the QIDP Coordinator Assistant enrolled in coursework (i.e., toward becoming a board certified behavior analyst) to increase the facility's expertise in the design of skill acquisition plans, training methodologies, and procedures to better ensure that SAPs are implemented with integrity. Another positive development was the continuation of bi-weekly SAP review meetings. The purpose of these meetings was to review SAPs and ensure that they contained all the necessary components of an effective plan discussed below. Finally, the facility recently modified the SAP format to clarify the necessary components, and the training process. At the time of the onsite review, the facility was transitioning from the old format to the new format. It is recommended that the new SAP format be expanded to all SAPs at LSSLC. The copies of the SAPs for Individual #467 were not legible and, therefore, were not included in this review. The monitoring team reviewed 52 SAPs across nine individuals. Twelve of those SAPs were in the old format and, therefore, were not used in the evaluation of this provision item. In 27 of the 40 new format SAPs reviewed (68%), the rationale appeared to be based on a clear need and/or preference. This represented an improvement from the last review	Noncompliance

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		when 47% of the SAPs reviewed appeared to be practical and functional for the individual. Examples of rationales that appeared to be based on a clear need and/or preference (i.e., practical and functional) were: • The rationale for individual #108's SAP for pressing a pressure plate to activate his TV was that he enjoys watching TV, and this skill would allow him to independently access this preference. • The rationale for Individual #444's SAP of applying moisturizing lotion was that a recent nursing report suggested that she was scratching herself due to dry skin. 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: • The rationale for Individual #106's SAP of identifying his medications was that he was unable to do it. The identification of his medications may be a practical and functional SAP for Individual #106, however, simply indicating that an individual cannot do something is not a sufficient rationale for choosing a SAP. There also needs to be a rationale for why this skill would be practical and functional for that individual. LSSLC should ensure that each SAP contains an individualized rationale for its selection. Additionally, the rationale should be 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	

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		The new SAP training sheets contained all of the above components. Additionally, the new SAP format was associated with improvements in the maintenance and generalization plans. 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. Thirty-two of the 40 SAPs in the new format reviewed (80%) included a plan for generalization that was consistent with the above definition. This was a dramatic improvement over the last report when 35% of generalization plans were judged to be consistent with the above definition. Additionally, 29 of the 40 SAPs reviewed (72%) included a plan for maintenance that was consistent with the above definition. This represented another significant improvement from the last review when only 7% of maintenance plans reviewed were judged to be consistent with the above plan. An example of a complete generalization plan was: • The plan for generalization in Individual #106's SAP of using a portable urinal in his bedroom stated, that he would use the portable urinal in other environments. An example of an unacceptable plan for generalization was: • The plan for generalization for Individual #249's SAP of exercising for 30 minutes stated, "…(she) will develop a habit to exercise." An example of a maintenance plan that was consistent with the above definition was: • Individual #176's SAP of identifying healthy snacks included a maintenance plan that instructed staff to discuss pictures of healthy snacks whenever the opportunity arose. An example of an incomplete maintenance plan was: • The plan for maintenance for Individual #380's SAP of brushing his teeth stated "(he) will show progress for one month and show maintenance for 3 consecutive months to ensure adequate understanding of the training objective." It is recommended that all SAPs contain generalization and maintenance plans that are individualized and are consistent with the above definitions. At the time of the onsite review, the facility used various training methodologies, including total task training and forward and backward chaining. As discussed in S3,	

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		however, several SAPs appeared to have unclear training instructions. For example, Individual #108's SAP of activating his TV did not clearly specify the level of assistance (e.g., verbal prompts, physical prompts) for training. Additionally, some training objectives (e.g., Individual #402's SAP to relax during massages) did not appear to be operational. The facility should be commended for their recent improvements in the overall quality of SAPs. Over the next six months, it is recommended that facility ensure that all SAPs are in the new format, continue to review SAPs, ensure that behavioral objectives are consistently operationally defined, training instructions are unambiguous, rationales for each SAP clearly demonstrate that they are based on individual needs and/or preferences, and generalization and maintenance plans are consistent with the above definitions. <u>Dental compliance and desensitization plans</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 two desensitization plan were developed since the last onsite review. 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 any of the nine individuals reviewed (0%) had skill acquisition programs targeting the enhancement or establishment of communication and language skills. This is consistent with the last review when none of the SAPs reviewed targeted 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 QIDPs. 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. 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, the 510-day program continued to represent a good example of meaningful individual engagement, and active participation of staff from various departments (e.g., psychologists). Additionally, the monitoring team was encouraged to observe consistent active individual engagement in several homes (e.g., 563-A, 561-A, 524, 549-C, etc.). Some treatment settings (e.g., 560 building), however, continued to have poor engagement.	

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		The table below documents this variability across settings along with the overall improvements in individual engagement at LSSLC. The average engagement level across the facility was 53%, an improvement from the last two reviews when engagement was 47% and 48%. LSSLC conducted its own engagement assessments. The self-assessment indicated that from January 2013 to April 2013 engagement averaged 77%, considerably higher than the monitoring team's engagement assessment. The monitoring team informally conducted engagement assessments with the QIDP coordinator assistant (who oversaw engagement at the facility and routinely collected engagement data at the facility) to evaluate if the definitions of engagement were similar. The QIDP coordinator assistant and monitoring team agreed on every occurrence and nonoccurrence of engagement. One potential reason for the variation between the facility's and monitoring team's engagement scores is the differences in how engagement data were collected. As described above, the monitoring team used a momentary time sample. That is, engagement data were recorded based on what was seen at that moment of observation. On the other hand, the facility did a one-minute time sample. That is, the facility's observers watched a particular individual for one minute and recorded engagement if that individual was engaged at <u>any time</u> during the 60-second observation period. It is generally acknowledged that the facility's method of data collection will yield a higher level of engagement than that used by the monitoring team. Although it is unlikely that both methods would yield the same percentages of engagement, they should both reflect changes in engagement across the facility. The monitoring team is encouraged by the improvements in individual engagement since the last review. It is now recommended that engagement targets for each home and day program site be established, and that the facility ensures that those levels of individual engagement be achieved. <u>Engagement Observations</u>: Location / Engaged / Staff-to-individual ratio 549-A / 1/3 / 1:3 549-A / 0/2 / 1:2 549-B / 6/8 / 2:8 549-D / 1/5 / 1:5 549-C / 3/3 / 2:3 557-A / 3/5 / 2:5	

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557-B	4/7	2:7
559-B	0/4	2:4
510	4/7	2:7
510	3/3	1:3
520 B	2/2	2:2
520-B	4/4	3:4
549 B	0/2	0:2
524	2/4	1:4
524	3/3	1:3
524	3/5	1:5
523	1/1	1:1
523	3/5	1:5
561-B	2/4	1:4
561-B	0/2	0:2
561-A	2/3	2:3
561-A	4/6	2:6
563-A	3/5	2:5
563-A	2/2	1:2
Large Voc. Building	7/10	2:10
Large Voc. Building	9/16	3:16
560	2/8	4:8
560	5/8	4:8
560	1/3	2:3
560	1/3	1:3
550	2/3	2:3
550	1/3	3:3
550	1/6	1:6
550	1/5	1:5
559-A	2/6	2:6

<u>Educational Services</u>
Twenty-one individuals at LSSLC qualified for educational services from the local ISD since the last review. Public school, however, was not in session during this onsite review; it was summer recess. School was scheduled to start again at the end of August. Two students graduated, so 19 students were to attend school in the upcoming year.

As they did last summer, rather than pursuing extended school year at the ISD, LSSLC developed an engaging summer program for all of the students, separate from the day

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		programming for the adults at the facility. It was overseen by the LSSLC Chaplain and appeared to be an excellent summer program. Since the last review, the facility developed a plan to switch from the Lufkin ISD to the Central ISD effective for the upcoming school year. Central ISD was the geographic ISD for the facility (which was located in Pollok Texas even though it was named the Lufkin LSSLC). Students who were already in the Lufkin ISD high school, however, were to continue at the Lufkin ISD until graduation (seven students). Of the other 12, six were to attend Central ISD (1 in elementary, 4 in middle, and 1 in high) schools. The other six were to attend the classroom that the ISD was going to maintain on the LSSLC campus. Central ISD hired the same teacher who had been at the on-campus classroom for the past few years. • Given that attendance at the on-campus classroom was a problem highlighted in the previous report, the monitoring team recommends that the facility keep data on attendance, counting anything less than attendance for the entire period as an absence. The LSSLC liaison and her assistant provided data showing reduction in the number of times that students were returned to the LSSLC campus mid-day during a school day. This was good to see and should be maintained with the new school district, too. Educational programming was being regularly included in the students' ISPs at LSSLC. This was evident the three ISP and ISPA documents reviewed by the monitoring team. Further, the QIDPs for 16 of 19 (84%) students provided lists of ARD/IEP objectives that also appeared in the ISPs as actions or objectives. The QIDPs had done a very nice job of this. Public school educational services were also discussed at pre-ISP and ISP meetings. For example, during the pre-ISP for Individual #116, the QIDP talked about her school placement and her final report card, and that they (the IDT) needed to incorporate what was in the ARD/IEP into the pre-ISP document and eventually into the ISP, such as participating with a group and vocational activities. She also said that teachers from LISD had come out to visit her here at LSSLC. Public school report cards and progress reports were regularly reviewed by the QIDP and the IDT. QIDPs attended LISD ARDIEP meetings.	

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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's self-assessment indicated that they achieved substantial compliance on this provision item because they conducted annual assessments of preference, strengths, skills, and needs. Although ensuring that each individual has these assessments is important, in order to achieve substantial compliance, the facility also needs to demonstrate that assessments were consistently used to develop SAPs. Although improving in this area, as discussed below, only 61% of SAPs reviewed were clearly based on assessments. At the time of the onsite review, all individuals at LSSLC had transitioned from the Positive Adaptive Living Survey (PALS) for the assessment of individual skills to the Functional Skills Assessment (FSA). As discussed in the last review, 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 in any of the FSAs reviewed. To assess compliance with this item, the monitoring team requested ISPs, FSAs, preference and strengths inventories (PSIs), and vocational assessments for five individuals. Overall, these five individuals had a total of 23 SAPs, and 14 of those (61%) had documentation that assessments (including assessments of preference) were used to develop them. This represented another dramatic improvement over the last review when none of the ISPs or assessments reviewed documented how assessments impacted the development of individual SAPs. Examples of assessments that were used to develop SAPs include: • Individual #176's nursing evaluation (discussed in her ISP) documented that she had diabetes. Her ISP further documented that she had indicated an interest in	Noncompliance

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		learning how to conduct her own blood tests. Therefore, a SAP to teach Individual #176 to conduct blood tests was developed. • Individual #402's PSI and ISP indicated that he enjoyed listening to music on his radio. Therefore, a SAP of learning how to select a station on the radio was developed. • Individual #249's PSI indicated that she wants to earn more money. Her vocational assessment indicated that a barrier to Individual #249 earning more money is that she did not remain on task. Therefore, a SAP was developed to teach her to increase her time on task, and increase the money she earned. Examples of SAPs where it was not clear how assessments impacted their development include: • Individual #300 had a SAP to make change, however, there was no rationale for this SAP in his ISP, and his FSA indicated that making change was not an applicable skill for Individual #300. • Individual #176 had a SAP to learn how to spend all her money at one time. Her PSI indicated that she liked having money, but there was no discussion in her FSA, ISP, or PSI that indicated a preference and/or need for spending all her money in one setting. • Individual #402 had a SAP to do arm exercises, but no mention in his ISP of any assessment results (e.g., FSA or PSI) that suggested that this was a practical and functional SAP for him. In order to achieve substantial compliance for this provision item, in addition to ensuring that all individuals have assessments of individuals' preferences, strengths, skills, needs, LSSLS must document that assessments were used to select the 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:		

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	(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	This provision item focuses primarily on ensuring that SAPs are implemented with integrity, and that decisions to continue, modify, or discontinue SAPs are data based. QIDPs at LSSLC summarized SAP data monthly. The QIDPs graphed monthly SAP outcome data to improve data based decisions regarding the continuation, modification, or discontinuation of SAPs. Six months of SAP data were requested for 10 individuals. None of the SAPs reviewed had six months of data. Additionally, for many individuals, the SAPs provided and the graphs were not for the same plans. Therefore, the monitoring team could not evaluate if progress was being made, or if decisions to continue, discontinue, or modify SAPs was data based. The facility should ensure that SAPs provided and SAP reviews are consistent, and SAP reviews should include six months of data. 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 #39's SAP of applying lotion appeared to be conducted as written, and staff were able to explain how to implement the plan. • Individual #302's SAP to identify the color red appeared to have ambiguous instructions. The DCP held up two colors and instructed Individual #302 to point to one. In the monitoring team's interpretation of the training instructions, however, the colors were to be presented one at a time. In discussion of the training instructions with the DCP, she indicated that either method would likely be effective. It is possible that the DCP was correct and either method would be effective, however, it is unlikely that SAP will be maximally effective if multiple trainers are using different methods of instruction. • Individual #151's SAP of reaching for materials was also not clear. The SAP indicated that Individual #151 should reach following a verbal prompt. The DCP implementing the plan verbally prompted Individual #151 three times and then recorded the reach as independent. The SAP, however, did not specify how many times to verbally prompt before an independent reach could be scored. 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. Over the next six months it is recommended that LSSLC ensure that data based decisions concerning the continuation, revision, or discontinuation of SAPs consistently occurs, and that SAP integrity checks are begun.	Noncompliance

#	Provision	Assessment of Status	Compliance
	(b) Include to the degree practicable training opportunities in community settings.	As discussed in past reviews, 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. The self-assessment indicated that the majority of individual's at LSSLC participated in community recreational activities each month. A spreadsheet listing training in the community indicated that all individuals had opportunities to work on SAP objectives in the community. The self-assessment, however, indicated that not all of these community outings were determined to be practical training opportunities. 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, three individuals at LSSLC had supported employment in the community. This was an increase from the last report when one individual was reported to have supported employment. 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.	Noncompliance

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, January 2012 o LSSLC facility-specific policies regarding most integrated setting practices • Client Management-38, Most Integrated Setting Procedures, 9/20/11 (remained the same, not re-reviewed) o LSSLC organizational chart, undated, probably June 2013 o LSSLC policy lists, undated, probably June 2013 o List of typical meetings that occurred at LSSLC, undated but likely June 2013 o LSSLC Self-Assessment, 6/27/13 o LSSLC Action Plans, 6/21/13 o LSSLC Provision Action Information, most recent entries 5/31/13 o LSSLC Admissions and Placement Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 7/8/13 o Community Placement Report, last six+ months, 11/6/12 through 7/15/13 o List of individuals who were placed since last onsite review (16 individuals) o List of individuals who were referred for placement since the last review (19 individuals) o List of individuals who were referred <u>and</u> placed since the last review (4 individuals) o List of total active referrals (14 individuals), as of 7/9/13 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 (1) • Those who requested placement, but not referred due to LAR preference (1) o List of individuals who were not referred solely due to LAR preference (data were incorrect) o List of rescinded referrals (6 individuals) • ISPA notes regarding each rescinding (3 of the 6) • Special Review ISPA Team minutes for each rescinding (2 of the 6) o List of individuals returned to facility after community placement (1) • Related ISPA documentation (0, occurred week prior to onsite review) • Root cause analysis (0, occurred week prior to onsite review) o List of individuals who experienced serious placement problems, such as being jailed, psychiatrically hospitalized, and/or moved to a different home or to a different provider at some point after placement, and a brief narrative for each case (6 of 16 individuals who moved since 7/1/12, i.e., 1 year since placement, and for whom LSSLC had information). Of these 6, 3 were resolved successfully.

	o List of individuals who died after moving from the facility to the community since placements of 7/1/09 (2, 0 since the last review) o List of individuals discharged from SSLC under alternate discharge procedures and related documentation (1 individual) o Graphs of some of the above data o APC weekly reports • Detailed referral and placement report for senior management (weekly, 5/8/13-5/29/13, and 7/10/13) o APC Department meeting minutes (none) o Variety of documents regarding education of individuals, LARs, family, and staff: • Provider Fair, (1 for one provider) • Community tours ▪ Exploration visits (4, April 2013 and May 2013) ▪ Pre-placement visits ▪ Summary data regarding tours (none) • Meetings/trainings with local LA (2), 3/27/13, 6/26/13 • Facility-wide staff trainings ▪ New employee orientation (none) ▪ QIDP training 6/24/13 • Family association meetings (none) • Brochure and facility newsletter (none) • CLOIP and PP tracking tools o Description of how the facility assessed an individual for placement o List of all individuals at the facility, indicating the result of the facility's assessment for community placement (i.e., whether or not they were referred) o New blank CLDP format shell o New blank CLDP pre- and post-move support template of pre-determined supports o Email from LSSLC ADOP regarding APC-PMM-IDT meetings and expectations for discharge assessments 5/20/13 o Specialized transitions plans for Individual #216 and Individual #99 o List of individuals who had a CLDP completed since last review o Blank checklist used by APC regarding submission of assessments for CLDP, completed checklists in the CLDPs reviewed o DADS central office written feedback on CLDPs (none) o State obstacles report and SSLC addendum, FY12 data, 2/26/13 o Facility community placement obstacles data, November 2012-April 2013 o PMM tracking sheet, 6/7/13 o Post move monitoring helpful hints, May 2013 o Blank new post move monitoring form o Transition T4 materials for: • Individual #578

	o ISPs for: • Individual #151, Individual #502, Individual #176, Individual #129, Individual #306, Individual #194 o Pre-ISP draft used during the pre-ISP meeting: • Individual #116 o Draft ISP used during the ISP meeting: • Individual #67 o CLDPs for: • New format: Individual #257, Individual #99, Individual #340, Individual #490, Individual #473, Individual #136 • Old format: Individual #4, Individual #177 o Draft CLDP for: • Individual #302 o In-process CLDPs for: • Individual #252, Individual #138, Individual #412 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 #29: 90 • Individual #166: 90, post-90 • Individual #162: 45, 90 • Individual #148: P, 7, 45, 90 • Individual #105: P, 7, 45, 90 • Individual #482: P, 7, 45, 90 • Individual #177: P, 7, 45, 90, post-90 • Individual #541: P, 7, 45, 90 • Individual #569: P, 7, 45, 90 • Individual #4: P, 7, 45 • Individual #136: P, 7, 45 • Individual #420: P, 7, 45 • Individual #490: P, 7 • Individual #340: P, 7 • Individual #99: P, 7 • Individual #263: P, 7 • Individual #431: 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, Transition Specialist o Community provider agency: Innovative Homes, Lufkin, TX, Jo Crowder, manager; Calvin, Kendall,

	and Robert, staff Observations Conducted: o CLDP meeting for: • Individual #302 o ISP and pre-ISP meetings for: • Individual #67, Individual #116, Individual #192, Individual #207 o Community group home visit for post move monitoring for: • Individual #431 o Senior management meeting/IMRT, referral review, 7/10/13 o Self-advocacy meeting, 7/11/13
	Facility Self-Assessment The APC's self-assessment was almost identical to the self-assessment presented during the last onsite review. Therefore, the monitoring team refers the APC back to the previous report where detailed commentary and suggestions were made. The ways in which the current self-assessment was not identical to the previous assessment was that there were a few provision items that were more streamlined and more in line with the monitoring team's report. The only disagreement in findings was for T1e. The APC self-rated this to be in substantial compliance and the monitoring team in noncompliance. The APC's self-rating assessed the presence of pre- and post-move supports, but did not self-assess the quality and comprehensiveness of these lists of supports. The APC's self-assessment needed improvement if it was to be useful to her and her department. The two primary problems were an (a) an over reliance on the statewide monitoring tools and (b) a failure to include in her self-assessment all of the aspects of section T that the monitoring team looks at and includes in this report. This has been a consistent statement from the monitoring team for many years now.
	Summary of Monitor's Assessment LSSLC continued to make progress across much of section T. The number of individuals who were placed and who were in the referral and placement process increased since the last review. Individuals were placed at an annual rate of about 7%. Approximately 4% of the individuals at the facility were on the active referral list. 16 individuals had been placed in the community since the last onsite review. 19 individuals were referred for placement since the last onsite review. 14 individuals were on the active referral list. Professionals' determinations regarding most integrated settings were included in only some of the annual ISP assessments, though there was commentary about the IDTs' determination (as a whole) in almost all of the written ISPs. An adequate living options discussion, however, was only evident in about half of the

	written and observed ISPs. Obstacles to referral and to transition were not adequately identified in the ISPs and plans to address these obstacles were not explicitly developed. One individual had an adequate individualized plan for learning more about community living options. The system of tours and provider fairs was improved. There was some, but not enough, training of staff, clinicians, and managers regarding community living options. CLDPs were created for every individual referred and ongoing activities occurred following referral. IDTs were very active in the transition planning and placement process. More work needed to be done to better prepare the receiving provider for the individual, such as more visits from SSLC staff and more clinician-to-clinician discussion. There were, however, individually thoughtfully-designed transition plans for two individuals. It would be good if this could occur more regularly. Discharge assessments were prepared and included good information about the individual, but they were not developed with the individual's new home, day, and employment environments in mind. This needs to be improved (T1d). The lists of pre- and post-move supports had greatly improved. With further effort, substantial compliance should be attainable for the next review (T1e). A quality assurance program did not exist. The annual obstacles report and community placement reports were submitted. Post move monitoring was occurring as required. It was done thoroughly and the PMM identified numerous areas that needed follow-up. She ensured that follow-up occurred by involving the IDT as needed. Substantial compliance was maintained for both provisions of T2.

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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	LSSLC continued to make progress across much of section T. Lisa Pounds Heath, the admission and placement coordinator (APC) continued to be the director of the department. The monitoring team remained impressed by her detailed knowledge of every individual on the referral list and every individual who had been placed. The specific numbers of individuals who were placed and who were in the referral and placement process increased since the last review. The number of individuals placed was at an annual rate of about 7%. Approximately 4% 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. • 16 individuals had been placed in the community since the last onsite review. This compared with 7, 8, 13, 9, 8, and 5 individuals who had been placed at the time of the previous monitoring reviews.	Noncompliance

	transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	o The number of community transitions showed an increasing trend. o This was the highest number of placements in any monitoring period. • 19 individuals were referred for placement since the last onsite review. o This compared with 15, 7, and 14 individuals who were newly referred at the time of the previous reviews. o 4 of these 19 individuals was both referred and placed since the last onsite review. o This indicated that IDTs were continuing to make referrals. • 14 individuals were on the active referral list. This compared with 18, 13, 17, 20, 25, and 17 individuals at the time of the previous reviews. o The number of community referrals showed a stable trend. o 3 of the 14 individuals were referred for more than 180 days. 2 of these 3, however, had CLDPs scheduled for the upcoming week. The referral of the third individual was slated to receive extra attention from the transition specialist. • 2 individuals were described as having requested placement, but were not referred. This compared with 2, 8, 6, 6, and 9 individuals at the time of the previous reviews. o Of the 2 individuals who requested placement, but were not referred, 1 individual had an LAR who made this decision. o Of the remaining 1 individual, he had changed his mind and his IDT was helping him as he continued to consider this decision. o LSSLC had a process for reviewing those individuals who requested placement, who did not have an LAR, and who were not referred. • The list of individuals not being referred solely due to LAR preference contained 0 names. This compared to 38, 107, 6, 3, and 17 individuals at the time of the previous reviews. o This was not an accurate count and should be completed correctly. • The referrals of 6 individuals were rescinded since the last review. This compared to 3, 3, 4, and 4 at the time of the previous reviews. o Documentation was provided for 6 of the 6 individuals (100%) regarding the reasons for the rescinding, including ISPA notes. o 3 of the 6 were rescinded due to LAR or individual request. o 1 of the 6 had now been re-referred. o A special review team was conducted to review the rescinded referrals of the remaining 2 of 2 (100%). The SRT report included the rationale for the rescinding and good recommendations for considerations for the individual's future referral. o An adequate review to determine if changes in the overall referral and transition planning processes at the facility, however, should also be conducted for the rescinded referrals. This can be done by the APC and her staff. If done and if actions were recommended, the monitoring	

		team would look for indication of implementation of actions. • 1 individual was returned to the facility after community placement. This compared with 0, 0, 0, and 2 individuals at the time of the previous reviews. o The return happened during the week prior to the onsite review, so little documentation was available for review. o A SRT was scheduled to occur. As noted above, the review should also include determining if any changes or improvements might be made to the overall referral and transition planning processes at LSSLC to reduce the likelihood of this type of occurrence in the future for all individuals at the facility. • 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 continued to be tracked and recorded. These data were now being obtained for at least a one-year period after moving. o Of the 16 individuals who moved in the past 12 months (and for whom information was available), 6 were reported to have had one or more untoward events (38%). ▪ It is important for the reader to understand that many individuals who are placed have histories of challenging behavioral, psychiatric, and medical issues. Therefore, it is not unexpected that these issues might occur in the community. o Of these 6, the issues with 3 (50%) were successfully resolved. Of the remaining 3, 1 returned to the facility, 1 was in a medical facility, and 1 was living with his aunt following psychiatric hospitalization from his group home. o LSSLC provided follow-up and remained involved with all 6 of the 6 individuals (100%), even past the 90-day post move monitoring period. o Of these, although follow-up was done with the individuals and their IDTs, an adequate review was not conducted in any of the cases to determine if changes in the overall referral and transition planning processes at the facility should be made. This should not be a complicated or overly time consuming activity. The benefits may be very helpful to the APC, PMM, and transition specialists. If this were done and if any actions were recommended, the monitoring team would look for indication of implementation of these actions. • 0 individuals had died since being placed since the last onsite review. This compared with 0, 0, 0, 0, and 2 at the time of the previous reviews. • 1 individual was discharged under alternate discharge procedures (see T4).	

		The monitoring team suggests that the APC create a 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 APC and for the reader. These graphs could then be part of the APC's QA program participation, such as in QAD-SAC meetings, QA reports, and QAQI Council (see sections E and T1f). The APC had created a number of these graphs. Of the 15 suggested graphs, she had created graphs for 8 (indicated by a check mark below). This was good to see. • √ Number of individuals placed each month or monitoring period • √ Number of new referrals each month or six-month period • √ 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 o Cumulative number of each type of untoward event for all placements • √ Number of rescinded referrals each month or each six-month period • √ Number of returns from the community in each six-month period • √ Number of deaths in each six-month period • √ Number of alternative discharges (T4) • 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 <u>Other activities</u> The facility's transition home continued to operate. A number of individuals lived in the home for a period of time before moving to the community. It appeared to be a good addition to the LSSLC referral and transition program.	

		Determinations of professionals 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. The monitoring team looks for indications in each professional's assessment, in the written ISP that is completed after the annual ISP meeting, and during the conduct of the annual ISP meeting. The monitoring team requested a set of recent ISPs, attachments, and assessments. Surprisingly, only four were submitted and two of the four were from April 2012, more than one year ago. The monitoring team did not include these two old ISPs in the review. Instead, the monitoring team found four other ISPs in portions of the documents submitted for other sections of this report. They are listed above under Documents Reviewed for a total of six ISPs from February to April 2013, facilitated by six different QIDPs. In assessments: Assessments were available for review for four of the six ISPs. Of these 4 ISPs reviewed, all of the assessments for 0 individuals (0%) included an applicable statement/recommendation. On the other hand, some of the assessments for all (100%) of the individuals included an applicable statement/recommendation. That is, all assessments done by psychiatry, psychology, nursing, habilitation, and day services included a specific statement and recommendation. Medical, nutrition, and residential services did not contain a statement. It seemed that opinions were included by those disciplines that included a prompt or section that asked for the writer's opinion within the assessment template. This may be an easy way to ensure that this occurs for all disciplines. In the written ISPs: Of the 6 ISPs reviewed, 5 (83%) included an independent recommendation from the professionals on the team to the individual and LAR. Of these 6, each professional's opinion was given and described in 3 (50%), though in 2 of these 3, the QIDP made a general statement rather than describing each professional's opinion. Observation of ISP meetings: Of the 4 ISPs observed, 1 (25%) included an independent recommendation from each of the professionals on the team and 1 (25%) included a nice summary of all of the professionals' opinions by the QIDP for a total of 50%. Individuals referred: In reviewing the 16 CLDPs, 16 (100%) individuals and/or LARs did not oppose transition to the community.	

		Referrals and Transitions There were no systemic issues delaying referrals (at the facility/local level) identified during this onsite review. Funding availability was not cited as a barrier to individuals moving to the community. Senior management at the facility was kept informed of the status of referral, transition, and placement statuses of individuals on the active referral list via a weekly Tuesday update by the APC to senior management at the start of an IMRT meeting. This was the same system in place for many years at LSSLC. Transitions were occurring at a reasonable pace. The state's expectation was that once a referral was made, the transition to the community should occur within 180 days. The IDT was required to meet monthly to review and address the obstacle to transition after the 180-day window. The ISPA was then to be sent to state office. • Of a sample of 16 of the 16 individuals placed since the time of the last onsite review, 7 (44%) were placed within 180 days of their referral. Of the 9 7, (another 44%) were placed two to four months after referral and 2 (16%) were placed more than one year after referral. • Of the 14 individuals on the active referral list for community transition, 3 had exceeded the 180-day timeframe (i.e., 79% were still within 180 days). o This compared with 2 individuals who were referred for more than 180 days during previous monitoring review. o Of these 3, 0 individuals had exceeded one year. This compared with 0 individuals at the time of the previous reviews. o 2 of the 3 were scheduled for CLDPs in upcoming weeks. o 1 of the 3 was slated for additional efforts and attention from the transition specialist. • The number of 180-day referrals was stable and low. • There were reasonable activity and actions related to the transition and placement, and no long gaps of time with no activity, for 14 of the 14 (100%) individuals. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Create a more accurate list of those individuals who would have been referred except for the preference of the LAR (also for T1h). 2. Include professionals' opinion in all of the annual ISP assessments; a prompt or template note would probably ensure that this occurs (also for T1b3). 3. Ensure professionals' opinions are presented in the annual ISP meeting (also for T1b3).	

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 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. Thus, there was not a state policy that adequately addressed all of the items in section T of the Settlement Agreement. All facility-specific policies regarding most integrated setting practices remained the same as at the time of the last review. The rating for T1b is based solely on the development of adequate state and facility policies. Sections T1b1 through T1b3 are stand-alone provisions that require implementation independent of T1b or any of the other provision items under T1b.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	LSSLC had received state training and consultation on the newest iteration of the ISP process (also see section F). Further training was expected, especially given that the state was focusing upon two other facilities to further refine this new ISP process. <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. DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was found for three provision items of section F: F1d, F2a1, and F2a3. As noted above in section F of this report, substantial compliance was not found for F1d, F2a1, and F2a3. Of the 8 CLDPs reviewed by the monitoring team, documentation indicated that the IDTs for 0 individuals (0%) included SAPs, and other supports, that were chosen with the individual's upcoming transition in mind. In the 1/24/13 email from the APC to the QIDP staff, she noted that when an individual is referred, his or her SAPs need to be reviewed. This was good to see, and was probably a good start, but hadn't yet appeared in CLDPs. <u>Obstacles to Movement</u> Of the 6 ISPs reviewed, 5 should have had obstacles defined (the other 1 was for an individual who was already referred). Of these 5 ISPs, 0 (0%) included an adequate list of obstacles to referral. Of the 4 annual ISP meetings observed, an adequate list of obstacles to referral or obstacles to transition was identified for 1 (25%) (Individual #192). The APC reported that they had just started a new database for obstacles and would be looking at obstacle identification and action, on an individual basis	Noncompliance

		When obstacles are identified in an ISP, the ISP should also include an action plan to address/overcome any obstacles identified. The plans should be individualized, measurable, and include expected timelines. Of the other 6, there were no plans to address obstacles to referral. Of the 4 annual ISP meetings observed, a plan to address/overcome the identified obstacles was included for 1 (25%). Of these, 1 (100%) was adequate (Individual #192). <u>Preferences of individuals and LARs</u> Of the 6 ISPs, 6 (100%) included an adequate description of the individual's preference and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities). Five of the 6 individuals could not adequately express a preference. The ISP indicated this and what the IDT had done to try to make this determination. Of the 4 annual ISP meetings observed, the individual's preference for where to live was adequately described in 1 (25%), and this preference appeared to have been determined in an adequate manner for 1 (100%). Of the 6 ISPs, 6 (100%) included an adequate description of the LAR's (or family member's) preference and how that preference was determined by the IDT, or indicated that there was no LAR. Of the 4 annual ISP meetings observed, there was an appointed LAR for two. LAR/family member preference was discussed in all meetings (100%). To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Show that SAPs were developed specifically for helping the individual prepare for his or her upcoming transition. 2. Ensure ISPs include obstacles to referral, and some plan or action to address each obstacle.	
	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 addressing some of these activities.	Noncompliance

		1. Individualized plan • There is an individualized plan for each individual (e.g., in the annual ISP) that is o Individualized and specifies what will be done over the upcoming year 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. LSSLC status: In reviewing 6 recently completed ISPs, 1 (17%) had a plan that addressed education about community options as per the above four bullets (Individual #502). Her ISP spoke about educational activities from the previous year, had objectives that were measurable, and included looking for/determining her reaction. All 6 of the ISPs included some general activities, such as tours, the provider fair, and/or community activities, and all included some reference to LAR/family, but they were not written in measurable terms and did not appear to address the individual's specific needs. It may be helpful to add some prompts or headers to the ISP shell to help the IDT address each of the above four open bullets. 2. Provider fair • 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 LSSLC status: The facility did hold a provider fair within the past 12 months (July 2012). During this review, the APC reported that she was, in addition to the annual provider fair, one provider each month was going to spend a day at the facility. This occurred only one time, only a few weeks prior to this onsite review (D&S Services was the provider). No other activities related to provider fairs were reported to have occurred. 3. Local Authority (LA) • Regular SSLC meeting with local LA • Apparent good communication and working relationship with LA • Quarterly meetings between APC/facility and LA • Agenda topics are relevant LSSLC status: The facility maintained good communication and a good working relationship with the LA, participated in quarterly meetings with the LA, and ensured relevant topics were on the agenda for the LA meetings.	

		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. 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. • Tours are for individuals or no more than four people • Individual's response to the tour is assessed (describe methodology and indicators) LSSLC status: The APC continued to work on making the system of tours manageable and appropriate for the individuals at LSSLC. To that end, work was done since the last review and a newer system was put into place in April 2013. Two tours were now held each month, organized by the LA and by the LSSLC transition specialists. They were focusing on one or two homes each month. Their goal was to ensure that every individual had the opportunity. The APC said that she had a list of individuals who were referred by their IDT for a tour. QIDPs were to review the individual's response to the tour at the next ISP related meeting. A form/checklist to document the individual's response was still in development. Since April 2013, 30 individuals had gone on six tours. This compared with 19, 23, 4, 39, and 40 individuals who had gone on tours prior to each of the previous monitoring team reviews. The APC kept a list of individuals who went on a tour in her weekly enrollment report. To make tour-related data useful to the APC, it should address the four bullets above: identify all current individuals at the facility for whom a tour was appropriate, what type of tour was appropriate, whether or not each went on a tour that was appropriate, and whether the individual's response was documented and sent to the QIDP/IDT. 6. Visit friends who live in the community LSSLC status: Since the last onsite review, there were not visits by individuals to friends who had moved to the community. Of the 6 ISPs reviewed, visits to friends did not appear to be appropriate any, however, the monitoring team could not determine if these individuals had any friends who had moved to the community. Even so, these types of visits were not offered to any individuals. This should be a relatively simple activity to add into the activities of those individuals for whom this	

		would be appropriate. 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: Since the last onsite review, other educational activities for individuals and LARs/family members did occur during one self-advocacy meeting (observed by the monitoring team), did not occur during any house meetings for individuals, and did not occur during any family association meeting. 8. A plan for staff to learn more about community options LSSLC status: Since the last onsite review, educational activities for DSPs did not appear to have occurred at least once. Since the last onsite review, educational activities for clinicians did occur at least once (during the LA inservice in June 2013, 130 members of IDTs). Since the last onsite review, educational activities for managers and administrators did occur at least once (detailed training for QIDPs in January 2013). 9. Individuals and families who are reluctant have opportunities to learn about success stories LSSLC status: Since the last onsite review, there was no plan or actions for information about successful community placements to be shared with (a) individuals who were reluctant to consider community placement and (b) LARs who reluctant to consider community placement. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Develop the individualized education plans described in the first item of this list of 9.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years	This provision item required the facility to assess individuals for placement. The facility reported that individuals were assessed during the living options discussion at the annual ISP meeting. In addition, a listing was given to the monitoring team showing every individual and his or her referral status. To meet substantial compliance with this provision item, the facility will need to 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 As noted in T1a, but this was not yet being done for all assessments.	Noncompliance

	of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	• 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 Based upon the written ISPs, this did not appear to be occurring regularly. In some of the written ISPs, the determinations of various professionals were listed, but the monitoring team could not determine if they were presented during the meeting or if the QIDP had copied the statements from the written assessments. o This did, however, explicitly occur during 1 of the 4 ISP meetings observed by the monitoring team and was nicely summarized by the QIDP in one of the other meetings (50%). • Living options for the individual were thoroughly discussed during the annual ISP meeting and, if appropriate, during the third quarter ISP preparation meeting. o There was a thorough living options discussion during 1 of the 4 ISPs observed (25%) and an adequate description of a thorough discussion was evident in 3 of the 6 ISPs reviewed (50%). o It is likely that the APC's self-monitoring tool for the living options discussion inadequately captures the important aspects of a living options discussion. It might be beneficial to modify the living options observation tool to more accurately reflect the topics that need to be discussed and their quality. • 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 The set of ISPs reviewed by the monitoring team included good statements about the decision made by the entire team for 5 of the 6 reviewed (83%). A number of parts of provision T require the efforts of the QIDP and IDT (T1a, T1b1, T1b2, T1b3). Therefore, the monitoring team recommends that the APC and PMM work with the QIDP coordinator. It might even make sense to form a work group or special project. The use of prompts, changes in the blank template form, and discussion with the APC and the QIDP department are likely to result in more expedient progress in these areas. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Ensure a good living options discussion. 2. Include professionals' opinion in all of the annual ISP assessments and during the annual ISP meeting (also for T1a).	

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 16 CLDPs completed since the last review. This was 100% of the CLDPs reported by the APC as being completed since then. Of these 16, 8 (50%) were reviewed by the monitoring team. A set of in-process CLDPs was also reviewed. Initiation: The APC reported that CLDPs were initiated within 2 weeks of referral, at the latest, however, there was no indication of when the CLDP was initiated in any of the 8 CLDPs. But, 2 of the 3 in-process CLDPs (67%) included the date the CLDP was initiated (CLDP profile date). Including the date that the CLDP was initiated/created and dates when the CLDP was updated should be helpful to the APC and transition specialists in monitoring their continued updating of the CLDPs. Timeliness: 8 of the 8 (100%) CLDPs included documentation to show that that ongoing activity was occurring for the individual's placement. 3 of the 3 (100%) in-process CLDPs indicated ongoing activity. The older the CLDP, the more information it contained, as would be expected. IDT member participation: 8 of the 8 (100%) CLDPs included documentation to show that IDT members actively participated in the transition planning process (i.e., visited potential homes and day providers, thoroughly discussed each potential provider, made changes in planning if necessary, responded to any problems exhibited by the individual). Coordination with LA: 8 of the 8 (100%) CLDPs included documentation to show that the facility worked collaboratively with the LA. This collaboration did not appear to be more than the LA's attendance at the CLDP meeting. On the other hand, there did not appear to be any activity that the LA was to engage in that he or she did not.	Substantial Compliance
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The 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. 0 of the 11 CLDPs reviewed (0%) clearly identified a comprehensive set of specific steps that facility staff would take to ensure a smooth and safe transition by including documentation to show that all six of the activities listed in the below six bullets occurred adequately and thoroughly. However, each of the CLDPs (100%) included some of these six activities. • Training of community provider staff, including staff to be trained and level of training required. Each CLDP had one standardized support that new staff would be trained on all of the aspects of the individual's support needs. Instead, the CLDP should indicate o (a) who needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff), o (b) the method of training (e.g., didactic classroom, community provider	Noncompliance

		staff shadowing facility staff, or demonstration of implementation of a plan in vivo, such as a PBSP or NCP), and o (c) a competency demonstration component, when appropriate. • Collaboration with community clinicians (e.g., psychologists, PCP, SLP). This was indicated in 2 of the 8 CLDPs (25%) and was great to see. This occurred for Individual #257's nurses and for Individual #490's psychiatrists. • Assessment of settings by SSLC clinicians (e.g., OTPT, psychology, training and recreation). This occurred in 2 of the 8 CLDPs (25%). One was for Individual #136, was done by LSSLC habilitation therapy staff, and was called a home assessment. The other was for Individual #257. Staff identified the need for her to have a chime on the door leading from her bedroom to outside. • Collaboration between provider day and residential staff is ensured. This was not described in any of the CLDPs. • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community). This was explicitly done in a thoughtful, individualized manner for Individual #99. His IDT, led by his psychologist, developed (and implemented) a series of steps for his transition that involved the individual spending more and more time at the new group home with his staff from LSSLC. This was great to see. An individualized detailed plan was also done for one of the individuals on the referral list (Individual #216). • Collaboration between Post-Move Monitor and Local Authority staff. This was likely occurring, but not indicated in the CLDP. <u>Day of move activities</u>: 8 of the 8 CLDPs reviewed (100%) clearly identified a set of activities to occur on the day of the move, and all 11 indicated the responsible staff member. Documentation for 0 of the 8 (0%) indicated that the activities did indeed occur. The PMM reported that the documentation was provided, however, the monitoring team could not find it. Instead, the monitoring team found that the PMM included the pre move site review findings in the post move monitoring report itself (which was fine to do). <u>CLDP meeting prior to moving</u>: A CLDP meeting occurred for 8 of the 8 individuals (100%). The CLDP meeting for Individual #302 was observed by the monitoring team. It was led by the APC. Of the seven aspects of the CLDP meeting listed below, items 1, 4, 5, and 6 were observed. The monitoring team could not determine if items 2 or 3 had happened, though after the meeting the APC reported that they had not yet begun to prepare individuals and DSPs for CLDP meetings. The post move monitor participated at various times during the meeting, however, she did not ensure that every support had clearly described the evidence she would look for during post move monitoring.	

		1. Attendance by all relevant IDT members, community providers, and LA 2. Individual preparation occurred prior to the CLDP meeting, if appropriate 3. DSP preparation occurred prior to the CLDP meeting, if appropriate to do so 4. Individual participation occurred, or was facilitated, if needed 5. There was active participation by team members 6. All relevant pre-move and post-move (essential/nonessential) supports were discussed and any issues resolved 7. The post move monitor actively participated to ensure that supports were adequately defined and required evidence specified. During the onsite review, no other CLDP, pre-CLDP, or transition meetings occurred.	
	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 pre- and post-move supports and other pre- and post-move activities. In 8 (100%) of the CLDPs, the facility identified all facility staff and other staff (e.g., LA, community provider staff) by name and/or title for each support. In 8 (100%) of the CLDPs, the facility identified specific timeframes/specific dates for completion and/or implementation for each support.	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.	8 of the 8 CLDPs (100%), included documentation that the plans had been reviewed with the individual and/or the LAR (or indicated that there was no LAR) as evidenced by • Signatures on CLDP • Narratives in the CLDP	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	The APC continued the process that was in place at the time of the last review, that is, in preparation for the CLDP meeting, assessments were updated and summarized. For 8 of the 8 CLDPs reviewed (100%), all necessary assessments were completed. For 8 of the 8 CLDPs reviewed (100%), all assessments were completed no more than 45 days prior to the date the individual moved to the community. For 8 of the 8 CLDPs reviewed (100%), all assessments were available to the APC and IDT prior to the final CLDP meeting. Each assessment should meet the following: • A summary of relevant facts of the individual's stays at the facility.	Substantial Compliance

		○ This was done sufficiently in the assessments. • Thorough enough to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. ○ This was done sufficiently. • Assessments specifically address/focus on the new community home and day/work settings; there are recommendations for the community residential and day/work providers. ○ This was not done sufficiently. Some of the nursing discharge summaries, however, contained a section with instructions for the new provider. • Assessments identify supports that might need to be provided differently or modified in a community setting, and/or make specific recommendations about how to account for these differences. ○ This was not done sufficiently. The assessor needs to indicate how he or she might see the supports recommended being implemented in the new settings. An email from the ADOP made explicit that discharge assessments needed to describe how supports would be provided for the individual in the community. The email was 5/20/13 and also noted that pre-CLDP meetings were no longer going to be held, thereby making it even more important for the discharge assessments to be done correctly, thoroughly, and with the new settings in mind. Given the recency of this email, its effect was not yet seen in any of the CLDPs and discharge assessments reviewed by the monitoring team. To move in the direction of <u>maintaining</u> substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The discharge assessments must better address the specific home, day, and employment sites and contexts into which each individual will be moving.	
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	The list of pre-move and post-move supports (previously called essential and nonessential supports) were identified in the CLDPs. There was improvement in these lists. The monitoring team continues to recommend that the APC and her staff use some type of checklist or guide to help ensure all supports were included. A checklist of items for this type of activity was suggested in previous monitoring reports. Further, the standards listed below could be used as a checklist by the APC and her staff. She also received a draft template from state office that pre-populated the pre- and post-move support list with about two dozen items. This can also be helpful to the APC, more so if she combines the state template with the list of items below.	Noncompliance

	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.	The list of pre- and post-move supports should meet the following standards. • The list should be comprehensive and inclusive, demonstrated by: o Sufficient attention paid to the individual's past history, and recent and current behavioral and psychiatric problems. ▪ This was demonstrated in 0 of the 6 (0%) CLDPs (it did not apply to the other 2). Many individuals had serious behavioral, psychiatric, or medical histories, but they were not adequately reflected in the supports chosen to reduce the likelihood of re-occurrence of problems. Most notable was the absence of detail regarding behavior support plans. For instance, for Individual #340, the CLDP clearly described problems he had with previous placements due to the need to keep him busy, active, and engaged. There was, however, no support directly related to doing this, such as having daily and weekly activity schedules. o All safety, medical, healthcare, risk, and supervision needs addressed. ▪ This was demonstrated in 8 of the 8 (100%) CLDPs. For instance, Individual #490's supports for g-tube were included. o What was important to the individual was captured in the list. ▪ There was improvement in this area and was evident in 8 of the 8 (100%) CLDPs. However, the CLDPs put all of the preferred items into a single support. This makes it difficult for the provider to know what to focus upon and makes it impossible for the PMM to adequately assess. These should be split up. o The list thoroughly addressed the individual's need/desire for employment. ▪ This applied to 1 of the CLDPs and was done thoughtfully and individually. Thus, the supports listed related to employment were adequate for 1 of the 1 (100%). o Positive reinforcement, incentives, and/or other motivating components to an individual's success were included. ▪ This was evident in 0 of the 6 CLDPs (0%) to which this applied. This was disappointing because the referrals of many of the individuals was as direct result of the progress they had made and this progress was due, in part, to the use of positive reinforcement. Having a support that merely says "continue to implement the BSP" was insufficient. o There were supports for the teaching, maintenance, and participation in specific skills, such as in the areas of personal hygiene, domestic, community, communication, and social skills. ▪ This was seen in 8 of the 8 (100%) CLDPs. However, similar to	

		the way the preferences were grouped into a single support, all of the skills to be taught were grouped into a single support and required to be informally or formally. ▪ It was surprising that there were no supports for teaching language skills to Individual #99 and social skills to Individual #340. These were clearly important needs as indicated in their CLDPs and assessments. On the other hand, these were not skills never explicitly or adequately addressed at the facility or by the ISD either. Therefore, it was not surprising to find their absence. The professionals on the IDT, however, have an opportunity to push this type of training forward during the CLDP and transition process. o 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. ▪ Important aspects of the BSP, PNMP, etc. should have their own support to highlight their importance and help ensure that the provider carries out these important aspects. This was seen in 0 of the 8 (0%) CLDPs. Examples of what should have been included were the interactional and positive reward components of BSPs and the most important details of the PNMP and dining plans. o Topics included in training had a corresponding support for implementation. ▪ This was not evident in any of 8 of the 8 (0%) CLDPs. • The wording of every support is in appropriate, measurable, and observable terms. o Supports regarding appointments were written adequately. The supports for provision of services and activities, however, were not written in a way that was measurable, so that the provider and PMM knew how much, how long, how many, etc. In other words, there was need for observable reportable outcomes and a criterion for each support. • Any important support identified in the assessments or during the CLDP meeting that was not included in the list of supports, should have a rationale as to why it was not included. o The CLDPs showed the recommendations that came out of the discussion at the CLDP meeting. • Every support should include a description of what the PMM should look for when doing post move monitoring (i.e., evidence): a criterion, and at what level/frequency/amount the support should occur.	

		○ The evidence that the PMM should look for was included in all of the CLDPs, however, most had merely said "interviews, observations, and review of notes." Interviews of staff and provider completion of a simple daily checklist were other ways that have been discussed by the monitoring team during previous reviews. This was seen in only one CLDP (Individual #4). 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. A sample of 8 pre move site reviews were reviewed by the monitoring team (see documents reviewed) and all indicated that the pre-move supports were in place. • Each of the nonessential supports needs to have an implementation date. ○ Each nonessential support in the CLDP did have an implementation date. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. At this point, the APC and transition specialists should be able to meet all of the criteria for a thorough and adequate list of pre- and post-move supports. Following the above comments regarding the 8 components of a comprehensive list, and the 3 additional characteristics will move the facility towards substantial compliance.	
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.	It appeared that little had been done regarding this provision item since the last review. In fact, little information was provided to the monitoring team compared with what was provided last time. Some activities, however, had occurred: • The APC worked with the QA director to create a long list of important outcome indicators. • A set of graphs (see T1a) were developed. • Living option discussion monitoring tools were completed, approximately eight per month (however, the tool data were not valid or useful). • The APC and her staff observed many ISP meetings. • The APC reported that state office was working on creating valid, reliable self-monitoring tools. There was not a written policy or written process for quality assurance to ensure the (a) development and (b) implementation of CLDPs.	Noncompliance

		Data/information were being collected. The data being collected were for all three statewide self-monitoring tools. The data were not relevant or valid (i.e., did not include everything that should be included, did not measure what they portended to be measuring). There was no indication if the data were being collected reliably. Data were not reviewed, summarized, or analyzed. Actions were not taken as a result of analysis of the data. The data were not included in the facility's QA program. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Develop a valid and reliable self-monitoring tool or set of tools. 2. Continue the APC's set of graphed data and consider the additional simple graphs described and listed in T1a. Use these in the facility/department QA program. 3. Conduct a simple quality assurance review for rescinded referrals, returns, and other negative/untoward outcomes (also for T1f and T2a).	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with	DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/12 from all 13 Facilities. The report was issued to the Monitors and DOJ on 2/26/13, six months after the data collection period ended. The following summarizes some positive aspects of the report: • The statewide report listed the 13 obstacle areas used in FY12. DADS indicated it would continue working with the facilities in relation to the annual reporting of obstacles to transition. Such technical assistance is needed given the continuing problems with data collection discussed below. • There was some effort to separate a review of obstacles to referral from a review of obstacles to transition once an individual was referred. • DADS included a list of 12 initiatives it was continuing to support. In general, these efforts were in the early stages of implementation and/or were ongoing activities related to Section T as well as other sections of the Settlement Agreement (e.g., revisions to the ISP process). • The report included attachments with each of the Facilities' annual reports. The following concerns were noted with regard to the report: • Definitions: Section T.1.b.1 of the Settlement Agreement required that the facility "identify the major obstacles to individuals' movement to the most integrated setting consistent with the individual's needs and preferences at least annually." The state's report, however, defined obstacles "as issues, barriers, or impediments that delay an individual from moving to a service delivery setting	Noncompliance

	developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	of his/her choice. These include any supports not currently available to meet the needs and preferences of the individual in the alternate setting." • Referrals: As indicated on page 3, if a team did not refer an individual for transition, then an obstacle to a referral should be identified. However, generally, the numbers of obstacles to referrals were much lower than they should have been given the limited numbers of referrals at each of the Facilities. o It appeared facilities had interpreted Table 4 differently. In some instances, data were provided for the list of obstacles for all individuals for whom they had data, regardless of whether the individual's preference was to transition to the community. In other instances, it appeared these data were for the subgroup of individuals who had expressed an interest in transition, but their guardians were reluctant to consider it. Both sets of information were important, but the reports certainly should have included the data on obstacles to referral for all individuals the Facilities supported. • Transitions: Surprisingly, adequate methodologies were not in place to collect data on obstacles to transition. As a result, the validity of the data provided in the report was questionable. • Data: It was concerning that valid and complete data were not available. In addition, the plans included in the facility reports often did not describe specific actions that would be taken to make improvements with the data. For example, for many of the SSLCs, the plan to improve data collection involved retraining QIDPs and IDTs, as well as using a new data system. This was presented in general terms, and it was unclear if it was based on an analysis to determine the underlying causes for teams not properly identifying obstacles to referral and/or transition. • Assessment: The facility-specific reports generally did not provide the "comprehensive assessment" the Settlement Agreement required. They merely stated the data with little to no analysis of the data. Beyond some minimal descriptions of often vague actions the Facilities would take, the reports offered no recommendations to DADS with regard to issues that went beyond the capacity of the facilities to address, and for which DADS' intervention was needed. • DADS initiatives: DADS included a list of initiatives, however, these initiatives did not address many of the obstacles that the Facilities had identified. For example, according to the 2012 Annual Obstacle Report Data spreadsheet, 112 individuals were not referred due to "Behavioral health/psychiatric needs requiring continuous monitoring/intervention," and 100 individuals faced a "Lack of supports for people with significant challenging behaviors." Similarly, 54 individuals were not referred due to "medical issues requiring 24-hour nursing interventions/services," and 92 individuals faced a "Lack of availability of specialized medical supports." Even without full data, it was clear that these	

		two areas required attention. However, beyond general statement about maximizing use of available funding and "Engaging local authorities and private providers in joint discussions on how to enhance provider capacity to meet the characteristics of those individuals transitioning from the SSLCs to community placement settings," the report provided no indication of the specific steps, if any, the State was taking "to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs…" • Assistance: In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). The LSSLC-specific portion of this report identified problems in accurate data regarding obstacles to referral and transition. It also identified LAR preference as a factor for more than 25% of the individuals (the data presented by the APC in T1a was incorrect). It identified the need for individual-specific educational plans (as also noted in T1b2). The APC made an interesting finding that the high turnover in QIDPs at LSSLC contributed to problems in accurate data and problems in individuals and LARs receiving thorough information about community options. She planned to work on this. The monitoring team recommends that she also draw upon the facilities social workers for this activity. Further, in the APC's summary data for 170 individuals (November 2012 to April 2013), very few individuals were reported to not be referred due to behavioral/psychiatric problems (only 1) or complex medical needs (only 5). This indicated that IDTs were making referrals based upon the appropriateness of the individual for referral and allowing the APC, transition specialists, and IDT to work out subsequent obstacles to transition (e.g., finding a competent provider). The LSSLC-specific portion of this report should also clearly differentiate issues related to referral for placement from issues related to transitioning to the community after being referred.	
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	The monitoring team was given a document titled "Community Placement Report." It was dated for the (more than) six-month period, 11/6/12 through 7/15/13. 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

	appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
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	LSSLC maintained substantial compliance with this provision item. Since the last review, 36 post move monitorings for 18 individuals were completed (including the post move monitoring observed by the monitoring team). This compared with 22 post move monitorings for 10 individuals, and 28 post move monitorings for 15 individuals at the time of previous onsite reviews. The monitoring team was given documentation for 33 of the 36 post move monitorings (92%) for 17 of the 18 individuals (94%). Individual #473's 3 post move monitorings were not submitted. Of the 33 post move monitorings, 33 (100%) were completed by the PMM, Mary Ramsey. The monitoring team reviewed 26 of the 33 (79%) post move monitoring reports for 17 different individuals. This included the completed documentation for the post move monitoring observed by the monitoring team.	Substantial Compliance

	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.	Timeliness of Visits: For the 18 individuals, 36 reviews should have been completed since the previous review. Based upon a chart presented to the monitoring team, of the 36 required visits, 36 (100%) were conducted and 36 (100%) were completed on time. Of the 26 post move monitoring forms reviewed by the monitoring team, all 26 (100%) included dates showing that they were completed on time. Locations visited: For the 26 post move monitorings reviewed, 26 (100%) indicated that the PMM visited the locations at which the individual lived and worked/day activity (e.g., day program, employment, public school) were visited. Content of Review Tool: 26 (100%) of the post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement. 10 of the 26 were completed using the newest iteration of the post move monitoring form. Below, the monitoring team provides five comments regarding this form. These comments have also been provided in other monitoring reports: 1. There was no explicit indication of what locations were visited by the PMM. The helpful hints document stated that all locations must be visited, but there was no requirement to report this. o The LSSLC PMM, however, clearly indicated all of the sites she visited on each of these 10 new forms. 2. The monitoring team could not determine what evidence the PMM was to look for, and what evidence the PMM examined "to assess whether supports called for in the CLDP are in place." a. The monitoring team recommends that the post move monitoring form include these three pieces of information for each pre- and post-move support: (a) what evidence was to be reviewed, (b) what evidence was reviewed, and (c) the due date. b. Examples of evidence to be reviewed are direct observation, staff interview, provider documentation, and daily checklists completed by the provider. The PMM should then specifically indicate what he or she observed and reviewed, and whom he or she interviewed. o The PMM, however, clearly indicated, in great detail, all of the evidence she looked at, on each of these 10 new forms. 3. The monitoring team agrees with the helpful hints guidance for question 5, that is, when examining staff training, to not limit this to documentation. The monitoring team, therefore, recommends that question 5 be expanded to indicate that interview or observation of staff showed that staff were trained and knowledgeable.	

		o The LSSLC PMM, however, clearly indicated the results of her observations and interviews/discussions with staff on each of these 10 new forms. 4. The helpful hints document required a narrative about direct observation of the individual. This was done in one of the two. The monitoring team agrees with the helpful hints item for question 11 that requires a short comment be written regarding individual and LAR satisfaction, and the PMM's overall opinion about the community home and day site. o The LSSLC PMM, however, provided comments regarding these aspects on each of these 10 new forms. o Moreover, the PMM "filled out" the helpful hints document as if it were a form to be completed and she attached it to the post move monitoring form for 6 of the 10 new forms. 5. In the helpful hints document, the list of negative outcomes is not an all-inclusive list. It would be helpful to indicate that these are potential negative outcomes and others that might be identified should be reported and addressed. The post move monitoring report forms were completed correctly and thoroughly, as follows: • The checklist was completed in a cumulative format across successive visits for all 10 (100%) of the individuals who had more than just the 7-day review. • Supports were verified, such as by indication of the evidence examined and the results of this examination, in 26 of the 26 (100%). • There was adequate justification for findings for each support in 26 of the 26 (100%). • Detail/comment was included in 26 of the 26 (100%). Almost every support received some narrative comments. • LAR/family satisfaction with the placement (question #9) and the individual's satisfaction (question #11) were explicitly stated in the comments section in 26 of the 26 reviews (100%), taking into account that some individuals did not have LAR or family involvement. • An overall summary statement of the post move monitor's general opinion of the residential and day/employment placements could easily be determined from the narrative comments provided by the PMM and/or was specifically indicated at the end of the report in 26 of the 26 (100%). The monitoring team recommends that the PMM include the names of provider staff who were interviewed to help the reader understand which staff were interviewed during the post move monitoring. This was done in 21 of the 26 (81%).	

		General status of individuals Based upon the monitoring team's review, of the 17 individuals who received post move monitoring, 15 (86%) transitioned very well and appeared to be having good lives. The other individuals continued to exhibit problems or problems continued with their placements, providers, and/or supports (Individual #177, Individual #420). As discussed with the APC, a root cause type of review needs to be done of any individuals whose placements failed or who had the kinds of problems noted in T1a. Use of Facility's best efforts when there are problems that can't be solved: In 11 of the 26 (42%) post move monitorings, additional follow-up, assertive action, and activities were required of the post move monitor. These were for 9 of the 17 individuals (53%). Examples of problems included a missing items (Wii, shower chair), lack of activities at home and/or day program, improper pureed diet, and medical concerns. There was appropriate follow-up and correction for 11 of the 11 (100%) visits for 9 of the 9 individuals (100%). Post 90-day follow-up was done by the PMM for 3 of the 17 individuals. ISPA meetings after post move monitoring visits: An ISPA meeting should occur after every post move monitoring during which a problem or concern was noted by the PMM. An ISPA meeting was held and there were minutes/documentation of the meeting following 100% of post move monitorings for which an ISPA was appropriate to have been held.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	The monitoring team observed one post move monitoring at the home of Individual #431. The PMM, Mary Ramsey, did a thorough and complete job post move monitoring. This was based on observation of the PMM's: • Examination and verification of every support • Review of documents • Direct observation of the individual and staff • Staff interview • Individual Interview (as much as possible) • Gathering of information by directly observing/examining, not only by provider staff report • Professional interaction style • No use of leading questions • Assertive and tenacious in obtaining information The provider was Innovative Homes. It was an adequate placement for the individual; he appeared to be happy and was engaged in activities with the home staff.	Substantial Compliance

T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations	This item does not receive a rating.	
T4	**Alternate Discharges –**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible	The APC reported that 1 individual was discharged as per provision T4. <u>Compliance with CMS-required Discharge Planning Procedures</u>: Based on a review of the discharge summaries completed for this 1 individual, all (100%) contained the all of the information consistent with the Centers for Medicare and Medicaid Services (CMS) requirements as follows below. The individual was found to no longer be eligible for services and was transferred to San Antonio State Hospital. Documentation indicated that for this 1 individual, there was: • Documentation in the individual's record that the individual was transferred or discharged for good cause. • Reasonable time to prepare the individual and his or her parents or guardian for the transfer or discharge (except in emergencies). • A final summary of the individual's developmental, behavioral, social, health and nutritional status. • With the consent of the individual, parents (if the client is a minor) or legal guardian, a copy provided to authorized persons and agencies. • A post-discharge plan of care that will assist the individual to adjust to the new living environment.	Substantial Compliance

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o LSSLC Giving and Withdrawing Informed Consent Training Curriculum o List of individuals for whom an LAR has been obtained since the last review o Prioritized list of individuals without guardians who also lack functional capacity to render a decision regarding health or welfare o LSSLC Self-Assessment and Provision Action Information for section U o ISPs for: • Individual #502, Individual #151, Individual #522, Individual #369, Individual #110, Individual #306, Individual #235, Individual #238, Individual #145, Individual #258, and Individual #301. o LSSLC Section U Presentation Book o A Sample of HRC Minutes 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 QIDPs in homes and day programs o Luz Carver, QIDP Coordinator o Royce Garrett, Consumer and Family Relations Director o Steven Webb, Human Rights Officer Observations Conducted: o Observations at residences and day programs o ISP preparation meeting for Individual #116 and Individual #185 o Annual IDT Meeting for Individual #192 and Individual #207 o Self-Advocacy Meeting
	Facility Self-Assessment: LSSLC submitted its self-assessment. 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. Activities engaged in to conduct the self-assessment for U1 and U2 included: 1. Reviewed the priority list for guardianship to ensure it was updated at least semi-annually. 2. Reviewed a sample of ISPs to determine if the ISP included discussion of the individual's ability to render a decision.

	3. Reviewed completed section U monitoring tools. The facility self-rated U1 and U2 as not in compliance. Based on the finding of the self-assessment, the Consumer and Family Relations Director noted that progress was underway, but this provision was not in substantial compliance. Findings from the facility self-assessment were similar to findings of the monitoring team for the two provisions of section U. The monitoring team agreed with the facility's compliance ratings for U1 and U2.
	Summary of Monitor's Assessment: The facility had not yet developed an adequate assessment process for determining the need for guardianship. IDTs were not holding adequate discussion at the annual IDT meeting to determine if individuals had the ability to make decisions and give informed consent. This assessment process will need to be fully implemented for compliance with U1. Then U2 will be the next step, which is procuring guardians for individuals assessed as high priority. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. The facility had not developed a priority list of individuals needing an LAR based on an adequate assessment process. IDTs continued 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. A priority list of those in need of a guardian had been developed, and the facility was moving 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	On 3/7/12, DADS State Office issued Policy #019: Guardianship. A second policy on consent remained in the development phase. The state is encouraged to finalize this policy because it should assist the facilities in moving forward with regard to the implementation of the Section U Settlement Agreement requirements. Steps taken to address compliance with the requirements of section U included: • The Consumer and Family Relations Director continued to provide information to community groups regarding the need for advocates and guardians. • Guardianship was obtained for four individuals at the facility. • Reminders were sent to guardians to renew paperwork when guardianship had expired. • The human rights officer worked with individuals and their IDTs to ensure protection of rights at the facility. He was actively involved at the facility and	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	served as a resource to IDTs. The facility did not have a tool to assess capacity to give informed consent. The Consumer and Family Relations Director was searching for a tool while waiting for the state office to offer further direction in moving forward with compliance. A sample of ISPs and relevant assessments was reviewed to determine the adequacy of IDT discussion regarding individuals' ability to express their own wishes or make determinations regarding their health or welfare. None of the ISPs in the sample documented adequate discussion regarding decision making skills, the need for training, or the need for guardianship. None included an adequate discussion of the individual's ability to express his or her own wishes or make determinations regarding his or her own health or welfare and the need for guardianship. For example, • The ISP for Individual #151 did not document discussion regarding her ability to make informed decisions. It was noted that she was an adult without guardian. Her team did decide that she could benefit from an advocate. • The ISP for Individual #145 indicated that guardianship information was shared with her family, but the family declined to seek guardianship at this time. There was no discussion regarding her ability to give informed consent or need to further pursue guardianship. • The ISP for Individual #502 did indicate that the team had determined that she was not able to give informed consent. It further noted that the family had been provided with guardianship information. There was no further discussion regarding obtaining guardianship. The facility continued to maintain a prioritized list of individuals lacking both functional capacity to render a decision and a LAR to render such a decision. The list was not based on an adequate assessment process. Progress had not been made towards meeting compliance with this provision. IDTs were not holding thorough discussions regarding the need for guardianship and ability to make decisions and give informed consent. 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	New guardianship had been obtained for four individuals at the facility. The Consumer and Family Relations Director was working with many current guardians to renew guardianship on an annual basis. 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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 offer self-advocacy opportunities for individuals at the facility, through the self-advocacy group at the facility. There was a Human Rights Committee (HRC) at the facility that met to review all emergency restraints or restrictions, all behavior support plans and safety plans, and any other restriction of rights for individuals at LLSLC. The facility had not made progress in this area. Compliance with U2 will be contingent on the development of an adequate assessment process. It will be important for the human rights officer to continue to work with IDTs to ensure assessments are completed and teams engage in an adequate discussion of each individual's needs.	

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o LSSLC recordkeeping-related policies: • Recordkeeping Practices, Adm-15, updated 6/4/13 • Management of Protected Health Information, Adm-3, updated 2/1/13 o LSSLC organizational chart, undated, probably June 2013 o LSSLC policy lists, undated, probably June 2013 o List of typical meetings that occurred at LSSLC, undated but likely June 2013 o LSSLC Self-Assessment, 6/27/13 o LSSLC Action Plans, 6/21/13 o LSSLC Provision Action Information, most recent entries 5/31/13 o LSSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 7/8/13 o List of all staff responsible for management of unified records o Caseload for the fifth/floater record clerk o Description of how documents are filed, 5/17/13 o List of other binders or books used by staff to record data (none) o Tables of contents for the active records (updated 5/31/13, with additional asterisks added 7/10/13), individual notebooks (updated 5/31/13), and master records (updated 11/16/12) o Packet of documents showing how the recordkeeping staff addressed the 5 V1 recommendations from the prior monitoring report o Daily paperwork checklist used in home 549C o Five-page spreadsheet that showed the status of state and facility policies for each provision of the Settlement Agreement, along with some information and data regarding training, undated, probably June 2013 o List of individuals whose unified record was audited by the record clerks, January 2013 to May 2013 o Blank unified record audit tool, 28 pages, 4/23/13 o For 10 individuals for April 2013 through May 2013: • Completed unified record audit tools for • List of errors and corrections needed • Emails from URC requesting corrections be made for all 10 individuals • One V4 interview of an IDT member for each of the 10 individuals o Packet of documents showing how the recordkeeping staff addressed the 4 V3 recommendations from the prior monitoring report o Set of graphed data on recordkeeping data (bar and line), January 2013 through June 2013

	o Database printouts of recordkeeping audit findings o Presentation of section V for QA report and QAQI Council (none) o 2 packets of documents showing how LSSLC attempted to address all six components of section V4 o Active records and/or individual notebooks of: • Individual #572, Individual #392, Individual #190, Individual #463, Individual #45, Individual #152, Individual #437, Individual #126, Individual #199, Individual #9, Individual #527, Individual #227, Individual #261 o Master records of: • Individual #547, Individual #594, Individual #167 <u>Interviews and Meetings Held</u>: o Stormy Tullos and Terri Fatheree, Unified Records Coordinators o Paula McHenry, Director of Quality Assurance; Darla Runnels, Data Analyst; Shela Gibson, Program Compliance Monitor; Georgette Brown, visiting new QA director from Richmond SSLC o Various staff, including Courtney Abercrombie, DSP III; Stephanie Randolph, DSP II; and Mary Herrington, RN <u>Observations Conducted</u>: o Records storage areas in residences o Master records storage area o CLDP, ISP, and pre-ISP meetings; clinic meetings
	Facility Self-Assessment The content and procedures of the self-assessment were much improved since the last review. The content was in line with the monitoring team's report. The V3 audits are essentially the self-assessment for V1. The data from those should be included in the self-assessment, separated by the three components of the unified record. In addition, the other aspects commented upon by the monitoring team in V1 should be included. For V2, self-assessment of the training information should be added. V3 should be a self-assessment of the quality review audit process, including, as reported upon by the monitoring, the frequency, quality, and reliability of the process, as well as the analysis of data/findings and implementation of any actions as a result. For V4, self-assessment for each of the six components should be included. The URCs had done some, but not all of this. The monitoring team agreed with the facility's self-ratings of V2, V3, and V4 being in noncompliance, but found V1 to be in substantial compliance.

	Summary of Monitor's Assessment: LSSLC again made good progress on all four of the items of provision V. The URCs, QA director, and the record clerks took very seriously the comments, suggestions, and recommendations in the previous monitoring report. Sixteen of 16 (100%) individuals' records reviewed included an active record, individual notebook, and master record. The active records continued to improve. For each record, more than 90% of required documents were present, current, and substantially in compliance with the requirements of appendix D of the Settlement Agreement. Individual notebooks continued to be used for all individuals. Staff were very aware of the individual notebooks and reported that they were available and useful. A master record in the new format existed for every individual. The master records now contained a note in the table of contents to describe the status of any missing document. Five reviews (audits) were conducted in each of the previous six months, for a total of 30. They were done in a consistent manner and were neatly and clearly documented. A new audit tool was developed at LSSLC. The record clerks continued to conduct the audits. The facility had a good system of conducting the audits, follow-up, and documentation of the findings. Consistency across record clerks remained a problem that questioned both the validity and reliability of the findings of the audits. For V4, the URCs had done a tremendous amount of work to address all six components. They documented how each was being addressed.

#	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 again continued to make good progress on all four of the items of provision V. This was due to the hard work of the unified record coordinators (URC) Stormy Tullos and Terri Fatheree, and the group of competent unit record clerks. Moreover, recordkeeping activities were being overseen by the new QA director. Also again, the URCs, QA director, and the record clerks took very seriously the comments, suggestions, and recommendations in the previous monitoring report. Regularly occurring meetings occurred with the URCs and record clerks. State policy and facility-specific policies remained the same as in previous reviews, though there were some minor updates to both policies that were in response to comments in the previous monitoring report. The Adm-15 policy now called for IPN entries to be done by hand, but if typed, they needed to be immediately put into the IPNs.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The table of contents and maintenance guidelines were updated in May 2013 for the active record and individual notebook. The master record table of contents and guidelines was updated in November 2012. The changes were statewide. LSSLC made some facility-specific modifications, following state procedure when doing so. The facility re-instated requiring record clerks to work late in the evening on the last night of the month, in order to work directly with the overnight staff to ensure proper transfer of documents from the individual notebook to the active record and the setting up of the new month's individual notebook contents. This likely played a positive role in helping the facility move forward towards substantial compliance with this provision. The QA department was engaged in responding to a number of recordkeeping-related DADS regulatory findings. The URCs were not aware of this activity or the specific contents of the findings. The QA department should make sure it works with the URCs when addressing anything related to recordkeeping practices. Sixteen of 16 (100%) individuals' records reviewed included an active record, individual notebook, and master record. <u>Active records</u> The active records continued to improve. The monitoring team reviewed active records in four of the four units at LSSLC. The monitoring team spoke with a number of staff about their experience with the active records. All reported that the active records were manageable and that it was easy to find documents when needed. Sometimes, however, the active records were not signed out properly and could not be located. This was not reported as a major problem by any staff because the active records were eventually located. Mary Herrington, an RN in Woodland Crossing reported that IPNs were easy to get to, make entries, and read. The URCs successfully addressed the comments, suggestions, and recommendations in the previous monitoring report, including: • Making all staff at the facility aware (via an email and then following-up) of the recordkeeping department and that they were available to assist, train, etc. • Inservices by home managers regarding missing data in SAP data sheets • Adding a tab for injury reports that were placed behind the observation notes • Using a list of whether a Reiss screen was supposed to be in the record • Asterisking those items in the table of contents/guidelines for which an asterisk was appropriate (e.g., HRC referral, rights, PNMT/PNMP). • Dr. Carlin, MD, and Tammy Nelson, LVN, conducted an inservice with physicians	

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		regarding legibility of IPN and physician orders entries, and provided a handbook about documentation. • However, improvements in nursing entries were still needed, as described in section M1 of this report. Moreover, the improvements noted in the last two reports maintained. The monitoring team's review of active records showed that for each record, more than 90% of required documents were present, current, and substantially in compliance with the requirements of appendix D of the Settlement Agreement. The URC's quality assurance audits described in section V3 had similar findings. The most significant problem was missing documents, approximately 5 per review across the 30 audits conducted over the past six months. Missing recent quarterly ISP reviews were the most frequently cited missing document, as also found by the monitoring team's own reviews. <u>Individual notebooks</u> Individual notebooks continued to be used for all individuals and as per state policies. The URCs successfully addressed a problem in previous reviews by now having the QIDP send two copies of the ISP to the record clerks, so that one would be placed in the active record and one in the individual notebook. Staff were very aware of the individual notebooks and reported that they were available and useful, not too large, and better than the system they had a few years ago in which data sheets and documents for numerous individuals were kept in a single binder. In home 563B, Stephanie Randolph, DSP II, made sure she had an individual's individual notebook when she went with him to the dining room. She told the monitoring team that individual notebooks always travel with them. In home 549C, Courtney Abercrombie, DSP III, created a daily paperwork checklist for new staff to help ensure they understood and correctly recorded all that needed to be recorded in the individual notebook. This is something that was only occurring in this home. It might be shared with the URCs and then possibly with other homes. It is possible that other homes may have developed their own unique recordkeeping practices trainings and management systems that would be of interest to the URCs, QA department, and facility. 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. <u>Other binders/logs</u>: The facility reported that there were no other binders or logs used to record data regarding the individuals.	

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		Master records A master record existed for every individual at LSSLC. All master records had been converted over to the newest format since the last review. The URCs successfully addressed the issue raised in previous monitoring reports. That is, they now added a note in the comment section of each master record to describe the status of any missing document, what they (and the IDT) were doing to obtain the missing document, and if the document could not be obtained (so that future audits would not use valuable time to repeat a document search). Shared drive The shared drive was described to the monitoring team. The recordkeeping department reported that all information in the shared drive also appeared in hard copy in the active record and/or individual notebook. Overflow files Overflow files were managed in the same satisfactory manner as during the previous onsite review.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	LSSLC now had a well organized spreadsheet to address this provision and to track and present progress. This was a nice improvement from the previous review. It was developed and managed by the CTD department director. It was five pages long, but three of the pages were for nursing policies. The QA director should explore this to find out if there were more policies than necessary on this list and/or if there were policies missing from other departments. Not all state policies were in place yet, though continued progress was evident. Only provisions G, H, and S did not have a state policy (though the spreadsheet incorrectly indicated that there was a section G policy). The spreadsheet contained four columns related to training: who provides training, what staff are required to receive training, how often training was to occur for each staff member (e.g., annually, once during employment), and the number of staff who received training. Two more columns are needed: one to state how many staff were required to receive the training, and the percentage calculation. The monitoring team recommends that spreadsheet include an "as of" date for each policy, so that the reader knows that the training data were valid/correct as of a certain date.	Noncompliance

#	Provision	Assessment of Status	Compliance
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 occurred for this provision item. Five reviews (audits) were conducted in each of the previous six months, for a total of 30. All of the reviews were done in a consistent manner and were neatly and clearly documented. The database of medical consultations continued to be used to assist the URC in conducting these reviews. The review consisted of four parts: • Completion of the new unified record audit tool (active record, individual notebook, master record) • A listing of all needed corrections • Emails to those responsible for making corrections • V4 interview of one IDT member The new audit tool replaced the previous use of two tools (the statewide self-monitoring tool and the table of contents tool). It was developed at LSSLC by the URCs with the support of the data analyst and the QA director. It not only audited the presence, it also assessed legibility, completeness, timeliness, and so forth. This was good to see. The record clerks continued to conduct the audits, as described in some detail in the previous report. There were five record clerks, each one conducted a unified record audit. The system of conducting the audit, listing all errors, emailing to the responsible person, following up on each error (with checks for corrections at one week, one month, and two months), and documenting the V4 interview continued in the same manner as described in some detail in the previous monitoring report. This was a very good system that was easy to understand. The URCs and data analyst reported that a new database had been created, but was still in the early stages, thus, not much was available for review by the monitoring team. Inter-rater agreement reliability checks were reported to have only recently begun (4/1/13). QA program compliance monitors were supposed to be doing two each month. Data were not yet available. Consistency across record clerks (i.e., inter-rater agreement reliability) was an issue raised in the previous report. The URCs said that it remained a problem. The monitoring team's review of the 10 audits submitted by the URCs also indicated that this continued to be a problem that questioned both the validity and reliability of the findings of the audits. Inter-rater agreement activities and perhaps training and discussion across clerks may be necessary. Below are the number of errors found by each clerk in each of	Noncompliance

#	Provision	Assessment of Status	Compliance
		the two audits reviewed by the monitoring team (April 2013 and May 2013). Clerk 1: 67, 25 Clerk 2: 4, 12 Clerk 3: 7, 5 Clerk 4: 7, 3 Clerk 5: 0, 1 Following the onsite review, the URCs reported that there was good agreement between the record clerks and the QA staff, however, no data were reported. Also, to somewhat repeat from the previous monitoring report: The monitoring team spoke with the URCs 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, that by doing an occasional audit, they would be even more likely to provide support to clerks, improvements to the audit system, and general knowledge of the unified record. The URCs said that they were going to begin participating in doing reliability audits in September 2013. The URCs and data analyst created a good set of graphs that adequately showed trending regarding the important data for their recordkeeping practices. Data points were graphed since January 2013: • Number of audits completed each month • Number of errors identified each month • Number of corrections made each month • Number of errors not corrected (the inverse of the above graph) each month • The total number of different types of errors (e.g., misfiled, missing, thinning) total since January 2013. • Complete, follow-up required, no correction possible, since January 2013. The monitoring team suggested that a time period be applied to the third and fourth graphs, that is, so that each reflected the number of errors corrected/not corrected by the end of the month in which the audit was conducted. Data were available on the audit forms reflecting corrections after one week, one month, and two months. The monitoring team did not understand what the sixth graph was portraying and how the data related to any of the other data graphs. This should be addressed. The monitoring team and the URCs and data analyst talked about whether a bar graph or a line graph would be better. The decision is up to the URCs and data analyst. Their criterion should be what is easiest for the reader to understand. In the monitoring team's opinion, a line graph with bigger data point icons would be best for showing	

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		trending, but again, the choice is up to these staff to make. Given that there are often very positive findings, the record clerks should provide praise to the responsible staff, too. The URCs should be sure to analyze (and explain) their graphs. This was not yet occurring and is an important part of a QA process. Even so, the URCs, over the past couple of years, have never hesitated to make changes to continually improve recordkeeping practices at LSSLC. All of these graphs should be included in the facility's QA program, QA report, and QAQI Council presentations. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Assess and obtain inter-rater agreement for the unified record audits. 2. Conduct an analysis of the recordkeeping department's data.	
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.	In previous monitoring reports and during previous onsite reviews, the monitoring team detailed the six types of activities that the facility was expected to engage in to demonstrate substantial compliance with provision item V4. The monitoring team reviewed all six with the URCs. They had done a tremendous amount of work to address all six components, and to document that these were being addressed, for their own review and for the monitoring team's review. The facility was in substantial compliance with three of the six items. Below, the six areas of this provision item are presented, with some comments regarding LSSLC's status on each. <u>1. Records are accessible to staff, clinicians, and others</u> The monitoring team observed that: • Active records were maintained in the home areas to which clinicians had access. • Direct support staff reported that the individual notebooks were easy to use and readily accessible. • A sample of plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. Both a current ISP and IHCP were available in 100% individual notebooks in the sample. • All volumes of active records for Individual #588 and Individual #517 were	Noncompliance

#	Provision	Assessment of Status	Compliance
		readily accessible and followed the facility's table of contents. • Clerks, during audits, now noted if that individual's active record and individual notebook were available and accessible. They noted how they made this determination, such as by talking with DSPs and nursing staff. It was entered into the audit tool. • The records were available to the physicians. Consideration should be given regarding ways to provide better access, such as a re-structuring of sick call to a clinic format where individuals would be seen and records made available. • The records were available to the clinicians (OT, PT, SLP). • Records were accessible to the psychiatrist during clinic. • This component of V4 was in substantial compliance. <u>2. Data are filed in the record timely and accurately</u> LSSLC was 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 could be used to satisfy this requirement, too. That is, the URCs should pull the data from the audits regarding documents in the active record being up to date. The monitoring team observed that: • Inservice was held with record clerks to talk about ensuring documents were filed in a timely manner. • Record clerks, in the late evening of the last day of each calendar month, worked directly with the overnight staff to transfer documents to the active record and to get the individual notebook set up for the new month. • Monitoring found omissions of injury reports on 7/9/13 for Individual #588 and Individual #517. • Some seizure records were incomplete. • The recordkeeping department had begun gathering data on the submission of documents for the active records. A list provided by facility reported that 57 of 173 (33%) of ISPs were filed more than 30 days after the annual ISP was held. <u>3. Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)</u> The monitoring team observed that: • QIDP monthly reviews indicated that data on progress towards ISP outcomes was often unavailable at the time of review. • Legibility of some medical entries would make it difficult to appropriately utilize the records. • Medical providers also provided inadequate information and did not adhere with the guidelines for documenting positive and negative findings. The exception to this was the APRN. • There were omissions in documentation on the client care flow tracking record,	

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		which records information about the individual's activities of daily living, intake of meals, provision of fluids, sleep, and bowel management. • In looking at whether behavior data were recorded in a timely manner, 56% of data sheets reviewed had timely data. This should be improved upon. • Inservices were conducted for DSPs by home managers regarding not having missing data boxes on SAP data sheets. Documentation was provided for approximately 300 staff attended training. • Data sheets were not typically utilized for direct therapy, and many of the IPNs written were not data driven to reflect progress as a result of interventions. <u>4. IPNs indicate the use of the record in making these decisions (not only that there are entries made)</u> Clerks now noted in each audit that they read the IPNs and made a determination based on there being references to assessments, reports, and/or other clinicians' entries. Specific criteria, however, should be determined for this and then the findings summarized and reported for this item of V4. • The facility now highly encouraged hand written IPNs, but allowed typed as long as they were immediately entered into the IPNs in the active record. • Observation and document review indicated regular psychiatrist use of the record. • Although nursing reported that the active record was used in making care, treatment, and training decisions, most all entries were driven from a complaint by the individual or from a person supporting the individual. The entry focused on the event or complaint, and rarely the entry contained historical data of prior assessments. • URCs did much work with the habilitation department regarding documentation in the IPNs. • Most of the habilitation therapy IPNs were handwritten and completed at the time of the contact. There were no IPNs identified as written by the PNMT related to assessment, actions, or follow-up. <u>5. Staff surveyed/asked indicate how the unified record is used as per this provision item</u> The 13 V4 interviews reviewed by the monitoring team (i.e., 10 attached to each of the 10 audits reviewed in V3 plus 3 additional) were across a variety of staff groups (e.g., DSPs, nurses, QIDPs, PNMPC, psychologists). Their responses indicated that they were very aware of the active record and that they had examples of how they used the unified record and the specific parts of the unified record that they used. In addition, • During random medication observations, clinical rounds, and interviews, the monitoring team asked RN and LVN staff how they used the individuals' record to assess, plan, implement and evaluate care. The nurses reported they review	

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		the individuals' medication administration record, physician orders, diagnostic testing, consults, functional assessments, laboratory data, and Integrated Progress notes, for problem oriented health concerns, and for quarterly and annual nursing assessments. • Psychiatry clinic staff were noted to utilize a variety of information from the active record with regard to making treatment decisions (e.g., psychology evaluations, data graphs, MOSES/DISCUS, nursing information, other data). • This component of V4 was in substantial compliance. <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 intent of this item is for the record to be present and available, and that it is used when, and if, needed, such as if there is a question about data, diagnoses, incidents, etc. Many times, there is no need to open the record because IDT members do not need to access additional information. In other words, it is possible to satisfactorily meet this component if the record is present, not used, and no examples of it failing to be used when it should have been used. The monitoring team found the following: • Records were present and used when needed at ISPs, ISPAs, PNMT meeting, quarterly reviews, at risk meeting, and quarterly psychiatric reviews. • The QIDP provided IDT members with a draft ISP and IHCP at the annual ISP meetings for Individual #192 and Individual #207. Data from assessments were entered into these two forms, so that team members could reference current assessments when developing necessary supports. The unified record was available at the meeting and was used by the team when additional information was needed. • QIDPs now indicated on the ISP signature sheet if the active record was available at the ISP meeting. • Pre-ISP meetings were observed for Individual #116 and Individual #185. The QIDP used information in the unified record to update IDT members to determine which assessments were needed prior to the annual meeting and to review progress towards outcomes. • The active record and individual notebook for Individual #67 were present during her ISP. The records were not used during the meeting, however, there did not appear to be any time during the meeting when the record was needed. • During observation of Individual #437 in the residence, the active record was located and utilized during an acute care event to review historical data, make decisions about care and treatment, and ensure sufficient health information was provided to outside receiving health entities.	

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		• The active record was used during psychiatry clinics. • The active records were not available during the PNMT and some other meetings observed for reference or documentation as required. • This component of V4 was in substantial compliance. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: • Report on the timely filing of documents. • Determine criteria for IPNs indicating use of the record to make decisions.	

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
CMQI	Continuous Medical Quality Improvement

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
DBW	Desirable Body Weight
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
EC	Environmental Control
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
EOC	Environment of Care
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
GIB	Gastrointestinal Bleed
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)
IA	Intelligent Alert
IAR	Integrated Active Record

IC	Infection Control
ICA	Intense Case Analysis
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
ICN	Infection Control Nurse
ICO	Infection Control Officer
ICP	Infection Control Preventionist
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
LLL	Left Lower Lobe
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
MCER	Minimum Common Elements Report
MCG	Microgram
MCP	Medical Care Plan
MCP	Medical Care Provider
MCV	Mean Corpuscular Volume
MD	Major Depression
MD	Medical Doctor
MDD	Major Depressive Disorder
MDRO	Multi-Drug Resistant Organism
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
NFS	Non Foundational Skills
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
OH	Oral Hygiene

OHI	Oral Hygiene Index
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
PECS	Picture Exchange Communication System
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
PNE	Pneumonia

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)
POC	Polypharmacy Overview Committee
POI	Plan of Improvement
POT	Post Operative Treatment
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
PUSH	Pressure Ulcer Scale for Healing
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
QIDP	Qualified Intellectual Disabilities Professional
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
RLL	Right Lower Lobe
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
SBO	Small Bowel Obstruction
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
SOP	Standard Operating Procedure
SOTP	Sex Offender Treatment Program

S/P	Status Post
SPCI	Safety Plan for Crisis Intervention
SPD	Sensory Processing Disorder
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
TFT	Thyroid Function Tests
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
UR	Unified Record
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
VAP	Vascular Access Port
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